STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105300	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Coast Center for Rehabilitation and Healthc	9555 SE Federal Hwy Hobe Sound, FL 33455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observation, interview, and record review, the facility failed to speak in a dignified manner during care, activities, and meals for 4 of 4 sampled residents (Resident #36, #86, #8, and #83), reviewed for dignity The findings included: 1) Record review revealed Resident #36 was admitted to the facility 06/26/24. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #36 had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. The MDS, section D, for Mood documented she sometimes felt lonely or isolated from those around her. Review of the Care Plan dated 10/15/24, documented Resident #36 had diagnoses of Major Depressive Disorder, Anxiety Disorder, and Schizoaffective Disorder. During an interview on 11/04/24 at 12:59 PM, when asked if she was being treated with dignity and respect, Resident #36 voiced that sometimes the Certified Nursing Assistants (CNAs) spoke another language in front of her. The Resident stated, Their feelings come out through their language spoken; I feel like they are talking about me. She explained sometimes she would go out to the nurses' desk to ask for something, and staff ignored her. When asked how that made her feel, the resident stated she didn't feel like she had done anything wrong and felt disrespected. When asked if she had told anyone about these interactions with staff, she stated she hadn't told anyone because she was afraid staff would be mad at her. During a follow up interview on 11/07/24 at 10:45 AM, when asked how her care had been since the last interview, Resident #36 stated There are only certain individuals who are not treating me nice; I wish nurses would ask me how I'm feeling more often. The resident voiced desire to address concerns with staff and thanked the surveyor for helping. During an interview on 11/07/24 at 10:56 AM, when Resident #36's concerns were brought up, the Social Services Director stated she was not aware of the situation. She agreed the resident was not treated in a dignified manner and should not fear retaliation from staff. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Record review revealed Resident #86 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #86 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the Care Plan dated 09/24/24, documented Resident #86 diagnoses include Major Depressive Disorder, Anxiety Disorder, dependence on Renal Dialysis, abnormalities of gait and mobility, and severe protein-calorie Malnutrition. During an interview on 11/05/24 at 8:35 AM, Resident #86 was observed to be visibly upset. When asked if staff treat her with dignity and respect, the resident replied, No they don't ever really respect me or treat me with dignity. When asked to provide an example, the resident stated One time I got back from dialysis and asked for my food, the (CNA) said it was too late to eat but offered me a peanut butter and jelly sandwich but I declined the sandwich. The resident stated the (CNA)'s response was Oh well then go walk and get it yourself. The resident replied to the (CNA) You know I can't walk. The (CNA) replied, Well then I guess you can't eat. When asked how that made the resident feel, she stated she felt disrespected. When asked if she had told anyone about the situation, she stated I don't tell them because they still have to take care of me and I don't want them to be meaner to me after. During an interview on 11/05/24 at 9:06 AM, when asked if he was aware of Resident #86's concerns, the Administrator was not aware of the concerns and agreed the resident had not been treated in a dignified manner and should not fear retaliation. During a follow up interview with Resident #86 on 11/07/24 at 10:40 AM, she thanked the surveyor for helping address her concerns. The resident stated, Thank you for helping me out the other day and reporting it for me, I just didn't want to get anyone in trouble. 25404 3) Record review revealed Resident #8 was admitted to the facility on [DATE], with readmission on 04/18/24, and resided on the secured memory care unit. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 5, on a 0 to 15 scale, indicating the resident was cognitively impaired, but exhibited clear speech. This MDS also documented Resident #8 had impaired vision secondary to glaucoma. Review of the current care plan initiated on 12/28/23 documented Resident #8 had potential impaired visual function related to glaucoma. A care plan initiated on 05/26/23 documented Resident #8 required set up assistance with the meal tray to eat. During an observation on 11/04/24 at 11:51 AM, 18 residents were in the main dining room awaiting lunch. Resident #8 was sitting at a long table with other residents, and loudly asked, Are we gonna eat? Staff responded yes and that the food was coming. The tray cart arrived at 12:22 PM, and a meal was provided to the resident sitting next to Resident #8, and she stated, I smell the food and again asked if she was going to eat. Staff did not provide food to Resident #8 until 12:38 PM, and never addressed her after her table mate received a meal. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent observation on 11/05/24 at 9:59 AM, Resident #8 was in the main dining room, which was also the activity room, and yelled out, Are we gonna eat? Staff F, Unit Manager responded, We just had breakfast about an hour and half ago and walked away. No staff asked if she was hungry and or if she wanted something to eat. 4) Review of the record revealed Resident #83 was admitted to the facility on [DATE], and currently resided on the secured memory care unit. Review of the current MDS assessment dated [DATE], documented the resident had not completed a BIMS evaluation as he was rarely understood. The most recent fall risk assessment dated [DATE] indicated the resident was at high risk for falls with a score of 23. Review of the care plan initiated on 08/22/23 documented Resident #83 exhibited a communication impairment due to Alzheimer's dementia, and staff were to gently approach the resident in an open, friendly, and relaxed manner. A care plan initiated on 