

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35961037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/04/2025
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NAME OF PROVIDER OR SUPPLIER LUXE AT JUPITER REHABILITATION CENTER (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 674 PIONEER ROAD JUPITER, FL 33458
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{N 000}	INITIAL COMMENTS An unannounced second revisit to a complaint survey was conducted on _____ at Luxe at Jupiter Rehabilitation Center (The), in conjunction with the State Relicensure survey. The citation N 201 remains uncorrected.	{N 000}		
{N 201} SS=E	400.022(1)(f), 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 observations, interviews, record review, and policy review, the facility failed to provide care and services for 11 of 34 as evidenced by the failure to provide grooming care of a resident's _____ of hair, _____ beard, and _____ for Resident #72; failure to implement the _____ program for Resident #44; failure to follow physician ordered _____ parameters for _____ medications for Residents #10 and #23; failure to ensure _____ for Resident #62; failure to notify physician of _____ levels as per order for Resident #303; failure to ensure supervision and after incident education to prevent _____ for Resident #19; failure to follow physician order for _____ feeding for Resident #31; failure to ensure timely _____ (_____) _____ changes for Resident #29; failure to ensure proper physician order and care for _____ use for Residents #54 and #302.	{N 201}	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 4.4.25 resident #72 was assessed by licensed nurse, provided hygiene assistance with nail care, grooming, shaving and shower; no other concerns identified.	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X8) DATE
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{N 201}	<p>Continued From page 1</p> <p>The findings included:</p> <p>1) A record review revealed that Resident #72 was admitted to the facility on . His diagnoses included Myopathy, and due to underlying . Review of an assessment dated . revealed that Resident #72 had a score equal to 15. This indicated that he was .</p> <p>A review of the assessment dated revealed that Resident #72 was on both sides of his lower extremities (, ankle,). Documentation showed Resident #72 required substantial, maximal assistance with bathing and . The tasks assigned to the Certified Nursing Assistants listed in the electronic medical records revealed that during the time period , Resident #72 was dependent on assistance with tasks related to personal self-hygiene.</p> <p>A record review revealed that Resident #72's care plan for activities of daily living (ADL) stated that he needed limited to by one or two people, to provide ADL care. The required assistance was related to multiple factors including , decreased mobility, and , to lower extremities.</p> <p>A review of the facility's policy: Standards and Guidelines ADL (Activities of Daily Living) Care and Services, revised , was performed. It stated: Appropriate care and services will be provided for residents who are unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance and</p>	{N 201}	<p>On 4.19.25 resident #72 was seen by the facility beautician and his hair was cut, he was shaved and his nails were trimmed per his preference.</p> <p>On 4.4.25 resident #44, 10, 23, and 62 were assessed by licensed nurse, no concerns identified.</p> <p>Resident #44 had movement on 4.7.25, no regimen required.</p> <p>On 4.16.25 physician reviewed medication regimen for resident #10, determined to be stable and hold parameters removed from hypertensive medication.</p> <p>On 4.9.25 physician reviewed medication regimen for resident #23, determined to be stable and hold parameters removed from hypertensive medication.</p> <p> , for resident #62 was completed on 4.9.25; resident #62 discharged on 4.10.25 and is no longer residing in facility.</p> <p>Resident #303 was discharged on 3.18.25 and is no longer residing in facility.</p> <p>On 4.4.25 resident #19 was assessed by licensed nurse, no concerns identified.</p> <p>On 4.4.25 staff activities aid G was educated by the Assistant Director of Nursing on prevention and safety, and on specifics of resident #19 plan of care.</p> <p>On 4.4.25 resident #31 was assessed by licensed nurse, no concerns identified.</p>	

