STATEMENT OF DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 95005	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF THE PALM BEACHES,THI	**301 NORTHPOINTE PARKWAY WEST PALM BEACH, FL**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
N 071	59A-4.109(1), FAC Components of Care Plan

(1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of:
(a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.
(b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission.
(c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be:
1. Reviewed no less than once every 3 months;
2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and,
3. Revised as appropriate to assure the continued accuracy of the assessment.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to accurately document the discharge status of 1 of 3 sampled residents reviewed as closed records, Resident #100.

The findings included:

Record review documented Resident #100 was admitted to the facility on and discharged home on . Resident #100's diagnoses upon admission included: , , , , , , in region, wasting and atrophy, Abnormalities of gait and mobility, , and , , .

Review of Resident #100's care plan for discharge, dated , documented, "The resident wishes / or Responsible Party wishes to: return home."

The goal of the care plan was documented as, "Safely discharge to a lower level of care (Home, Home with Home Health Aide, Assisted Living Facility, Independent Living Facility, other) when rehab goals are met."

Reivew of a progress note, dated , documented, "Resident discharge from [name of facility] to home at 300 pm, VIA PRIVATE CAR accompanied, 2-persons food / medication administered as ordered before leaving the facility one of the staff accompanied resident to the lobby skin warm / intact / dry, sound clear no [ ] or distress noted, vs WNL [vital signs within normal limits]. Discharge instruction reviewed with resident voice understood the explanation; med list / medication provided, follow-up with MD [medical doctor] within days post discharge."

Review of a Social Services progress note, dated , documented, "Discharge Summary note. Res [resident] is A&Ox3 [alert and oriented times three], independent with decision making, requested to speak with this writer yesterday as she would like to d/c [discharge] home today. Res informed this writer yesterday

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
N 071	Continued From Page 1

that the hospital was planning to d/c her spouse home today thus she wanted to be at home, plus res feels she can manage safely at home and prefers being at home. DME [durable medical equipment] ordered thru [through] [name of company] DME yesterday."

Review of Resident #100's discharge Minimum Data Set (MDS) assessment, dated , documented Resident #100's discharge status as 'Short-Term General Hospital."

An interview was conducted on at 9:59 AM with the MDS Coordinator, who when asked about Resident #1's discharge status, confirmed that the resident was discharged home. The MDS Coordinator stated that she would update and resubmit the assessment.

Class

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105039	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF THE PALM BEACHES,THE	301 NORTHPOINTE PARKWAY WEST PALM BEACH, FL 33407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint survey, complaint number 2025003926, was conducted on to at The Rehabilitation Center of the Palm Beaches. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint number 2025003926 was not substantiated.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to honor the resident representative's request to ensure, 1 of 3 sampled residents reviewed for Choices, Resident #71, received a shower on the scheduled shower days. The findings included: Record review documented Resident #71 was admitted to the facility on . Review of the quarterly Minimum Data Set (MDS) assessment done on documented Resident #71 had a ( ) score of 3 indicating severe , and the resident is dependent for all care needs. During an observation in the room of Resident # 71, there was a white sheet of paper posted on the bulletin board with the following handwritten message: "please see that she (Resident #71) get a shower on her shower days". Review of the orders shows the resident's shower schedule is every Monday and Thursday on the 3 PM - 11 PM shift. Review of the documentation on the Certified Nursing Assistant (CNA) task list from to showed Resident #71 received 4 bed baths and 3 tub baths on the scheduled shower days. An interview was conducted on at 4:39 PM, Staff C, CNA, who stated she provided a bed	F 561	Preparation and/ or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the alleged or conclusion set forth in the CMS measured star ratings. The plan of correction is prepared and executed solely because it is required by Federal and State Laws. F561 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #71 was provided with a shower as scheduled. Staff C was re-educated to provide and document showers provided on residents' shower days and any additional days that the residents receive a shower. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Facility audit conducted to ensure residents' showers are completed on scheduled shower days and documented appropriately. Other residents found to be affected were corrected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not	

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REHABILITATION CENTER OF THE PALM BEACHES,THE	301 NORTHPOINTE PARKWAY WEST PALM BEACH, FL 33407

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F 561	Continued From page 2 bath to Resident #71. An interview and observation were conducted with Staff D, Licensed Practical Nurse (LPN) in the room of Resident # 71. The LPN stated that the note on the bulletin board was written by the resident's sister who is involved in her care. A side-by-side review of the record and interview on at 10:54 AM with the Director Of Nursing (DON), who confirmed the lack of shower documentation on the task list for Resident #71. She also confirmed the facility does not have a tub.	F 561	recur: Certified Nursing Assistants (C.N.As) have been re-educated regarding Resident Rights/Right of Choices as related to receiving shower on the scheduled shower days. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Random observation will be conducted three times per week /three months to ensure compliance. Director of Nursing/Designee will conduct weekly shower audits times four weeks and will report the findings of the audits to the QAA&C monthly times three months or until substantial compliance is met.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately document the discharge status of 1 of 3 sampled residents reviewed as closed records, Resident #100. The findings included: Record review documented Resident #100 was admitted to the facility on and discharged home on . Resident #100's	F 641	F641 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #100 assessment was corrected by the Clinical reimbursement director and resubmitted. No other residents were	