08/16/24, documented the resident was at risk for falls related to muscle weakness, incontinence, poor safety awareness, and medication use. This care plan instructed staff to encourage the resident to participate in activities that promote exercise, physical activity for strengthening, and improved mobility. During an observation on 11/06/24 at 9:30 AM, Resident #83 was in the activity room and attempted to stand up from his wheelchair. Staff G, Certified Nursing Assistant (CNA) approached the resident, and spoke with him, telling him to be calm, as she was gently pushing on the resident's left shoulder. The CNA did not allow the resident to stand up from the wheelchair. At 9:34 AM Resident #83 again attempted to stand up from his wheelchair, and the same CNA did not allow the resident to stand all the way up and immediately encouraged him to sit back down. The Unit Manager went over to the resident and stated, [First name of resident], sit down on your butt please. Stay down . promise? At 9:42 AM, Resident #83 attempted to stand up again. Staff G, CNA, immediately stated, [First name of resident] sit down and gently pushed him back in the chair and stated, Sit back and relax. At 9:44 AM, Resident #83 again attempted to get up. Staff I, CNA, had just entered the common area, and went over to help Resident #83 stand for a few minutes. Resident #83 sat back down on his own, and did not try to stand back up. During an interview on 11/06/24 at 9:21 AM, Staff I, CNA stated Resident #83 could walk, and that she and Staff J, CNA, would often work together and they both allow him to walk from his bed to the bathroom, or down the hall with assistance. During an observation on 11/06/24 at 3:12 PM, Resident #83 was in his wheelchair near the nurse's station and stood up unattended. Staff H, Licensed Practical Nurse (LPN), went to him and immediately tried to get him to sit down, and the resident resisted. The resident stood for a few moments and was trying to walk. When asked if he could walk down the hall with assist, the LPN stated, Yes, but that is when he falls. After the surveyor questioned, the LPN walked with Resident #83 back to the activity room and sat back down in his wheelchair. The resident settled down and sat at the table.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on interviews and record reviews, the facility failed to provide showers per resident's preferences and according to the shower schedule for 1 of 2 sampled residents reviewed for choices, (Resident #309). The findings included: Record review for Resident #309 revealed that the resident was admitted to the facility on [DATE] and moved to her current room on 10/11/24. According to the resident's most recent complete assessment, a Medicare 5-Day Minimum Data Set (MDS), dated [DATE], Resident #309 had a Brief Interview for Mental Status score of 14, indicating that the resident was 'cognitively intact'. The assessment documented that Resident #309 required 'substantial/maximal assistance' for bed transferring from the bed, and 'partial/moderate assistance' for bed mobility. Resident #309's diagnoses at the time of the assessment included: Hypertension, UTI (Urinary Tract Infection) (last 30 days), DM (Diabetes Mellitus), Hyponatremia, Hyperlipidemia, Malnutrition, Anxiety disorder, Depression, Polyneuropathy, Immunodeficiency, Muscle weakness, Dysphagia, Abnormalities of gait and mobility, Need for assistance with personal care, Constipation, Adjustment disorder with mixed anxiety and depressed mood, Muscle wasting and atrophy, necrotic bilateral lower legs (heels) and that the resident was at risk for pressure development with none present upon admission. Resident #309's orders dated 11/05/24 included: Resident prefers to shower Tuesday, Thursday and Saturday 1500PM-2300PM; Bed bath PRN (as needed) - every evening shift every Tuesday, Thursday, and Saturday. Resident #309's care plan for Activities of Daily Living (ADLs), initiated on 08/19/24 and most recently revised on 08/28/24, documented, Resident has an ADL self-care performance deficit related to Diabetes Mellitus, Urinary Tract Infection, history of Deep Vein Thrombosis, Hypertension, Hyperlipidemia, history of Cerebrovascular Incident, Neuropathy, history of Anxiety, Depression, Right lower extremity Cellulitis, Muscle Spasms, muscle weakness. The goal of the care plan was documented as, Resident will improve current level of function in ADLs through the review date. Date Initiated: 08/19/2024 Revision on: 09/05/2024 Target Date: 09/12/2024 Interventions to the care plan included: o showers as scheduled Date Initiated: 08/19/2024. o BED MOBILITY: The resident requires partial/moderate assistance by 1 staff to turn and reposition in bed frequently and as necessary. Date Initiated: 08/19/2024. o TRANSFER: The resident requires substantial/maximal assistance by 1 staff to move between surfaces frequently and as necessary. Date initiated: 08/28/24. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 11/05/24 at 9:19 AM with Resident #309 and the resident's daughter, when asked about being provided with showers, Resident #309 stated that she had not been showered since being admitted to the facility. The resident's daughter stated that the resident had only been showered on two occasions since being admitted to the facility. Record review of an ADL task worksheet for the previous 30 days, documented that Resident received showers on 5 occasions and was provided bed baths multiple times. Further review of the resident's electronic health record revealed no documentation of Resident #309 refusing ADL care and showers. During an interview, on 11/06/24 at 4:43 PM with Staff C, CNA, when asked about providing showers to Resident #309, Staff C replied, I only work 2-3 days a week on 3 PM to 11 PM shift. She never refuses, if they refuse, I would let the supervisor know and document in the POC (Plan of Care). During an interview, on 11/06/24 at 4:46 PM, with Staff D, RN (Registered Nurse) Supervisor, when asked about ensuring that residents are provided showers per preferences and according to schedule, Staff D replied, I know when I am working, the CNA gives me the paper and I sign off on them and they go to the Unit Manager (UM). During an interview, on 11/06/24 at 4:52, with Staff E, LPN (Licensed Practical Nurse) /UM, when asked about ensuring that residents are provided showers per preferences and according to schedule Staff E replied, the shower sheets reflect what is in the electronic health record. I talk to them every day (referring to Resident #309 and the resident's family member) and they have not said anything to me about showers being an issue.