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{N 201}	<p>Continued From page 2</p> <p>care with hygiene (bathing, grooming, nail care, and oral care).</p> <p>During the initial resident screening performed on at 5:04 PM, Resident #72 was observed with long nails. Eight out of ten were approximately 3/4 of an inch in length. Resident #72's beard was very long, with an underneath layer that appeared longer than the upper layer.</p> <p>During an interview with Resident #72 on at 5:05 PM, he explained that his nail clippers, wallet, electric shaver, and other items had been left at the facility that he resided in prior to the Luxe. He said that his hair was washed once in the past three months. He said that his hair was knotted, and that some parts needed to be cut off. The resident lifted a chunk of matted hair from the left side of his head. The resident said that nursing is more concerned with vital signs than grooming. Resident #72 said that he didn't shower in months because his hair didn't work.</p> <p>During an observation on at 10:55 AM, Resident #72 was in his bed. His beard, and hair were still long. Staff D, a CNA, entered the room and introduced herself to the resident. She said it was her first time working with Resident #72 and then she offered to provide him with assistance in bathing. Resident #72 agreed to the provision of care.</p> <p>During an interview with Staff D on at 12:24 PM, the CNA said that the clean-up went well. When asked what she thought about Resident #72's nails, she said they were long. She explained that she asked the resident if he wanted her to cut them, and he said all he needed was a clipper and a file and he could do it</p>	{N 201}	<p>On 4.4.25 staff C nurse was provided 1:1 education by Assistant Director of Nursing on following physician orders for the administration of feeding.</p> <p>On 4.1.25 resident #29 was assessed by licensed nurse, no concerns identified.</p> <p>On 4.1.25 the site was changed for resident #29 by LPN staff L.</p> <p>On 4.2.25 resident #54 and #302 were assessed by licensed nurse, no concerns identified.</p> <p>On 4.2.25 physician orders reviewed for resident #354 and #302 to ensure administered per physician orders and monitoring in place, any concern identified were corrected.</p> <p>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>On 4.22.25 the Director of Nursing completed a quality review of current residents to ensure grooming/hygiene/nail care/showers provided per resident preferences; any concerns identified were corrected at the time.</p> <p>On 4.22.25 a quality review was completed by Director of Nursing on current residents for parameters, monitoring, management monitoring and orders</p>	

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{N 201}	<p>Continued From page 3</p> <p>by himself.</p> <p>Staff D also said that while cleaning the resident she noticed he had a dreadlock on the of his . She said that there's a barber who can come and cut his hair.</p> <p>During an interview with Resident #72 on at 1:17 PM, when the surveyor asked if he requested grooming services for his hair, nails, and beard to be performed, Resident #72 answered: "That should be part of the curriculum. The man cannot get out of bed, maybe we should help him wash his hair, and trim his nails. Total care is care of the total body, from the top of the to the tip of the ."</p> <p>2) Review of the record revealed Resident #44 was admitted to the facility on . Review of the current assessment dated . documented the resident had a () score of 13, on a 0 to 15 scale, indicating the resident was .</p> <p>Review of the current care plan initiated on revealed Resident #44 was at risk for irregularity related to decreased mobility, and potential side effects of medications. The documented goal was that the resident would have a movement at least once every three days. One of the interventions was to administer the medications as per physician orders.</p> <p>Review of the current physician orders revealed Resident #44 was on two routine medications daily for . The resident also had three orders for medications as needed, to include Milk of for Protocol, a</p>	{N 201}	<p>to ensure parameters in place per physician orders and follow up scheduled as indicated. Any issues identified were corrected.</p> <p>On 4.14.25 a quality review was completed by Director of Nursing/designee on current residents who sustained a within the last 30days to ensure follow up documentation in place, care plan updated, and staff education completed. Any concerns identified were corrected.</p> <p>On 4.11. 25 a quality review was completed by Director of Nursing/designee on current residents receiving nutrition to ensure appropriate formula in place and rate reflective of physician orders. Any issues identified were corrected.</p> <p>On 4.11.25 a quality review was completed by Director of Nursing/designee on current residents with sites in place to ensure in place, changed timely and physician orders for monitoring being followed. Any issues identified were corrected.</p> <p>On 4.14.25 a quality review was completed by Director of Nursing/designee on current residents with in place to ensure physician orders being followed and is administered properly. Any issues identified were corrected.</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p>	