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F 641	Continued From page 3 diagnoses upon admission included: , , , , , , , , in region, wasting and atrophy, Abnormalities of gait and mobility, , and , , . Review of Resident #100's care plan for discharge, dated , documented, "The resident wishes / or Responsible Party wishes to: return home." The goal of the care plan was documented as, "Safely discharge to a lower level of care (Home, Home with Home Health Aide, Assisted Living Facility, Independent Living Facility, other) when rehab goals are met." Reivew of a progress note, dated , documented, "Resident discharge from [name of facility] to home at 300 pm, VIA PRIVATE CAR accompanied, 2-persons food / medication administered as ordered before leaving the facility one of the staff accompanied resident to the lobby skin warm / intact / dry, sound clear no [ ] or distress noted, vs WNL [vital signs within normal limits]. Discharge instruction reviewed with resident voice understood the explanation; med list / medication provided, follow-up with MD [medical doctor] within days post discharge." Review of a Social Services progress note, dated , documented, "Discharge Summary note. Res [resident] is A&Ox3 [alert and oriented times three], independent with decision making, requested to speak with this writer yesterday as she would like to d/c [discharge] home today. Res informed this writer yesterday that the hospital was planning to d/c her spouse home today thus	F 641	affected by the deficient practice. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Clinical reimbursement director/designee reviewed discharged residents for the last 30 days to ensure accurate documentation for discharge. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Clinical reimbursement director/designee will educate the Clinical Reimbursement , on proper documentation and capturing discharge information accurately including assessment of discharge destination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Clinical reimbursement director/designee will audit discharge care plans and assessments for appropriate discharge status. Audits will be done weekly times for four weeks, Findings to be reported monthly times three months at QAA&C or until substantial compliance is met.	

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F 641	Continued From page 4 she wanted to be at home, plus res feels she can manage safely at home and prefers being at home. DME [durable medical equipment] ordered thru [through] [name of company] DME yesterday." Review of Resident #100's discharge Minimum Data Set (MDS) assessment, dated , documented Resident #100's discharge status as 'Short-Term General Hospital." An interview was conducted on at 9:59 AM with the MDS Coordinator, who when asked about Resident #1's discharge status, confirmed that the resident was discharged home. The MDS Coordinator stated that she would update and resubmit the assessment.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow physician orders for 2 of 6 sampled residents, as evidenced by the , cream for Resident #5 was not applied as ordered, and the , medication was not given as needed for Resident #58; and failed to follow physician orders to	F 684	F684 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	

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F 684	Continued From page 5 obtain a consultation as ordered for 1 of 2 sampled residents reviewed for Resident #63. The findings included: 1. Record review revealed Resident #5 was readmitted to the facility on . Review of the current Minimum Data Sheet (MDS) assessment dated , documented the resident had a ( ) score of 05, on a 0 to 15 scale, indicating severe . Review of a physician order dated instructed the staff to apply an cream to the areas affected with a (skin condition) on the day (7 AM to 3 PM) and evening (3 PM-11 PM) shifts. Review of the care plan dated , documented Resident #5 was at risk for potential or actual of the skin related to itching, with a goal that the resident's skin will be healed with an intervention that the nurse will administer medication as ordered. An observation on at 10:08 AM revealed Resident #5 was scratching her arms and profusely. Further observation revealed Resident#5 had scattered bumpy and reddened areas on her arms, and . An observation on at 3:23 PM in Resident #5's room revealed Resident #5 had her closed, scratching her arms and . During an interview on at 10:08 AM, when asked how she was doing, Resident #5 stated, "I have all these bites." When asked how long she has had the , Resident #5 stated, "I	F 684	1.The was obtained from the vendor and provided the unit on in the afternoon. Resident #5 was provided with the cream as ordered. The Physician for Resident #5 was notified and will continue with treatment plan. Resident #5 had physician and family notified of medication omissions and new orders received for medication administration with no negative outcomes to the patient. Nurse D, Staff F and Unit Manager were re-educated on the process of following physician orders and timely ordering of supplies. Central Supply Clerk re-educated on timely ordering of supplies. 2.Resident #58 medication was given as ordered. Medication review completed by physician and the continued to be as needed Q 8 hours. Order provided to monitor 3 times/day and as needed. Licensed nurses re-educated on documenting the for Resident #58 every eight hours as ordered and PRN. 3. Resident #63's consultation was rescheduled from to per family request. The physician was notified of the change of the consultation date. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: 2.A facility wide audit was completed for current residents to identify any other residents affected by the deficient	

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F 684	Continued From page 6 just came from the hospital, but I had the before." When Resident #5 was asked if the nurse was aware of the , she stated "I think so, I will let them know." When asked if any cream had been applied to the , Resident #5 stated, "No." During an Interview on at 3:25PM, when asked if any treatment was provided to Resident #5, Staff D, Licensed Practical Nurse (LPN), reviewed Resident #5's orders in the computer and stated " (for the skin)." Staff D went into the clean utility room, where the treatment cart was stored. Staff D looked throughout the treatment cart and did not find the . Staff D stated, "I used the last of the cream this morning on the resident and I threw the tube away. I will have to order a new one. She was in the hospital, and she came ." When asked if that was the only treatment that was to be provided to Resident #5, Staff D stated "Yes." During an interview on at 9:15AM, when asked if an cream was ordered for a resident what medication is used, the Unit Manager stated, "It's a stock medication that comes in a tube." When asked to show the cream that was ordered for Resident #5, the Unit Manager looked in the treatment cart and she picked up a jar of and stated, "This is for that resident". When asked if the is the medication that would be used if the order was for an cream the Unit Manager stated, "No. Sometimes the cream comes in small packets. I will go get some from the supply room."	F 684	practice. No other residents were affected by the deficient practice. Current residents Treatment Administration Records have been audited by the Director of Nursing /designee to ensure compliance with following physicians' orders. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: 3. Licensed nurses will be re-educated on the importance of following physician orders related to Quality of Care including customer service, monitoring and follow-up care for those residents with rashes, , medication monitoring, ensuring consultations are scheduled timely. Compliance will be monitored through Audits three times a week, four weeks and weekly thereafter to ensure the practice does not recur. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/designee will conduct treatment observations and consultation audits weekly for four weeks and then monthly for two months to ensure continued compliance. Director of Nursing /Designee will report the findings of the audits to the QAA&C monthly times three months or until substantial compliance is met.	