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide housekeeping and maintenance services as a means to provide a clean, safe, and home like environment on 3 of 4 units, in the Shower room and the outside patio. The findings included: During a tour of the facility, conducted on 11/04/24 from 9:00 AM to 4:00 PM, the following was observed: On the 200 unit: In room [ROOM NUMBER], the wall behind the head of the B (window) bed was damaged. In room [ROOM NUMBER], the wall to the left of the hand sink in the shared restroom was damaged and the wall to the resident's right side of the bed (A bed) was damaged. On the 300 unit: In room [ROOM NUMBER], the seat of the wheelchair for the resident in the D bed (closest to the door and on the right) was worn and there were multiple black marks on the floor. In room [ROOM NUMBER], the laminate surfaces of the over bed tables were damaged to a point where the particle board underneath was exposed. In room [ROOM NUMBER], the over bed table for the B bed was damaged to a point where the table leaned and was not sturdy. In room [ROOM NUMBER], there was a strong urine odor noted during all four days of the survey by several members of the survey team. On the 400 unit: Outside of room [ROOM NUMBER], a ceiling tile by the air conditioning vent was stained in a manner indicative of the tile being wet at some point. In room [ROOM NUMBER], the arms on both of the residents' wheelchairs were damaged to a point where the foam padding underneath was exposed and there was no remote for the television for the B bed. In room [ROOM NUMBER], the privacy curtain between the beds was stained and the wall by the closet was damaged. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In room [ROOM NUMBER], the overbed tables were damaged to a point where the particle board underneath was exposed; the remote control for the television of the B bed was damaged; and there was a red light on the wall mounted air conditioning unit that indicated the filter needed to be cleaned or changed. In the shower room on the 100 unit, the baseboard and wall inside of the entrance to the room was damaged; the kick plate on the back side of the entry door was damaged; and there was a black mold like residue on the walls and in the grout of the shower stall. During the environmental tour, on 11/07/24 at 1:35 PM, the Maintenance Director and the Housekeeping/Laundry Supervisor acknowledged understanding of the concerns. The Maintenance Director stated, We are in the process of replacing the tiles. We have extra tiles, we are focusing on the tiles that need to be replaced and then we are going to overhaul room by room. The Administrator stated, we are waiting for regional to assist with the planning and the manpower to plan on re-doing the floors and the doors. The company that took over started managing the facility with a CHOW (Change of Ownership) in January 2024. We started ordering the new ones (referring to the over bed tables) and the issue that we had was that some of them were coming out of the box like that and we switched to the plastic ones. We are getting 20-30 per month and replacing the old ones. The Administrator and the Director of Maintenance were not able to provide a time frame for the repairs and replacement of the over bed tables when asked.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078 Based on interview and record review, the facility failed to ensure the participation of the resident in the development of the resident's care plan and ongoing participation in resident care planning meetings for 1 of 2 sampled residents reviewed for Care Planning (Resident #34). The findings included: On 11/04/24 at 9:14 AM during the initial resident interview with Resident #34, he stated that he was very upset at being unable to leave the facility. I want to get out of here. I am here against my will. As far as I know, I am still responsible for my own health care decisions, but no one lets me make decisions about my health care. I do not have a power of attorney or a health care surrogate. I have never been invited to any care plan meetings. All decisions are made by my sister, and I don't want anything to do with her. A review of Resident #34's Minimum Data Set (MDS) assessment showed that Resident #34 was assessed to have a Brief Interview Mental Status score of 13 out of a possible 15 (mildly impaired). There was no documentation in his electronic record which showed he had an assigned power of attorney or named anyone in his family as a health care surrogate or legal representative. There was also no documentation which showed that he was mentally incapacitated to make his own health care decisions. All the care plan meetings reviewed showed that Resident #34's sister had been invited to the care plan meetings, and she had attended, but there was no evidence that Resident #34 had been invited or attended any of the meetings other than his initial meeting at the time of admission. Record review revealed on 08/20/2024 at 1:13 PM MDS / Care Plan Note: care plan meeting held with [sister] reviewed care plan no care concerns noted. 04/02/2024 14:01 MDS/Care Plan Note: care plan meeting held with sister via phone would like resident to have double portions for breakfast in am, no other care concerns noted. 03/21/2024 13:04 - Social Services Note: Writer spoke with [resident's] sister that if [resident] has to be transferred to an ALF, she is requesting a facility in Okeechobee . 01/17/2024 13:59 - Social Services Note: CP [care plan] meeting held on 1/9/24 with IDT (Interdisciplinary Team), Pt's (patient) sister [name] and Brother in Law [name] as POC [plan of care] continues as reviewed. Pt is alert and oriented, with confusion however is able to communicate his needs effectively .They are requesting LTC for Pt (patient) . 