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{N 201}	<p>Continued From page 4</p> <p>(a) _____ as needed for _____, and a _____ to be administered if no _____ movement in 5 days.</p> <p>Review of the documented _____ management in the resident's record, along with the corresponding Medication Administration Records (MARs) for Resident #44 revealed the following:</p> <p>On _____ on the day shift (7 AM to 7 PM) through _____ on the day shift, a total of 4 days, the record lacked any documented movement or the administration of any as needed medication for</p> <p>On _____ on the night shift (7 PM to 7 AM) through _____ on the night shift, a total of 3 days, the record lacked any documented movement or the administration of any as needed medication for</p> <p>On _____ on the night shift through _____ on the day shift, a total of 3 days, the record lacked any documented _____ movement or the administration of any as needed medication for</p> <p>During an interview on _____ at 10:34 AM, Resident #44 stated she gets _____ and had an issue with it every month. The resident stated the _____ she gets when constipated was "horrible." Resident #44 confirmed she was taking something every day, but did not think it was enough. When asked if she gets anything as needed or upon her request, the resident stated once in a while she gets Milk of Magnesia.</p> <p>During an interview on _____ at 12:37 PM, when asked to explain the _____ Protocol, Staff L, Licensed Practical Nurse (LPN), explained that the electronic dashboard would notify the nurse when a resident does not have a</p>	{N 201}	<p>On 4.22.25 Director of Nursing completed education with current staff on the components of N201 right to adequate and appropriate health care with emphasis on providing hygiene/grooming/nail care/showers per resident preference by the Assistant Director of Nursing/designee.</p> <p>Newly hired nursing staff will be educated on the components of N201 right to adequate and appropriate health care with emphasis on providing hygiene/grooming/nail care/showers per resident preference by the Assistant Director of Nursing/designee at orientation as a part of the systematic changes.</p> <p>On 4.22.25 Director of Nursing completed education with current staff on the components of N201 right to adequate and appropriate health care with an emphasis on _____ parameters, _____ monitoring, _____ management monitoring and orders to ensure parameters in place per physician orders and follow up _____ scheduled as indicated by the Director of Nursing/Designee.</p> <p>Newly hired licensed nursing staff will be educated on the components of N201 right to adequate and appropriate health care with an emphasis on _____ parameters, _____ monitoring, _____ management monitoring and orders to ensure parameters in place per physician orders and follow up _____ scheduled as indicated by the Assistant Director of</p>	

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{N 201}	<p>Continued From page 5</p> <p>movement in three days. The LPN stated when notified, she would confirm the lack of a movement with the resident and or staff. The LPN explained that when she is notified, she would provide the as needed dose of Milk of to the resident listed on the dashboard. When asked specifically about Resident #44, the LPN agreed the resident had an issue with . During a side-by-side review of the record at this time, the LPN agreed with the findings.</p> <p>3) Review of the record revealed Resident #10 was admitted to the facility on . Review of the current orders revealed the order initiated on for the medication 25 milligrams, to give two tablets twice daily. This order further documented the physician ordered parameters that the resident was not to receive the medication if his (/upper number) was less than 110 or his rate was less than 60.</p> <p>Review of the Medication Administration Record (MAR) documented the was administered to Resident #10 on at 9 AM with a .</p> <p>During a side-by-side review of the record and interview on at 12:22 PM, Staff L, LPN, agreed with the findings and stated the medication should have been held.</p> <p>4) Resident #23 was admitted to the facility on with diagnoses including . failure and (high). An annual comprehensive assessment on included a brief interview with a mental</p>	{N 201}	<p>Nursing/Designee, at orientation as a part of the systematic changes.</p> <p>On 4.22.25 Director of Nursing completed education with current nursing/activities/ , staff on the components of N201 right to adequate and appropriate health care with emphasis on ensuring staff education completed and follow up documentation in place for by the Director of Nursing/Designee.</p> <p>Newly hired nursing/activities/ , staff will be educated on the components of N201 right to adequate and appropriate health care with emphasis on ensuring staff education completed and follow up documentation in place for by the Assistant Director of Nursing/Designee at orientation as a part of the systematic changes.</p> <p>On 4.22.25 education completed with current licensed nursing staff on the components of N201 right to adequate and appropriate health care with an emphasis on ensuring accurate formula administered at rate per physician orders by the Director of Nursing/designee.</p> <p>Newly hired licensed nursing staff will be educated on the components of N201 right to adequate and appropriate health care with an emphasis on ensuring accurate formula administered at rate per physician orders by the Assistant Director of Nursing/Designee during orientation as part of the systematic change.</p> <p>On 4.22.25 Director of Nursing completed</p>	