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F 684	Continued From page 7	F 684		

During an interview on at 9:40 AM, when asked if there was any ˬ cream in stock, Staff F, Central Supply staff, stated, "We are out of it. I'm in the process of ordering it now. When asked how long they had been out of the ˬ cream, Staff F stated, "We've been out since Tuesday." When asked if she meant yesterday on Tuesday, Staff F stated, "No, last week I had two tubes of the cream on the shelf that were expired on Friday, so I threw them out, but I forgot to reorder it at that time. If I order it today, it will come tomorrow."

During an interview on at 10:06 AM, the Unit Manger stated, "I'm trying to figure out which nurse used the last of the ˬ cream for the resident and did not reorder it. I called central supply to see if there was any cream and she said the ones she had were thrown out on Friday because they were expired."

During an interview on at 10:50 AM, when asked how long Resident #5 had the , Staff D, LPN) stated, "She has a off and on. She has seen a dermatologist in the past. I think a few months ago."

During an interview on at 10:56 AM, when ask how Resident #5's skin looked when she provided care, Staff G, Certified Nursing Assistant, stated, "She has a that she has had for a while."

Review of Treatment Administration Record (TAR) for Resident #5 documented that the nurses had signed off on the order for the administration of the ˬ cream, but the medication had not been available.

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F 684	Continued From page 8	F 684		

2. Record review revealed Resident #58 was admitted to the facility on with diagnoses to include essential primary (high). Review of the current MDS assessment dated documented Resident #58 had a score of 15, on a 0 to 15 scale, indicating the resident was . This MDS also documented a current diagnosis of . Review of the current care plan initiated on documented the resident had and staff were to administer medications as ordered and monitor vital signs as ordered.

Review of the current orders revealed Resident #58 was receiving three routine medications. These medications included which was originally ordered at 50 milligrams (mg) daily and increased to 100 mg twice daily on 10 mg three times daily, and 5 mg twice daily was added to the regimen as of . The orders also included for staff to administer 0.1 mg every eight hours as needed for a reading greater than 150. This order did not include any time frame in which staff were to measure the resident's . The only active order for the monitoring of vital signs was to complete a set once during the night shift (11 PM to 7 AM). There was one discontinued order to monitor vital signs every shift for three days only upon return from a brief hospitalization.

During an interview on at 9:56 AM, Resident #58 stated his only concern was that his was running high.

Review of the Medication

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F 684	Continued From page 9	F 684		

Administration Record (MAR) for Resident #58 revealed the following high , with no 'as needed' , administered:
a) On on the night shift, the resident's was
b) On on the night shift, the resident's , was .
c) On on the night shift, the resident's , was .

Further review of the record revealed staff were not documenting the , for Resident #58 every eight hours, or with each shift, in order to know when the 'as needed' , was needed. Review of the , readings from through revealed a lack of three daily , readings every day except on , , , , and .

During an interview on at 3:32 PM, when asked the process for , monitoring, Staff A, Licensed Practical Nurse (LPN), stated she takes the , of her residents on , medications every morning upon arrival and documents them in the electronic medical record (EMR) at the end of her shift. The LPN provided a handwritten paper with documented , for several residents and stated she was getting ready to document the readings from this morning at the time of the interview.

Further review of the MAR and , readings for Resident #58 on , revealed Staff A, LPN had cared for the resident on , , , , , and , but only documented his , on and .

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	105039	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF THE PALM BEACHES,THE	301 NORTHPOINTE PARKWAY WEST PALM BEACH, FL 33407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 During an interview on at approximately 4:15 PM, when asked the process for , monitoring, Staff B, Registered Nurse (RN), stated she takes the , for her residents who are on , medications at the beginning of the shift. When asked about documentation, the RN stated she might document them in the vital sign section of the EMR, or she may just document, "OK to give" in the electronic MAR. When asked specifically about Resident #58, the RN stated she had just taken his , , and it was . The RN volunteered, "I told him to hang loose for a bit and I'd bring his meds." Further review of the MAR and , readings lacked any documented , reading of for Resident #58 on . During an interview on at 9:51 AM, when asked the process for , monitoring for Resident #58 who had an 'as needed' order for , , the Director of Nursing (DON) stated she would expect staff to check the resident's , at least once a shift and document the reading. During a side-by-side review of the record, the DON agreed with the concern of the lack of , monitoring and provision of , for Resident #58. The DON confirmed the physician recently increased his routine , medications. 3. Record review documented Resident #63 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild	F 684		

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F 684	Continued From page 11 , and was dependent on staff for activities of daily living (ADLs). The assessment further documented the resident had an (,). Resident #63 was readmitted to the facility on after a hospitalization. Resident #63's had care plan for using a , with a documented risk for an and/or complications. Review of Resident #63's physician orders revealed an order dated to follow up with , for , (an of the lining that leads to). Further record review revealed the resident had not followed up with , and there was no documentation of the resident refusing follow up with . An interview was conducted with the Director of Nursing (DON) on at 10:00 AM, who acknowledged the above finding.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso- and , tubes, both , , and , endoscopic , , , and fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body or desirable body range and electrolyte balance, unless the resident's clinical condition	F 692		

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F 692	Continued From page 12	F 692		

demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to provide adequate hydration for 1 of 1 sampled resident, as evidenced by not ensuring that Resident #16 was able to have the fluids she was allowed.

