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
	35961037	A. BUILDING: **02** B. WING _____	**04/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE AT JUPITER REHABILITATION CENTER (THE)	**674 PIONEER ROAD JUPITER, FL 33458**

(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) COMPLETE DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 04/07/25 at Luxe at Jupiter Rehabilitation Center (The), a nursing home in Jupiter, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K 000		
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18/19.7.4(3) shall not apply where the patient is under direct	K 741		4/22/25

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K 741	Continued From page 1 supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 (Note smoking tower disposal receptacles are not ashtrays) This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain their smoking policy in accordance with NFPA 101. This could affect all residents and staff. The findings include: On 04/07/25 at approximately 3:30 PM while exiting the facility, it was observed that two residents were smoking just outside the main entrance of the facility. The facility does not have a smoking policy or a designated smoking area due to the campus being a non-smoking campus. It was also observed that the residents had personal possession of cigarettes and lighters, and were smoking without supervision from the facility. An interview was conducted with the Administrator concurrent with the observations and the findings were confirmed. NFPA 101 (2021 edition) 18.7.4 (1-6) Class III	K 741	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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The 2 residents observed smoking just outside the main entrance were educated on safe smoking practices, removed from front patio and smoking materials were secured by staff. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: Facility audit completed of current residents who smoke to ensure assessments completed and smoking	

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K 741	Continued From page 2	K 741	contracts signed acknowledging facility policies and safe smoking practices. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On 4.22.25 the facility implemented a smoking policy and a designated smoking area adopting smoking regulations as outlined in K741, for current residents identified as smoking residents; required . Newly admitted residents shall be informed that they will be admitted under the non-smoking campus policy and regulations. On 4.22.25 Administrator completed education with current staff on safe smoking practices, storage of smoking materials and designated smoking area. Newly Hired staff will be educated on safe smoking practices, storage of smoking materials and designated smoking area during new hire orientation by the Assistant Director of Nursing as part of the systematic changes. 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: The Maintenance Director/designee will conduct random audits of the smoking area as well as all areas of the facility premises to ensure compliance with the smoking policy 2 times a week for 4 weeks, every week for a month and then	

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K 741	Continued From page 3	K 741	monthly. Findings will be shared with the Quality Assurance and Improvement Committee until committee determines substantial compliance has been met.	

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CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		4/22/25

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to remain in compliance with maintaining the Comprehensive Emergency Management Plan (CEMP). This plan helps to instruct those at the facility on proper actions during an emergency. The findings included: During record review with the Administrator on 04/07/25 between the hours of 11:30 AM thru 2:00 PM, it was revealed the facility did not have the CEMP reviewed for the current year by the local emergency management agency. The facility could not provide a copy of the most recent approval letter from any prior year. The last rejection was on 12/16/24. At the time of the survey the facility had yet to submit their CEMP to the local emergency management agency for the current year. An interview was conducted with the Administrator concurrent with the record review the findings were confirmed. The findings were reviewed with the Administrator and the Maintenance Director at the exit conference on 04/07/25 at 4:00 PM. Florida Administrative Code 59A-4.126. Class III	CZ830	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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by alleged deficient practice. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: No residents were affected by alleged deficient practice. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: An annual review of the facility emergency management plan was conducted on 4.8.25 and submitted to the local emergency county on 4.8.25. The facility is currently waiting on a response from the county for the approval of the	

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CZ830	Continued From page 3	CZ830	Comprehensive Emergency Management Plan; proof of payment submitted on 4.8.25. 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: The Facility administrator will continue to be in touch on a weekly basis with the county emergency management office to ensure the actual review was completed and the facility is in compliance with the CEMP and that will be reviewed on an annual basis. The findings of these quality reviews will be reported to the Quality Assurance/ Risk Management Committee until committee determines substantial compliance has been met. The Administrator ensure that compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106148	A. BUILDING **02 - FED BUILDING** B. WING _____	**04/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE AT JUPITER REHABILITATION CENTER (THE)	**674 PIONEER ROAD JUPITER, FL 33458**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted on 04/07/25 at Luxe at Jupiter Rehabilitation Center (The), a nursing home in Jupiter, Florida. Luxe at Jupiter Rehabilitation Center (The) is not in compliance with 42 CFR 483.90 (a) and National Fire Protection Association (NFPA) 101 (2012 edition), NFPA 99 (2012) requirements for nursing homes. Initial Plan Review: 2011 New NFPA 220 Construction Type: I (322) Number of beds: 129 Census: 112 The following is description of the noncompliance.	K 000		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: 1. Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. 2. In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. 3. Smoking by patients classified as not responsible shall be prohibited. 4. The requirement of 18.7.4(3) shall not apply	K 741		4/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2025

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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K 741	Continued From page 1 where the patient is under direct supervision. 5. Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. 6. Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain their smoking policy in accordance with NFPA 101. This could affect all residents and staff. The findings include: On 04/07/25 at approximately 3:30 PM while exiting the facility, it was observed that two residents were smoking just outside the main entrance of the facility. The facility does not have a smoking policy or a designated smoking area due to the campus being a non-smoking campus. It was also observed that the residents had personal possession of cigarettes and lighters, and were smoking without supervision from the facility. An interview was conducted with the Administrator concurrent with the observations and the findings were confirmed. NFPA 101 (2012 edition) 18.7.4 (1-6)	K 741	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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The 2 residents observed smoking just outside the main entrance were educated on safe smoking practices, removed from front patio and smoking materials were secured by staff. How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: Facility audit completed of current residents who smoke to ensure assessments completed and smoking contracts signed acknowledging facility	

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K 741	Continued From page 2	K 741	policies and safe smoking practices. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On 4.22.25 the facility implemented a smoking policy and a designated smoking area adopting smoking regulations as outlined in K741, for current residents identified as smoking residents; required . Newly admitted residents shall be informed that they will be admitted under the non-smoking campus policy and regulations. On 4.22.25 Administrator completed education with current staff on safe smoking practices, storage of smoking materials and designated smoking area. Newly Hired staff will be educated on safe smoking practices, storage of smoking materials and designated smoking area during new hire orientation by the Assistant Director of Nursing as part of the systematic changes. 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: The Maintenance Director/designee will conduct random audits of the smoking area as well as all areas of the facility premises to ensure compliance with the smoking policy 2 times a week for 4 weeks, every week for a month and then	

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K 741	Continued From page 3	K 741	monthly. Findings will be shared with the Quality Assurance and Improvement Committee until committee determines substantial compliance has been met.	

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E 000	Initial Comments During the recertification survey conducted on 04/07/25 at Luxe at Jupiter Rehabilitation Center (The), a nursing home, the Emergency Preparedness Program (EP) was reviewed. Luxe at Jupiter Rehabilitation Center (The) is in compliance with Emergency Preparedness rule per CFR (Code of Federal Regulations) 42, Part 483.73, Requirements for Long Term Care Facilities. The facility was found in compliance at the time of the survey.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2025

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