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{N 201}	<p>Continued From page 6</p> <p>status score 15, indicating that Resident #23 was . This assessment did not record any concerns related to or behavior.</p> <p>According to the physician's order from , was prescribed to be administered one tablet by every 12 hours for the management of , with the stipulation to hold the medication if the , below 110.</p> <p>However, a review of the medication and treatment administration records (MARs and TARs) evidenced the lack of adherence to these parameters. A review of the MARs and TARs from , conducted on at 10:55 AM, indicated that was administered outside of the established parameters on several occasions:</p> <ul style="list-style-type: none"> - On , at 9 PM, the recorded , was , and the medication was administered. - On , at 9 AM, the was , and the medication was given. - On , at 9 AM, the was noted as , and the medication was administered. - On , at 9 PM, the was recorded at , and the medication was administered. <p>During an interview with the Director of Nursing (DON) on , at 11:55 AM, the DON was made aware of the issue regarding the noncompliance with the physician's orders concerning medication administration and the associated parameters.</p>	{N 201}	<p>education with current licensed nursing staff on the components of N201 right to adequate and appropriate health care with emphasis on ensuring in place, changed timely and monitoring per physician orders by the Director of Nursing/designee.</p> <p>Newly hired licensed nursing staff will be educated on the components of N201 right to adequate and appropriate health care with emphasis on ensuring in place and monitoring per physician orders by the Assistant Director of Nursing/Designee during orientation as part of the systematic change.</p> <p>On 4.22.25 Director of Nursing completed education with current licensed nursing staff on the components of N201 right to adequate and appropriate health care with emphasis on residents with in place to ensure physician orders being followed and is administered properly by the Director of Nursing/designee.</p> <p>Newly hired licensed nursing staff will be educated on the components of N201 right to adequate and appropriate health care with emphasis on residents with in place to ensure physician orders being followed and is administered properly by the Assistant Director of Nursing/Designee during orientation as part of the systematic change.</p> <p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:</p> <p>Director of Nursing/Designee to conduct random audits of 5 residents 2 times a</p>	