01/12/2024 10:16 - MDS/Care Plan Note: Care plan meeting held with IDT and [Sister and Brother-in-Law]. Reviewed medications, weight, diet, meal intake, ADL's, Therapy, Code status, D/C (discharge) plan. Stated she would like to get POA (power of attorney) papers completed and will meet with notary and then give POA papers to SS (social services). Stated [resident] will not be able to return home, he was a Hoarder and will not be able to return to home he was living in. Continue with current plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/22/2023 12:30 - Social Services Note: 48 hr CP meeting held with IDT team, sister, Niece and Pt at bedside as POC continues as reviewed. Pt is alert with confusion although is able to communicate his needs. Mood is stable with no behaviors evident. Family is very supportive and are requesting LTC (Long Term Care).No DPOA (Designated Power of Attorney) or AD (Advanced Directives) are on file, therefore Pt is a Full Code. On 11/07/24 at 11:51 AM, the Social Services Director was interviewed and asked to assist in locating any documentation as to why Resident #34 was not in attendance at this care plan meeting. On 11/07/24 at approximately 1:00 PM, the Social Services Director reported that she was unable to determine why the resident was not being invited or attending his care plan meetings. She also stated that she could not locate any documentation in the resident's record that the resident was unable to make his own health care decisions. On 11/07/24 at 2:29 PM, the MDS Coordinator stated, I have only been working for 2.5 weeks. She acknowledged that she could not find any documentation that Resident #34 was provided with an invitation to his care plan meetings. She stated, The Receptionist will mail out the letters to the family members, and the Activities Department hands out the letters to the residents. On 11/07/24 at 2:42 PM, the Activities Assistant stated that all the care plan meeting letters that are to be handed out to the residents are put in her mailbox, and she passes them out. She stated that she had no documentation to show that an invitation was provided to Resident #34. On 11/07/24 at 2:44 PM Resident #34 was again asked if he was provided with a letter of invitation to his care plan meetings, he adamantly stated, I have never been invited to a care plan meeting. If they gave me something, I wouldn't be able to read it anyways; I am illiterate. On 11/07/24 at 2:59 PM, the Social Worker was interviewed about Resident #34 being illiterate. She stated, He asks for the Chronicle every morning, and he was able to read the paper that I just now provided to him. I don't know why he would claim to be illiterate On 11/07/24 at approximately 4:00 PM, the Administrator was informed of the concern regarding Resident #34 not being involved with his care plan and lack of any documentation showing resident was invited and encouraged to attend his care plan meeting. It was also discussed with the Administrator that since the resident had no documentation showing he had appointed anyone to be his POA, Health Care Surrogate or Representative, it may not be appropriate for the resident's sister and brother-in-law to be invited to participate in his care plan meetings unless he gives his consent.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, interview, and record review, the facility failed to provide assistance with grooming, including hair washing and nail care to 3 of 5 sampled residents, who were dependent upon staff for care (Resident #28, #40, and #44). The findings included: 1) Review of the record revealed Resident #28 was admitted to the facility on [DATE] and resided in the secured memory care unit. Review of Minimum Data Set (MDS) assessment dated [DATE] lacked a Brief Interview for Mental Status (BIMS) score as the resident was rarely understood. This MDS documented the resident needed partial to substantial assistance from staff for Activities of Daily Living (ADLs). Review of a care plan initiated 03/18/23 documented Resident #28 had a communication problem and impaired ability to make self understood and another initiated on 06/07/23 that she needed the assistance of staff for all ADLs. Review of the Certified Nursing Assistant (CNA) tasks indicated the resident had only had one shower in the past month. Observations on 11/04/24 at 12:16 PM, 11/05/24 at 9:58 AM, and on 11/06/24 at 9:49 AM all revealed the resident's hair needed to be washed as it appeared flat and greasy. During an interview on 11/07/24 at 11:40 AM, when asked about showers and hair washing for Resident #28, Staff J, CNA, stated that most of the time the resident was already up out of bed when she arrived to work. When asked if that was a reason to not provide a shower, the CNA did not answer. When asked if she had provided a shower to Resident #28, or washed her hair this week, the CNA stated, I think Monday. 2) Review of the record revealed Resident #40 was admitted to the facility on [DATE] and resided in the secured memory care unit. Review of Minimum Data Set (MDS) assessment dated [DATE] lacked a Brief Interview for Mental Status (BIMS) score, as the resident was rarely understood. This MDS documented the resident needed substantial assistance from staff for showering and bathing. Review of care plans initiated on 09/18/21 documented Resident #40 was severely cognitively impaired for daily decision making and needed the assistance of one staff for all ADLs. Observations on 11/04/24 at 12:11 PM, 11/05/24 at 9:39 AM. and 11/06/24 at 9:38 AM revealed the resident's hair needed to be washed. During the first two observations the resident's hair was hanging loose and appeared flat and greasy. The resident had her hair pulled back in a ponytail on the third observation and it remained greasy looking. 3) Review of the record revealed Resident #44 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 4, on a 0 to 15 scale, indicating severe cognitive impairment. An MDS assessment dated [DATE] documented a BIMS score of 7, and the resident indicated the provision of a bath and shower were very important. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105300	A. Building B. Wing	11/07/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although a care plan initiated on 04/07/24 indicated the resident refused showers and ADL at times, review of progress notes and CNA documentation lacked any documented refusal of care in the past 30 days. Observations on 11/04/24 at 11:20 AM and on 11/05/24 at 2:10 PM revealed Resident #44's hair needed to be washed as it appeared greasy. During a supplemental observation and interview on 11/07/24 at 11:48 AM, when asked if she felt as if Resident #44 was receiving proper care and services, the Power of Attorney (POA) stated, No look at that hair. It looks like it hasn't been washed in weeks. And these fingernails are way too long. [Name of Resident #44] would always keep her nails short and clean. Observation of the resident's fingernails revealed they were all very long. When asked if she had spoken to staff about her concerns, the POA stated she had just last week, to include the Social Services Director (SSD). During an interview on 11/07/24 at 11:58 AM, when asked if she was able to trim fingernails, Staff G, assigned CNA, stated she could but had not done so for Resident #44. During an observation and interview on 11/07/24 at 12:08 PM, Staff H, Licensed Practical Nurse (LPN) agreed the resident had excessively long fingernails and greasy hair. The LPN stated she was unaware the aides where not doing the ADLs and just hadn't noticed. The LPN agreed she should have noticed the needed care. On 11/07/24 at 12:18 PM, the SSD stated she did not recall any conversation with the POA of Resident #44.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, interview, and policy review, facility staff failed to assess lung sounds and vital signs pre and post nebulizer treatments for 3 of 3 sampled residents reviewed for nebulizer treatments (Residents #42, 95 and #63). The findings included: 1) Review of the policy titled, Respiratory Care and Oxygen Administration revised 10/2022 documented, in part, 12. Evaluation of respiratory status and breath sound and response to treatment should be documented in the clinical record. Review of the record revealed Resident #42 was ordered a nebulizer treatment, Ipratropium-Albuterol, every four hours for lung congestion. This order dated 11/05/24 specifically instructed to assess and document the resident's lung sound, pulse and respiration rates, and oxygen saturation level pre and post treatment. During an observation on 11/06/24 beginning at 4:18 PM, Staff N, Licensed Practical Nurse (LPN), obtained the nebulizer treatment for Resident #42 from the medication cart, placed the medication into the nebulizer mask, and started the treatment. The LPN checked the resident's oxygen saturation level and pulse rate, then looked at the resident for a moment and stated, No cough so breathing is clear. At 4:32 PM the LPN stated the treatment was complete and assessed the resident's oxygen saturation level and pulse rate again and left the room. The LPN confirmed she had completed the treatment. When asked if she would normally assess lung sounds with a stethoscope, the LPN stated she would. When asked why she did not do so for Resident #42, Staff N stated, If she is not coughing, she is clear. If she is coughing, I would listen. I used nursing judgement. She was clear. 2) Record review revealed Resident #95 was ordered the nebulizer treatment of Acetylcysteine Solution 10% for secretions, twice daily for three weeks, as of 10/23/24. A second nebulizer treatment initiated on 09/26/24 for Ipratropium-Albuterol was to be administered via nebulizer four times daily. Both orders specified to assess and document lung sounds, pulse and respiratory rates, and oxygen saturation levels, pre and post treatments. The second nebulizer treatment lacked any place to document the assessments. During an observation on 11/06/24 beginning at 12:44 PM, Staff K, LPN, gathered the Ipratropium Albuterol nebulizer to administer to Resident #95. The LPN put the medication into the nebulizer, hooked up the tubing to the resident's tracheostomy (an opening surgically created through the neck into the trachea to allow air to fill the lungs), and began the treatment. The LPN stood at the bedside during the entire treatment, but did not perform any type of assessment or do any vitals. During an interview on 11/07/24 at 10:23 AM, when asked the assessment process when administering a nebulizer treatment, Staff K stated she took the resident's vitals prior to the treatment. When asked if there was any other type of assessment that needed to be done, the LPN was unsure. The LPN was unaware of the need to complete additional vitals after the treatment or to assess the lung sound pre or post treatment. (continued on next page)

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	105300	A. Building B. Wing	11/07/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51137 3) Review of the policy titled, Standards and Guidelines: SG Respiratory Care and Oxygen Administration issued 3/2020 and revised 10/2022 documented, Guidelines: . 12. Evaluation of respiratory status and breath sounds and response to treatment should be documented in the clinical record, especially if treatment is provided as needed for an exacerbation or acute onset of a respiratory condition. Record review revealed Resident #63 was admitted to the facility 10/19/24. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #63 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS section I Active Diagnoses documented he had respiratory failure. Review of the Care Plan dated 10/19/2024 documented, Resident #63 has congestive heart failure and will have clear lung sounds, heart rate, and rhythm within normal limits through review date. This same care plan revealed interventions such as check breath sounds and monitor/document for labored breathing, monitor/document for the use of accessory muscles while breathing, and vital signs as ordered/PRN (as need.) During a medication administration observation on 11/06/24 at 04:20 PM, Staff L, Licensed Practical Nurse (LPN), administered a nebulizer treatment to Resident #63 without performing a pre-administration or post administration assessment. When asked how she knew if the medication was working for the Resident, Staff L states I could check his vitals and his breathing. When asked how she would do that and why she had not done that, Staff L stated she would check his pulse oxygenation, but she forgot. Staff L did not mention she would auscultate (listening with intent to examine) for lung sounds.