The findings included:

Record review revealed Resident #16 was admitted to the facility on . Review of current Minimum Data Sheet (MDS) assessment dated , documented the resident had a ( ) score of 05, on a 0 to 15 scale, indicating severe .
Review of the physician order dated instructed the staff that Resident #16 was on a 1200 milliliters per day fluid restriction with 900 milliliters to be given by dietary daily and 300 milliliters to be given by nursing daily.

During an interview on at 10:42 AM, Resident #16 stated, "I was put on liquid restriction. I get 2 juices, 4 ounces at lunch and dinner. I leave it on my table to sip on it throughout the day and the aides always take it away. They have been asked not to, but they still dump it." When asked if she had fluids this

F692

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #16 was provided with additional fluid; no other residents were affected by the deficient practice. Resident's BIM score was redone and now 11. Psych services provided for emotional support and . Licensed nurses and Certified Nursing Assistants were educated on sufficient fluid intake to maintain proper hydration and health. Additionally, not removing the fluids allowed to the residents. Care plan updated to reflect resident's preference to sip on her drink throughout the day.

How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:

Facility audit completed for residents on fluid restrictions to ensure they are

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F 692	Continued From page 13 morning, Resident #16 stated, "Yes, but they dumped it. They aren't supposed to just take my food. It's so depressing to me, because I like to sip on it. My , are so dry." An observation on at 10:44 AM in the hallway, revealed Resident #16 was in the hallway complaining to the MDS coordinator about her juice being taken away from her room. She stated "[Name], Licensed Practical Nurse (LPN) poured one 4 ounce cup of juice in my ice and they took it away. I did not even have coffee. My is so dry. Why do they keep doing this." Staff D stated, "I will go get you another 4-ounces of juice since they took it away." Resident #16 asked "Why can't we put up a sign or something, so they know not to take it." Staff D stated, "I will just inform the aides not to take your juice."	F 692	receiving adequate hydration as ordered. Director of Nursing/Designee to audit/monitor documentation weekly times four weeks. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Assistant Director of Nursing/designee will re-educate nursing staff on the following: • Ensure residents with fluid restrictions have adequate time for consumption. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Will conduct audits weekly times four weeks. Director of Nursing /designee will report findings at monthly QAA&C monthly times three months or until substantial compliance is achieved.	
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 712		

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F 712	Continued From page 14 §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse , in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure physician visits in a timely manner for 1 of 2 sampled residents reviewed for , Resident #63. The findings included: Record review revealed Resident #63 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild , and was dependent on staff for activities of daily living (ADLs). The record revealed Resident #63 was hospitalized on , and readmitted to the facility on . Review of Resident #63's physician progress notes revealed a progress note dated . There was no further evidence the resident was seen or evaluated by a physician between through . An interview was conducted with the Director of Nursing (DON) on at 10:00 AM, who acknowledged the above finding.	F 712	F712/N55- Physician Visits- Ensure Physicians visits in a timely manner What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #63 was seen on . The Physician assigned was re-educated on timely documentation and submission to facility as required. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: 2. Current residents' charts have been audited over the past 30 days and timely Physician visits are in place. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: 3. Medical Records have been in-serviced	

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F 712	Continued From page 15	F 712	on monitoring timely Physician visits. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 4. Medical Records/designee will audit Physician's progress notes biweekly for timely visits times four weeks and report findings to QAA&C committee for three months or until substantial compliance is met.	

Agency for Health Care Administration

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N 000	INITIAL COMMENTS An unannounced Relicensure survey and complaint survey, complaint number 202503926, was conducted on to at The Rehabilitation Center of the Palm Beaches. The facility had deficiencies at the time of the survey. Complaint number 2025003926 was not substantiated.	N 000		
N 055 SS=D	59A-4.107(6), FAC Physician Visit Timeframes 6) Each resident must be seen by a physician or another licensed health professional acting within their scope of practice at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. If a physician documents that a resident does not need to be seen on this schedule and there is no other requirement for physician's services that must be met due to Title XVIII or XIX of the Social Security Act, the resident's physician may document an alternate visitation schedule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure physician visits in a timely manner for 1 of 2 sampled residents reviewed for , Resident #63. The findings included: Record review revealed Resident #63 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild , and was dependent on staff for activities of daily living (ADLs).	N 055	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #63 was seen on . The Physician assigned was re-educated on timely documentation and submission to facility as required. How you will identify other residents having potential to be affected by the same deficient practice and what	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 055	Continued From page 1 The record revealed Resident #63 was hospitalized on , and readmitted to the facility on . Review of Resident #63's physician progress notes revealed a progress note dated . There was no further evidence the resident was seen or evaluated by a physician between through . An interview was conducted with the Director of Nursing (DON) on at 10:00 AM, who acknowledged the above finding. Class III	N 055	corrective action will be taken: 2. Current residents' charts have been audited over the past 30 days and timely Physician visits are in place. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: 3. Medical Records have been in-serviced on monitoring timely Physician visits. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: 4. Medical Records/designee will audit Physician's progress notes biweekly for timely visits times four weeks and report findings to QAA&C committee for three months or until substantial compliance is met.	
N 063 SS=D	400.23(3)(a)2,(b)1,2,3,5,6;59A-4.108(4) Minimum Nursing Staff 59A-4.108(4) In accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and , , well-being of each resident, as determined by resident assessments and individual plans of care.	N 063		