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{N 201}	<p>Continued From page 7</p> <p>5) Review of the records revealed that Resident #62 was admitted to the facility on . He has diagnoses to include .</p> <p>of , Retention of , and . A review of the physician's orders revealed that the resident has an . A review of a physician's progress note dated documented that he had a , hardened to right side of . Another progress note dated documented patient seen today in bed prior to going to . Earlier this week he complained of , and , to , hardened noted to right side of , along with . Patient reports that , has improved. He also continues to have penile discharge. Spoke with him about ensuring these issues are addressed with , today. He returned with an order for a scheduled for at 11:00 AM. The surveyor reviewed the Physician's order and did see an order for a , on at 11:00 AM.</p> <p>During an interview on at 10:30 AM, Resident #62 stated to the surveyor that he was upset, he is waiting to be picked up to go to the Urologist at 11:00 AM for a test. He said he mentioned it to the nurse, but she said he did not have one and no one appeared to be taking him.</p> <p>During an interview on at 10:45 AM, with Staff M, RN she was asked about a doctor's , , today at 11:00 AM. She stated, "he is , , I don't see an , , ."</p> <p>During an interview on at 8:58 AM</p>	{N 201}	<p>week for 4 weeks, then once a week for 4 weeks and then monthly for 1 month to ensure compliance with N201 right to adequate and appropriate health care with emphasis on providing hygiene/grooming/nail care/showers per resident preference.</p> <p>Director of Nursing/Designee to conduct random audits of 5 residents twice a week for 4 weeks, then once a week for 4 weeks and then monthly for 1 month to ensure compliance with N201 right to adequate and appropriate health care with an emphasis on , parameters, , monitoring, management monitoring and orders to ensure parameters in place per physician orders and follow up , , scheduled as indicated.</p> <p>Director of Nursing/Designee to conduct random audits of 5 residents who sustained a twice a week for 4 weeks, then once a week for 4 weeks and then monthly for 1 month to ensure compliance with N201 right to adequate and appropriate health care with emphasis on ensuring staff education completed and follow up documentation in place for</p> <p>Director of Nursing/Designee to conduct audits of 5 residents with nutrition twice a week for 4 weeks, then once a week for 4 weeks and then monthly for 1 month to ensure accurate formula administered at rate per physician orders.</p> <p>Director of Nursing/Designee to conduct audits of 5 residents with sites twice a</p>	

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{N 201}	<p>Continued From page 8</p> <p>with Staff M, RN, she was asked again about Resident #62's . . . that was scheduled for Monday She stated she wasn't aware he had an . . . until the Surveyor brought it to her attention. She texted the Activities Director around 10:45 AM asking if he had one. She said usually if they have an . . . it will pop up on the computer as a one-time order but for him it wasn't put in correctly, so it didn't pop up. She said that Activities will set up the transportation.</p> <p>During an interview on . . . at 9:05 AM with Staff N, Unit Manager, she stated that she spoke to the resident yesterday and she called the Urologist's office to find out about his . . . but have not heard . . . from them yet.</p> <p>During an interview on . . . at 9:45 AM with the Activities Director she remembers the text the nurse sent her about this resident on Monday . . . The Activities Director stated we will set up the residents' transportation if they are long-term care residents. The surveyor then stated that this resident is long term care.</p> <p>During a subsequent interview on . . . with Staff N, Unit Manager, she stated the resident was communicating with the doctor's office and had changed his . . . himself. The surveyor stated that it has been on the computer since . . . Staff N then stated the resident told someone and they put it on the computer but did not put it in correctly and since he made the . . . we were not aware that he needed transportation. The surveyor stated that this . . . has been scheduled for over a month and had opportunity to get transportation scheduled, which she acknowledged.</p>	{N 201}	<p>week for 4 weeks, then once a week for 4 weeks and then monthly for 1 month to ensure . . . in place, changed timely and monitored per physician orders.</p> <p>Director of Nursing/Designee to conduct audits of 5 residents with . . . twice a week for 4 weeks, then once a week for 4 weeks and then monthly for 1 month to ensure . . . in place to ensure physician orders being followed and . . . is administered properly.</p> <p>The findings of these quality monitorings to be reported to the Quality Assurance/Performance Improvement Committee monthly until the committee determines substantial compliance has been met.</p>		

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{N 201}	<p>Continued From page 9</p> <p>During an interview with Staff N, Unit Manager, on _____ at 11:50 AM she was asked about this resident transportation for the upcoming _____. She said the Activities driver was going to pick him up.</p> <p>During a telephone interview on _____ at 12:50 PM with the Activities Director she stated that she only oversees transportation for outings and the ALF. The unit manager would take care of the resident going to the doctor's _____.</p> <p>6) Review of Resident #303 records revealed that Resident #303 was admitted to the facility on _____ and discharged _____. Resident had a diagnosis to include Type II _____ with _____, _____, and _____ and Aphasia Following a _____. A review of the Physician's Order revealed Accu-Chek twice daily; if _____ is above 250 to notify the MD/ARNP start date _____ 0630. A review of the MAR (Medication Administration Record) revealed 3 days that the Accu-Chek was taken, and the _____ was above 250 but the physician or ARNP was not notified.</p> <ul style="list-style-type: none"> ✓ 301 6:30 AM ✓ 295 4:30 PM ✓ 252 4:30 PM <p>The resident is also on _____ Tablet 1000 MG (_____) Give 1 tablet by _____ two times a day for _____; _____ Solution 100 UNIT/ML Inject 15 unit _____ at bedtime for _____.</p> <p>During an interview on _____ at 3:39 PM with _____</p>	{N 201}		