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	105300	A. Building B. Wing	11/07/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 25404 Based on observation, record review, and interview, the facility failed to ensure pain management for 1 of 5 sampled residents, as evidenced by the failure to administer a lidocaine patch, as per physician order for Resident #99. The findings included: Review of the record revealed Resident #99 had an order initiated on 10/31/24 for a lidocaine 5% patch, to be applied to the lower back daily at 9 AM and removed daily at 9 PM. A medication pass observation was made for Resident #99 on 11/06/24 at 8:57 AM, with Staff K, Licensed Practical Nurse (LPN). The LPN obtained a lidocaine 5% patch from the medication cart, took a piece of paper tape and applied to the outside of the patch, and wrote the date on the piece of tape, using a thick black marker. The LPN entered the resident's room, and upon pulling up the back of the resident's shirt, a lidocaine patch with the initials of Staff K and the date of 11/04/24 was noted on the resident's lower back. The LPN confirmed that was the patch she had placed on the resident's back on Monday 11/04/24, and that she did not work on Tuesday 11/05/24. The LPN also confirmed the order was for the patch to be placed on the resident's back every morning and removed every night. Further review of the November 2024 Medication Administration Record (MAR) revealed Staff K documented the placement of the patch on Monday 11/04/24. This MAR documented another nurse removed the patch on 11/04/24 at 9 PM, while a second nurse applied and removed a patch on 11/05/24. This obviously did not happen as the patch observed on Wednesday 11/06/24 was dated Monday 11/04/24. The Director of Nursing was made aware of observation on 11/06/24 during the morning, and agreed with the concern.

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	105300	A. Building B. Wing	11/07/2024

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078 Based on interviews and record review, the facility failed to ensure sufficient and appropriate social services are provided to meet the needs of 1 of 1 sampled resident (Resident #34), related to the following: 1) Advocating for resident and assisting in the assertion of their rights within the facility; 2) Assisting resident in voicing and obtaining resolutions to grievances about discharge wishes; 3) Assisting resident with financial and legal matters (e.g., referrals to lawyers); and 4) Assisting with transitions of care services (e.g., assisting the resident with identifying community placement options and completion of the application process, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities. The findings included: On 11/04/24 at 9:14 AM during the initial resident interview with Resident #34, he stated that he was very upset at being unable to leave the facility. I want to get out of here. I am here against my will. As far as I know, I am still responsible for my own health care decisions, but no one lets me make decisions about my health care. I do not have a power of attorney or a health care surrogate. I have never been invited to any care plan meetings. All decisions are made by my sister, and I don't want anything to do with her . I really need some help with finding a lawyer to assist me. My sister took my house, my car and all my money out of my bank account .the only way I am getting out of here is in a body bag. Can you please help me! A review of Resident #34's Minimum Data Set (MDS) assessment showed that Resident #34 was assessed to have a Brief Interview Mental Status score of 13 out of a possible 15 (mildly impaired). There was no documentation in his electronic record which showed he had assigned power of attorney or named anyone in his family as a health care surrogate or legal representative. There was also no documentation which showed that he was mentally incapacitated to make his own health care decisions. All the care plan meetings reviewed showed that Resident #34's sister had been invited to the care plan meetings, and she had attended, but there was no evidence that Resident #34 had been invited or attended any of the meetings other than his initial meeting at the time of admission. On 08/20/2024 at 1:13 PM MDS/Care Plan Note: care plan meeting held with [sister] reviewed care plan no care concerns noted. 04/02/2024 14:01 - MDS / Care Plan Note: care plan meeting held with sister via phone would like resident to have double portions for breakfast in am, no other care concerns noted. 03/21/2024 13:04 - Social Services Note: Writer spoke with [resident's] sister that if [resident] has to be transferred to an ALF, she is requesting a facility in Okeechobee . (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/17/2024 13:59 Social Services Note: CP [care plan] meeting held on 1/9/24 with IDT (Interdisciplinary Team), Pt's (patient) sister [name] and Brother-in-Law[name] as POC (plan of care) continues as reviewed. Pt is alert and oriented, with confusion however is able to communicate his needs effectively .They are requesting LTC (Long Term Care) for Pt (patient) . 01/12/2024 10:16 - MDS/Care Plan Note: Care plan meeting held with IDT and [Sister and Brother-in-Law]. Reviewed medications, weight, diet, meal intake, ADL's, Therapy, Code status, D/C (discharge) plan. Stated she would like to get POA (power of attorney) papers completed and will meet with notary and then give POA papers to SS (social services). Stated [resident] will not be able to return home, he was a Hoarder and will not be able to return to home he was living in. Continue with current plan of care. 12/22/2023 12:30 - Social Services Note: 48 hr CP meeting held with IDT team, sister, Niece and Pt at bedside as POC continues as reviewed. Pt is alert with confusion although is able to communicate his needs. Mood is stable with no behaviors evident. Family is very supportive and are requesting LTC.No DPOA or AD are on file, therefore Pt is a Full Code. On 11/07/24 at approximately 1:00 PM, the Social Services