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N 063	Continued From page 2 400.23(3)(a)2 For purposes of this subsection, direct care staffing hours do not include time spent on nursing administration, activities program administration, staff development, staffing coordination, and the administrative portion of the minimum data set and care plan coordination for Medicaid. 400.23(3)(b)1. Each facility must determine its direct care staffing needs based on the facility assessment and the individual needs of a resident based on the resident's care plan. At a minimum, staffing must include, for each facility, the following requirements: a. A minimum weekly average of 3.6 hours of care by direct care staff per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday. b. A minimum of 2.0 hours of direct care by a certified nursing assistant per resident per day. A facility may not staff below one certified nursing assistant per 20 residents. c. A minimum of 1.0 hour of direct care by a licensed nurse per resident per day. A facility may not staff below one licensed nurse per 40 residents. 2. Nursing assistants employed under s. 400.211(2) may be included in computing the hours of direct care provided by certified nursing assistants and may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties. 3. Certified nursing assistants performing the duties of a qualified medication aide under s. 400.211(5) may not be included in computing the hours of direct care provided by, or the staffing ratios for, certified nursing assistants or licensed	N 063		

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N 063	Continued From page 3 nurses under sub-subparagraph 1.b. or sub-subparagraph 1.c., respectively. 5. The agency must recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be counted twice. 6. Evidence that a facility complied with the minimum direct care staffing requirements under subparagraph 1. is not admissible as evidence of compliance with the nursing services requirements under 42 C.F.R. s. 483.35 or 42 C.F.R. s. 483.70.	N 063		

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N 063	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on facility staffing hours review and interview, the facility failed to meet the daily average minimum staffing requirement for Certified Nurse Assistants (CNA) for the FY (Fiscal Year) 1st Quarter 2025 (-). The findings included. A review of State Minimum Nursing Staff for Long Term Care Facilities revealed the facility's daily average hours for the Certified Nurse Assistants (CNAs) did not meet the requirement on , , , and . On , the CNAs' daily average hours were 1.9411. On , the CNAs' daily average hours were 1.9316. On , the CNAs' daily average hours were 1.9837. On , the CNAs' daily average hours were 1.8799. An interview was conducted with the Director of Nursing (DON) on at 10:00 AM, who acknowledged the above finding. Class III	N 063	Preparation and/ or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the alleged or conclusion set forth in the CMS measured star ratings. The plan of correction is prepared and executed solely because it is required by Federal and State Laws. N63- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The staffing coordinator and Nurse Managers have been re-educated on ensuring that Certified Nursing Assistant minimum daily hour of direct care is at least 2.0 per resident per day. No residents were affected by the deficient practice. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Audit completed for the past 30 days, and no deficient practice identified. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Nursing Home Administrator educated the Director of Nursing and those responsible for staffing on the requirements of meeting	

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N 063	Continued From page 5	N 063	the daily per patient day direct care hours. The Nursing Home Administrator, Director of Nursing and Staffing Coordinator during staffing meetings will continue to ensure compliance with the requirement. On weekends Director of Nursing will verify with Supervisor and monitor callouts for replacement. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee will review findings weekly times four weeks and report compliance during the monthly QA&A Committee monthly times three months or until substantial compliance is met.	
N 066 SS=D	400.23(3)(b)4, FS Posting Staff Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of licensed nurses and certified nursing assistants on duty for the benefit of facility residents and the public. Facilities must maintain the records documenting compliance with minimum staffing standards for a period of 5 years and must report staffing in accordance with 42 C.F.R. s. 483.70(q). This Statute or Rule is not met as evidenced by:	N 066		

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N 066	Continued From page 6 Based on observation and interview, the facility failed to daily post the names of licensed nurses and certified nursing assistants on duty for the benefit of facility residents and the public. The findings included: Review of the facility's nursing staff posting, on a board across from the nursing station, was conducted on , , and . The posting revealed names, but not titles, of who were presumably nurses. The posting did not reveal identifiable room assignments for the 4 units for Nurses and Certified Nurses Assistants (CNA). The surveyors had to inquire which staff member was responsible for specific residents. Random residents were questioned on who their assigned nurse was, and they could not tell by looking at the posted assignments. An interview was conducted with the Assistant Director of Nursing (ADON) on at 1:00 PM, who acknowledged the above finding. Class III	N 066	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The missing staffing information such as titles and room assignments for the Certified Nursing Assistants and Licensed Nurses identified were corrected. No residents were affected by the deficient practice. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Meeting scheduled with the resident council on to review the posted assignments to ensure understanding. Random residents will be questioned on who their assigned nurses and the Certified Nursing Assistant to ensure understanding. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Nurse Managers and Licensed Nurses have been re-educated regarding posting nurse staffing information to include titles and room assignments. Weekly audits will be completed to ensure compliance times four weeks. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Director of Nursing/Designee will review	