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{N 201}	<p>Continued From page 10</p> <p>the DON (Director of Nursing) the surveyor asked her where the nurses document when they notify the physician or ARNP. She stated they are documenting either on the computer on the MAR which sometimes floats over to Progress Note or putting it in progress note. The surveyor requested to pull up Resident #303 Physician Notes/ MAR. She reviewed them and acknowledged that she does not see any notes that the physician or ARNP was notified and should have been per the order.</p> <p>7) Review of the policy titled, " - Managing, Preventing, and documentation" revised documented, in part, "Resident-Centered Approaches to Managing and Risk: 1. The staff will implement a resident-centered prevention plan to reduce the specific risk factor(s) of for each resident at risk or with a history of ... Documentation: ... 2. The resident's care plan should be updated timely with the new interventions determined by the interdisciplinary team."</p> <p>Review of the record revealed Resident #19 was admitted to the facility on . Review of the current Minimum Data Set (MDS) assessment dated documented Resident #19 had a () score of 6, on a 0 to 15 scale, indicating the resident was . Review of the current care plan initiated revealed Resident #19 was at risk for related to , use of , medications, decreased endurance, and a history of .</p> <p>Review of progress note dated written by Staff A, Licensed Practical Nurse (LPN) revealed that Resident #19 was in her room and</p>	{N 201}			

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{N 201}	<p>Continued From page 11</p> <p>observed lying on the floor on her right side. A risk evaluation was completed after care was provided and family was notified. The risk evaluation revealed that Resident #19 was oriented to self, not place and time and had periods of . She presented with an altered awareness of physical environment and lack of understanding of physical limitations.</p> <p>During a family interview on _____ at 9:42 AM, Resident #19's husband stated that his wife _____ out of the wheelchair when she was left alone in her room.</p> <p>During an Interview on _____ at 12:10 PM, Staff A, LPN stated that a staff member from the Activities department pushed Resident #19 in her wheelchair _____ into her room and left her alone and did not notify the nursing staff that Resident #19 was _____ in her room.</p> <p>During an interview on _____ at 12:47 PM, the Activities Director stated that it was Staff G, a part time Activity Assistant, who brought Resident #19 _____ to her room on _____ as Staff G did not know that the resident should be taken to the nursing station instead of her room. When asked how Staff G, would've known which residents need to be brought to the nursing station instead of their rooms and if there was a policy for that she replied, "I am not sure, but I think it is in the resident's care plan</p> <p>Review of the current care plan initiated on _____ that includes interventions carried over from 2024, lacked any intervention related to the need to always keep Resident #19 with staff while positioned in her wheelchair. Furthermore, the list of interventions and approaches did not include training for all facility staff to communicate with</p>	{N 201}		

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{N 201}	<p>Continued From page 12</p> <p>the nursing staff when Resident #19 is positioned in her wheelchair and returned to her room after attending activities, an outing or . . .</p> <p>Review of the facility investigation completed after Resident #19's on , revealed education only to Staff G, the Activity Assistant involved in the incident, and lacked education to all staff.</p> <p>8) A record review revealed Resident #31 was admitted to the facility on . Diagnoses included without loss of , Unspecified Protein Calorie , Major , Unspecified , and Wasting in Multiple Sites with Atrophy. This resident's () score, per an assessment dated was 4. This indicated that Resident #31 had severe .</p> <p>A record review revealed Resident #31's most recent was . Her () was 18.3. This indicated that Resident #31 was . She lost in six months from on . The quarterly assessment completed on documented that Resident #31 received 51% or more of the calories ingested daily via endoscopy () tube feedings, and 51% or more fluids from feedings. Resident #31 was dependent on feeding to meet her daily needs for nutrition. This included hydration.</p> <p>A record review of Resident #31's care plan for nutrition last revised on , documented</p>	{N 201}		