Director reported that she was unable to determine why the resident was not being invited or attending his care plan meetings. She also stated that she could not locate any documentation in the resident's record that the resident was unable to make his own health care decisions. She also confirmed that Resident #34 had not appointed a power of attorney or health care surrogate to make health and/or financial decisions for him. The Social Services Director did not provide any information showing that she had offered the resident any assistance in resolving his numerous voiced requests to be discharged out to a less restrictive living facility. There was a note on 12/22/23 that the sister was requesting long term care, but no documentation showing legal authority for her to do so. There was no documentation that the Social Services Director had addressed Resident #34's requests to be referred to a lawyer, or that Social Services had addressed Resident #34's accusations that his family had misappropriated his house, car and money in his bank account. The Social Services Director stated that she believed the Resident's BIMS was lower than a 13 and questioned if he was able to make his own decisions. However, there was nothing found in the resident's health record, or provided by the facility, that supported that the resident was not able to make his own health care decisions. A psychotherapy note, dated 10/25/2024, documents: Resident is generally unhappy .Pt has a diagnosis of Adjustment disorder Pt wants to call his friends, but has no access to his phone, stated 'my sister took home my phone'. Pt denied any history of mental health treatment, psychiatric hospitalization s, psychosis or suicide attempts. Pt is oriented x 4 and alert. SLUMS were administered. He was able to participate in this evaluation and answer questions asked. Speech was WNL [within normal limits] and thought processes are organized. No psychosis evident during this evaluation. Memory functioning good for both recent and remote memory. Insight and judgment is fair. Mood reported to be anxious and affect congruent with mood. He was polite and cooperative throughout . (continued on next page)

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	105300	A. Building B. Wing	11/07/2024

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary (narrative): 2 out of 12--Pt is calm, cooperative, confused, up in bed, well-groomed, and has good eye contact. Pt is alert and oriented x 4. Pt's speech is WNL. No psychosis noted during this session. Pt is in a pleasant mood, with an affect congruent with mood. Pt had breakfast. Pt processed his concerns with his sisters, in session today. Pt's thought processes are organized. Judgment and insight is fair. Short-term and long-term memory is good. No suicidal and homicidal ideations noted during this visit. Pt's concentration is good. Pt's anxiety is rated a 7/10 today. Provided support and guidance to patient during session. Pt was engaged and open to feedback and support offered. (sic) Psychotherapy Note dated 8/30/2024 documents: Summary (narrative): 8 out of 12-- Pt is calm, cooperative, up in bed, well-groomed, and has good eye contact. Pt is alert and oriented x 4. Pt's speech is WNL. No psychosis noted during this session. Pt is in a sad mood, with an affect congruent with mood. Pt had breakfast. Pt stated 'I feel lonely'. Pt infoms 'my sisters hasn't visited in 2 weeks'. Pt processed his memories of his past work experiences, in session today. Pt's thought processes are organized. Judgment and insight is fair. Short-term and long-term memory is good. No suicidal and homicidal ideations noted during this visit. Pt's concentration is good. Pt's anxiety is rated an 7/10 today. Provided support and guidance to patient during session. Pt was engaged and open to feedback and support offered. (sic) Psychotherapy Note dated 8/20/2024 documents: Summary (narrative): 7 out of 12-- Pt is calm, cooperative, confused, well-groomed, and has good eye contact. Pt is alert and oriented x 4. Pt's speech is WNL. No psychosis noted during this session. Pt is in a pleasant mood, with an affect congruent with mood. Pt had breakfast. Pt has a new roommate. Pt processed his rapport with his new roommate, in session today. Pt's thought processes are organized. Judgment and insight is fair. Short-term and long-term memory is good. No suicidal and homicidal ideations noted during this visit. Pt's concentration is good. Pt's anxiety is rated an 7/10 today. Provided support and guidance to patient during session. Pt was engaged and open to feedback and support offered. (sic) On 11/07/24 at approximately 4:00 PM, the Administrator was informed of the concern regarding Resident #34 not being involved with his care plan. It was also discussed with the Administrator that since the resident had no documentation showing he had appointed anyone to be his POA, Health Care Surrogate or Representative, it may not be appropriate for the resident's sister and brother-in-law to be invited to participate in his care plan meetings unless he gives his consent. Concerns regarding the lack of appropriate social services provided to Resident #34 were also discussed with the Administrator.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38893 Based on observations, interviews and record review, the facility failed to follow the approved menu for lunch on 11/06/24, and failed to notify the residents of the change in the menu. The findings included: 1. The approved menu for the lunch being served on 11/06/24 documented that residents were to be served 'Golden Fried Chicken'. The approved recipe for the 'Golden Fried Chicken' (no reference date) provided instructions that were documented as: Procedures: 1. For Frying: Fry at 350 degrees Fahrenheit (F) for 10-12 minutes, or until done. 2. For baking: place pieces in a single layer on a parchment paper lined sheet pan sprayed with pan release. Heat at 350 degrees F for 20-25 minutes or until done. 3. Serve 3 oz (ounces) portion. 