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N 066	Continued From page 7	N 066	findings weekly times four weeks and report compliance during the monthly QA&A Committee monthly times three months or until substantial compliance is met.	
N 071 SS=A	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to accurately document the discharge status of 1 of 3 sampled residents reviewed as closed records, Resident #100.	N 071		

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N 071	Continued From page 8 The findings included: Record review documented Resident #100 was admitted to the facility on and discharged home on . Resident #100's diagnoses upon admission included: , , , , , , , in region, wasting and atrophy, Abnormalities of gait and mobility, , and Review of Resident #100's care plan for discharge, dated , documented, "The resident wishes / or Responsible Party wishes to: return home." The goal of the care plan was documented as, "Safely discharge to a lower level of care (Home, Home with Home Health Aide, Assisted Living Facility, Independent Living Facility, other) when rehab goals are met." Reivew of a progress note, dated , documented, "Resident discharge from [name of facility] to home at 300 pm, VIA PRIVATE CAR accompanied, 2-persons food / medication administered as ordered before leaving the facility one of the staff accompanied resident to the lobby skin warm / intact / dry, sound clear no [ ] or distress noted, vs WNL [vital signs within normal limits]. Discharge instruction reviewed with resident voice understood the explanation; med list / medication provided, follow-up with MD [medical doctor] within days post discharge." Review of a Social Services progress note, dated , documented, "Discharge Summary note. Res [resident] is A&Ox3 [alert and oriented	N 071		

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N 071	Continued From page 9 times three], independent with decision making, requested to speak with this writer yesterday as she would like to d/c [discharge] home today. Res informed this writer yesterday that the hospital was planning to d/c her spouse home today thus she wanted to be at home, plus res feels she can manage safely at home and prefers being at home. DME [durable medical equipment] ordered thru [through] [name of company] DME yesterday." Review of Resident #100's discharge Minimum Data Set (MDS) assessment, dated , documented Resident #100's discharge status as 'Short-Term General Hospital." An interview was conducted on at 9:59 AM with the MDS Coordinator, who when asked about Resident #1's discharge status, confirmed that the resident was discharged home. The MDS Coordinator stated that she would update and resubmit the assessment. Class	N 071		
N 181 SS=D	400.022(1)(a), FS Right to Civil, Religious Liberties & Choice (1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to	N 181		

Agency for Health Care Administration

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N 181	Continued From page 10 encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to honor the resident representative's request to ensure, 1 of 3 sampled residents reviewed for Choices, Resident #71, received a shower on the scheduled shower days. The findings included: Record review documented Resident #71 was admitted to the facility on . Review of the quarterly Minimum Data Set (MDS) assessment done on documented Resident #71 had a ( ) score of 3 indicating severe , and the resident is dependent for all care needs. During an observation in the room of Resident # 71, there was a white sheet of paper posted on the bulletin board with the following handwritten message: "please see that she (Resident #71) get a shower on her shower days". Review of the orders shows the resident's shower schedule is every Monday and Thursday on the 3 PM - 11 PM shift. Review of the documentation on the Certified Nursing Assistant (CNA) task list from to showed Resident #71 received 4 bed baths and 3 tub baths on the scheduled shower days. An interview was conducted on at 4:39 PM, Staff C, CNA, who stated she provided a bed	N 181	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #71 was provided with a shower as scheduled. Staff C was re-educated to provide and document showers provided on residents' shower days and any additional days that the residents receive a shower. How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: Facility audit conducted to ensure residents' showers are completed on scheduled shower days and documented appropriately. Other residents found to be affected were corrected. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: Certified Nursing Assistants (C.N.As) have been re-educated regarding Resident Rights/Right of Choices as related to receiving shower on the scheduled shower days. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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N 181	Continued From page 11 bath to Resident #71. An interview and observation were conducted with Staff D, Licensed Practical Nurse (LPN) in the room of Resident # 71. The LPN stated that the note on the bulletin board was written by the resident's sister who is involved in her care. A side-by-side review of the record and interview on at 10:54 AM with the Director Of Nursing (DON), who confirmed the lack of shower documentation on the task list for Resident #71. She also confirmed the facility does not have a tub. Class III	N 181	program will be put in place: Random observation will be conducted three times per week /three months to ensure compliance. Director of Nursing/Designee will conduct weekly shower audits times four weeks and will report the findings of the audits to the QAA&C monthly times three months or until substantial compliance is met.	
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide adequate hydration for 1 of 1 sampled resident, as evidenced by not ensuring that Resident #16 was able to have the fluids she was allowed; failed to follow physician orders for 2 of 6 sampled residents, as evidenced by the , cream for Resident #5 was not applied as ordered, and the , medication was not given as	N 201	1. Resident #16 was provided with additional fluid; no other residents were affected by the deficient practice. Resident's BIM score was redone and now 11. Psych services provided for emotional support and , Licensed nurses and Certified Nursing Assistants were educated on sufficient fluid intake to maintain proper hydration	