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that the resident was at risk for because she had inadequate intake of nutrition by _____ was her primary source of nutrition. She had a history of _____ loss, and in addition to receiving feeding by _____ Resident #31 also received food by _____. Her food by _____ diet order dated _____ was for a regular diet, with a mechanical soft texture, and thin consistency fluids.

A record review showed that Resident #31's current _____ feeding diet order dated _____ was for a continuous feeding of Jevity 1.5 to be administered at 85 milliliters per hour for 12 hours daily between 7:00 PM and 7:00 AM. The doctor's order specified that the total amount of 1,020 ml of Jevity was to be infused. There was another active order for a bolus feeding (administered all at the same time) of 237 milliliters to be administered at 5:00 PM daily.

A record review of the Registered Dietitian's (RD) progress note on _____ revealed that Resident #31 often refused the 5:00 PM bolus feedings. The RD recommended increasing the rate of Jevity 1.5 from 80 milliliters per hour to 85 milliliters per hour. This increase in rate also increased the volume of Jevity to be administered. In addition, the RD's progress note documented Resident #31's difficulty swallowing and poor intake of foods by _____.

An observation during the initial screening activity on _____ 09:39 AM revealed that Resident #31's _____ was dry, and the tip of her _____ was deep red. A vertical crevice was observed on the tip of her _____. The surveyor offered the resident water from the cup that was on her tray table. The resident accepted the cup in her _____.

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{N 201}	<p>Continued From page 14</p> <p>and drank some water.</p> <p>During an observation on _____ at 06:12 PM, Resident #31 was lying down in bed. The surveyor asked the resident to stick out her _____ and Resident #31 complained that her _____ was dry.</p> <p>An observation on _____ at 7:04 AM revealed that Resident #31 was in bed, receiving feeding. The rate of feeding was 80 milliliters per hour. The total amount of Jevity that was administered, based on the amount of formula that remained in the plastic 1000 ml bottle, was approximately 540 ml. The doctor's order specified the total volume to be administered between 7:00 PM and 7:00 AM was 1,020 ml. Approximately 460 ml of Jevity 1.5 remained in the plastic bottle.</p> <p>An interview on _____ at 7:15 AM was conducted with Staff C, the nurse who provided Resident #31 with care during the night shift. The surveyor asked Staff C to view the _____ pump and to describe the rate of administration of the Jevity formula that was in progress. Staff C said that the rate was 80 milliliters per hour. When asked to check the doctor's order in Resident #31's medical record, Staff C said that the order specified 85 milliliters per hour. The surveyor asked why she provided the Jevity at 80 milliliters per hour, and Staff C said that she didn't open and check the order for the administration of Jevity.</p> <p>9) Review of the policy titled, " _____ Change" revised _____ documented in part, "Standard: This purpose of this procedure is to minimize _____ -related _____ associated _____"</p>	{N 201}		

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{N 201}	<p>Continued From page 15</p> <p>with contaminated, loosened, or soiled -site . Procedure: 1. changes to be completed if it becomes damp, loosened or visibly soiled and at least every 7 days."</p> <p>Review of the record revealed Resident #29 was admitted to the facility on . Review of the current orders revealed a was ordered on for the resident to receive medications. These orders also contained instructions to flush the before and after two current that were being administered via the line, to include and . These orders lacked any instructions for the nursing staff to change the .</p> <p>A culture dated revealed the resident had a that was with a multi-drug resistant organism (MDRO).</p> <p>During an interview on beginning at 11:31 AM, when asked why he was on Contact precautions, Resident #29 stated he had a . A mid-line was noted to the resident's right arm. The was loose all around the perimeter and dated . When asked about the changes, Resident #29 stated, "It wouldn't have been changed then () if I wouldn't have said anything. I have to beg them to change it. Then when the nurses do finally change it, they complain the whole time."</p> <p>During an interview on at 2:08 PM, when asked if she does the changes for a mid-line , Staff L, Licensed Practical Nurse (LPN) stated she does not, but would as the Unit Manager or another Registered Nurse</p>	{N 201}		
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{N 201}	<p>Continued From page 16</p> <p>(RN) to complete the task. When asked how she knows when it is due, the LPN stated it would pop up on her computer. When asked if she had noticed the mid-line for Resident #29, the LPN stated, "Yes, it was dated _____ and I corrected that on ____." The LPN agreed it was completed late. When asked to locate and provide the order for the mid-line change, the LPN stated she did not see it in the computer, but it should be changed every 7 days.</p> <p>10) Review of the Policy titled, "Standards and Guidelines for _____ Administration" revised _____, documented, in part, _____ is administered by way of an _____ mask, or other device per physicians' orders with the appropriate flow of _____.</p> <p>Review of record revealed that Resident #54 was admitted to the facility on _____. On _____ Resident #54 was admitted to the Hospital with Diagnosis of Acute _____ Failure, and was readmitted to the facility on _____ with a _____ care order for _____ at 2 liters via _____ as needed for _____ on exertion every 24 hours.</p> <p>Observation on _____ at 8:10 AM, Resident # 54 resident in bed awake on _____ on 4 liters via _____.</p> <p>Observation on _____ at 11:15 AM, Resident #54 in bed and awake on 4 liters of _____ via _____.</p> <p>During an interview on _____ at 11:07 AM, Staff A, Licensed Practical Nurse (LPN) was asked about Resident # 54's _____ order as she was leaving Resident #54's room. Staff A</p>	{N 201}		
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{N 201}	<p>Continued From page 17</p> <p>checked her computer stating the order is for 2 Liters and the tubing is changed on Sundays or as needed on the night shift.</p> <p>During an observation after the interview with Staff A, on at 11:10 AM, Resident #54 was in bed awake with 4 liters of . . . via a . . .</p> <p>11) Observations of Resident #302 on . . . revealed that the resident is on . . . by . . . The setting of his . . . is set at 4.5 lpm (liters per minute). A review of Resident #302's records revealed that Resident #302 was admitted to the facility on with a diagnosis to include (. . .) with Acute Exacerbation, . . . Failure with Hypercapnia, Dependent on . . . Type II . . . A review of the Physician's Orders documents the order to read continues . . . will tolerated every shift Start . . . It does not state the liters per minutes (lpm) nor what type of device the resident should be using.</p> <p>During an interview on with Staff N, Unit Manager/RN she was asked what the process is for a resident on . . . She stated they check the every shift, he has . . . and the is set at 3 LPM, every Thursday they change his . . . Requested her to pull up his orders. She read off that it showed "continues will tolerated every shift Start . . ." she said OK and didn't seem concerned that the order did not have how many lpm nor by what method. We went into resident's room and the surveyor asked what the was at. She stated 4.5 LPM. The resident interjected and stated that he always</p>	{N 201}			

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{N 201}	<p>Continued From page 18</p> <p>has it at 4 lpm at home but because he is more active here at the facility it is at 5 lpm. Staff N, Unit Manager stated she will call the physician to get orders updated. On _____ it now reads _____ Continuous. Encourage and assist resident to use _____ @ 4.5L via NC continuously as tolerated for _____ every shift for _____ and _____ Tubing Change: Change _____ tubing/mask/bag Q week and PRN every night shifts every Thursday for monitoring.</p> <p>Uncorrected Class III</p>	{N 201}		
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