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N 201	Continued From page 12 needed for Resident #58; and failed to obtain a consultation as ordered for 1 of 2 sampled residents reviewed for , Resident #63. The findings included: 1. Record review revealed Resident #16 was admitted to the facility on . Review of current Minimum Data Sheet (MDS) assessment dated , documented the resident had a ( ) score of 05, on a 0 to 15 scale, indicating severe . Review of the physician order dated instructed the staff that Resident #16 was on a 1200 milliliters per day fluid restriction with 900 milliliters to be given by dietary daily and 300 milliliters to be given by nursing daily. During an interview on at 10:42 AM, Resident #16 stated, "I was put on liquid restriction. I get 2 juices, 4 ounces at lunch and dinner. I leave it on my table to sip on it throughout the day and the aides always take it away. They have been asked not to, but they still dump it." When asked if she had fluids this morning, Resident #16 stated, "Yes, but they dumped it. They aren't supposed to just take my food. It's so depressing to me, because I like to sip on it. My , are so dry." An observation on at 10:44 AM in the hallway, revealed Resident #16 was in the hallway complaining to the MDS coordinator about her juice being taken away from her room. She stated "[Name], Licensed Practical Nurse (LPN) poured one 4 ounce cup of juice in my ice and they took it away. I did not even have coffee. My is so dry. Why do they keep doing	N 201	and health. Additionally, not removing the fluids allowed to the residents. Care plan updated to reflect resident's preference to sip on her drink throughout the day. Facility audit completed for residents on fluid restrictions to ensure they are receiving adequate hydration as ordered. Director of Nursing/Designee to audit/monitor documentation weekly times four weeks. Assistant Director of Nursing/designee will re-educate nursing staff on the following: • Ensure residents with fluid restrictions have adequate time for consumption. Will conduct audits weekly times four weeks. Director of Nursing /designee will report findings at monthly QAA&C monthly times three months or until substantial compliance is achieved. 2.The , was obtained from the vendor and provided the unit on in the afternoon. Resident #5 was provided with the , cream as ordered. The Physician for Resident #5 was notified and will continue with treatment plan. Resident #5 had physician and family notified of medication omissions and new orders received for medication administration with no negative outcomes to the patient. Nurse D, Staff F and Unit Manager were re-educated on the process of following physician orders and timely ordering of , supplies. Central Supply Clerk re-educated on timely ordering of , supplies.	

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N 201	Continued From page 13 this." Staff D stated, "I will go get you another 4-ounces of juice since they took it away." Resident #16 asked "Why can't we put up a sign or something, so they know not to take it." Staff D stated, "I will just inform the aides not to take your juice." 2. Record review revealed Resident #5 was readmitted to the facility on . Review of the current Minimum Data Sheet (MDS) assessment dated , documented the resident had a ( ) score of 05, on a 0 to 15 scale, indicating severe . Review of a physician order dated instructed the staff to apply an cream to the areas affected with a (skin condition) on the day (7 AM to 3 PM) and evening (3 PM-11 PM) shifts. Review of the care plan dated , documented Resident #5 was at risk for potential or actual of the skin related to itching, with a goal that the resident's skin will be healed with an intervention that the nurse will administer medication as ordered. An observation on at 10:08 AM revealed Resident #5 was scratching her arms and profusely. Further observation revealed Resident#5 had scattered bumpy and reddened areas on her arms, and . An observation on at 3:23 PM in Resident #5's room revealed Resident #5 had her closed, scratching her arms and . During an interview on at 10:08 AM, when asked how she was doing, Resident #5 stated, "I have all these bites." When asked how long she has had the , Resident #5 stated, "I	N 201	3. Resident #58 , medication was given as ordered. Medication review completed by physician and the continued to be as needed Q 8 hours. Order provided to monitor , three times/day and as needed. Licensed nurses re-educated on documenting the , for Resident #58 every eight hours as ordered and PRN. 4. Resident #63's consultation was rescheduled from to per family request. The physician was notified of the change of the consultation date. A facility wide audit was completed for current residents to identify any other residents affected by the deficient practice. No other residents were affected by the deficient practice. Current residents Treatment Administration Records have been audited by the Director of Nursing /designee to ensure compliance with following physicians' orders. Licensed nurses will be re-educated on the importance of following physician orders related to Quality of Care including customer service, monitoring and follow-up care for those residents with rashes, , medication monitoring, ensuring consultations are scheduled timely. Compliance will be monitored through Audits three times a week, four weeks and weekly thereafter to ensure the practice	

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N 201	Continued From page 14 just came from the hospital, but I had the before." When Resident #5 was asked if the nurse was aware of the , she stated "I think so, I will let them know." When asked if any cream had been applied to the , Resident #5 stated, "No." During an Interview on at 3:25PM, when asked if any treatment was provided to Resident #5, Staff D, Licensed Practical Nurse (LPN), reviewed Resident #5's orders in the computer and stated " (for the skin)." Staff D went into the clean utility room, where the treatment cart was stored. Staff D looked throughout the treatment cart and did not find the . Staff D stated, "I used the last of the cream this morning on the resident and I threw the tube away. I will have to order a new one. She was in the hospital, and she came ." When asked if that was the only treatment that was to be provided to Resident #5, Staff D stated "Yes." During an interview on at 9:15AM, when asked if an cream was ordered for a resident what medication is used, the Unit Manager stated, "It's a stock medication that comes in a tube." When asked to show the cream that was ordered for Resident #5, the Unit Manager looked in the treatment cart and she picked up a jar of and stated, "This is for that resident". When asked if the is the medication that would be used if the order was for an cream the Unit Manager stated, "No. Sometimes the cream comes in small packets. I will go get some from the supply room." During an interview on at 9:40 AM,	N 201	does not recur. Director of Nursing/designee will conduct treatment observations and consultation audits weekly for four weeks and then monthly for two months to ensure continued compliance. Director of Nursing /Designee will report the findings of the audits to the QAA&C monthly times three months or until substantial compliance is met.	

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N 201	Continued From page 15 when asked if there was any ␣ cream in stock, Staff F, Central Supply staff, stated, "We are out of it. I'm in the process of ordering it now. When asked how long they had been out of the ␣ cream, Staff F stated, "We've been out since Tuesday." When asked if she meant yesterday on Tuesday, Staff F stated, "No, last week I had two tubes of the cream on the shelf that were expired on Friday, so I threw them out, but I forgot to reorder it at that time. If I order it today, it will come tomorrow." During an interview on at 10:06 AM, the Unit Manger stated, "I'm trying to figure out which nurse used the last of the ␣ cream for the resident and did not reorder it. I called central supply to see if there was any cream and she said the ones she had were thrown out on Friday because they were expired." During an interview on at 10:50 AM, when asked how long Resident #5 had the , Staff D, LPN) stated, "She has a off and on. She has seen a dermatologist in the past. I think a few months ago." During an interview on at 10:56 AM, when ask how Resident #5's skin looked when she provided care, Staff G, Certified Nursing Assistant, stated, "She has a that she has had for a while." Review of Treatment Administration Record (TAR) for Resident #5 documented that the nurses had signed off on the order for the administration of the ␣ cream, but the medication had not been available. 3. Record review revealed Resident #58 was admitted to the facility on with diagnoses	N 201		

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N 201	Continued From page 16 to include essential primary ,, (high ,). Review of the current MDS assessment dated documented Resident #58 had a score of 15, on a 0 to 15 scale, indicating the resident was , , . This MDS also documented a current diagnosis of ,, . Review of the current care plan initiated on documented the resident had ,, and staff were to administer medications as ordered and monitor vital signs as ordered. Review of the current orders revealed Resident #58 was receiving three routine , medications. These medications included , which was originally ordered at 50 milligrams (mg) daily and increased to 100 mg twice daily on , , 10 mg three times daily, and , 5 mg twice daily was added to the regimen as of . The orders also included for staff to administer , 0.1 mg every eight hours as needed for a , , reading greater than 150. This order did not include any time frame in which staff were to measure the resident's , . The only active order for the monitoring of vital signs was to complete a set once during the night shift (11 PM to 7 AM). There was one discontinued order to monitor vital signs every shift for three days only upon return from a brief hospitalization. During an interview on at 9:56 AM, Resident #58 stated his only concern was that his , was running high. Review of the Medication Administration Record (MAR) for Resident #58 revealed the following high , with no 'as needed' , administered:	N 201		

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N 201	Continued From page 17 a) On on the night shift, the resident's , was . b) On on the night shift, the resident's , was . c) On on the night shift, the resident's , was . Further review of the record revealed staff were not documenting the , for Resident #58 every eight hours, or with each shift, in order to know when the 'as needed' , was needed. Review of the , readings from through revealed a lack of three daily , readings every day except on , , , , , and . During an interview on at 3:32 PM, when asked the process for , monitoring, Staff A, Licensed Practical Nurse (LPN), stated she takes the , of her residents on , medications every morning upon arrival and documents them in the electronic medical record (EMR) at the end of her shift. The LPN provided a handwritten paper with documented , for several residents and stated she was getting ready to document the readings from this morning at the time of the interview. Further review of the MAR and , readings for Resident #58 on , revealed Staff A, LPN had cared for the resident on , , , , , and , but only documented his , on and . During an interview on at approximately 4:15 PM, when asked the process for , monitoring, Staff B, Registered Nurse	N 201		

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N 201	Continued From page 18 (RN), stated she takes the , for her residents who are on , medications at the beginning of the shift. When asked about documentation, the RN stated she might document them in the vital sign section of the EMR, or she may just document, "OK to give" in the electronic MAR. When asked specifically about Resident #58, the RN stated she had just taken his , , and it was . The RN volunteered, "I told him to hang loose for a bit and I'd bring his meds." Further review of the MAR and , readings lacked any documented , reading of for Resident #58 on . During an interview on at 9:51 AM, when asked the process for , monitoring for Resident #58 who had an 'as needed' order for , , the Director of Nursing (DON) stated she would expect staff to check the resident's , at least once a shift and document the reading. During a side-by-side review of the record, the DON agreed with the concern of the lack of , monitoring and provision of , for Resident #58. The DON confirmed the physician recently increased his routine , medications. 4. Record review documented Resident #63 was admitted to the facility on . A comprehensive assessment dated documented the resident had mild , and was dependent on staff for activities of daily living (ADLs). The assessment further documented the resident had an (,). Resident #63 was readmitted to the facility on	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95005	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF THE PALM BEACHES,1	301 NORTHPOINTE PARKWAY WEST PALM BEACH, FL 33407

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N 201	Continued From page 19 after a hospitalization. Resident #63's had care plan for using a with a documented risk for an and/or complications. Review of Resident #63's physician orders revealed an order dated to follow up with for (an of the lining that leads to). Further record review revealed the resident had not followed up with , and there was no documentation of the resident refusing follow up with . An interview was conducted with the Director of Nursing (DON) on at 10:00 AM, who acknowledged the above finding. Class III	N 201		