4. CCP (Critical Control Point): [NAME] to a minimum internal temper of 165 degrees F. Notes: 3. Note: fry in batches; overcrowding the chicken will lower the oil's heat, leading to greasy chicken. 4. Note: Product is fully cooked. Do not overheat. During the follow up kitchen tour, on 11/06/24 at 11:30 AM, accompanied by the Dietary Manager and the Registered Dietitian (RD), it was noted that the chicken being plated and served to the residents was chicken wings that did not have an appearance of being 'Golden Fried Chicken', as the wings had no breading and did not have a 'Golden' color. Furthermore, the kitchen did not have the means to fry the chicken as instructed due to not having a fryolator or deep fryer for cooking. When the Dietary Manager was asked about the chicken wings not being Golden Fried Chicken, the Dietary Manager stated, the chicken was pan fried. The Dietary Manager further stated that the supplier was out of the fried chicken that would have been prepared for the meal. During an interview with Staff B, Dietary Aide, when asked about the preparing the 'Golden Fried Chicken' Staff B described the chicken as being chicken breasts that come breaded and commercially processed/cooked and that the kitchen only had to reheat to the appropriate temperature prior to hot holding and serving. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The approved menu that was posted on the units for the residents documented that the facility would be serving Golden Fried Chicken for lunch on 11/06/24. During the follow up kitchen tour, on 11/06/24 at 11:30 AM, accompanied by the Dietary Manager and the RD, it was observed that the facility was serving chicken wings that did not appear to be fried as there was no breading on the chicken wings and they did not have a color or appearance of being fried. During an interview with the Dietary Manager, when asked about the facility serving the chicken wings instead of the 'Golden Fried Chicken', the Dietary Manager stated that the supplier did not have the commercially processed fried chicken breasts that were supposed to be served according to the approved menu. When asked about the timing of the delivery of the chicken, the Dietary Manager stated that the delivery that did not include the chicken was on Monday (11/04/24). The Dietary Manager acknowledged that the menu displayed for the residents should have been changed and the residents should have been notified of the change. 3. The approved menu documented that the residents were to be served 4 ounces (oz) of fried chicken for the lunch meal on 11/06/24. During the Follow up kitchen tour, on 11/06/24 at 11:30 AM, accompanied by the Dietary Manager and the RD, while observing the meal being plated, Staff B was observed placing 3 bone-in chicken wings on the plates and then completing the meal with starch and vegetables. At the request of this Surveyor, Staff B placed 3 of the chicken wings that represented one serving on the facility's calibrated kitchen scale. It was noted that the chicken wings appeared to be equal parts bone (not edible) and chicken. The chicken weighed 4.5 oz. Staff B continued plating the meal and use a scoop to place a portion of mechanically altered chicken on plate. At the request of this Surveyor, Staff B placed a scoop of the mechanically altered chicken that represented one serving on the facility's calibrated kitchen scale. The portion of the mechanically altered chicken was 4.2 oz and did not contain bones in the portion. The Dietary Manager acknowledged that the residents were not being served the appropriate amount of chicken due to not having considered that the chicken being served contained bones for the regular menu, and instructed the kitchen staff to retrieve the regular meals that had already been placed in a cart so that an additional bone-in chicken wing could be added to the meals.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38893 Based on observations, interviews and record reviews, the facility failed to provide meals prepared, served and stored in a sanitary manner in accordance with standards for food safety. The findings included: 1. During the initial kitchen tour, on 11/04/24 at 8:43 AM, accompanied by the Dietary Manager, Staff A, Dietary Aide, was observed handling open foods and working with food equipment without wearing any kind of restraint over his beard. The Dietary Manager instructed Staff A to put on an appropriate hair restraint. 2. During the follow up kitchen tour, on 11/06/24 at 11:30 AM, accompanied by the Dietary Manager and the Registered Dietitian, the internal temperature of cut melons on fruit plates was 51 degrees Fahrenheit (F) and the internal temperature of deli sandwiches (sliced ham) was 49 degrees F. It was noted that the fruit plates and the sandwiches were kept on a speed rack that was located directly next to the hot holding area at an ambient temperature with no additional cooling mediums to ensure that the foods are maintained at a safe temperature. The Dietary Manager acknowledged that the foods were not at the appropriate temperature and instructed staff to place the speed rack in the walk in cooler until proper temperature were reached. During an interview with the Dietary Manager, when asked about the process for preparing and cooling the fruit plates and deli sandwiches, the Dietary Manager stated that the items were prepared in the morning at ambient temperature in the processing area and then the whole rack is placed in the reach in cooler, and removed from the cooler just as the staff were prepared to begin plating the lunch meal. 3. The facility's policy, titled, 'Food Brought in the Facility by Family or Visitor', with a reference date of March 2020, documented: Policy: It is the right of the residents of this facility to have food brought in by family or other visitors. The food will be handled in a way to ensure the safety of the residents. Procedure: All food items that are already prepared by the family or visitor brought in will be labeled with name and dated. a. The facility will refrigerate label and dated prepared items in the nourishment refrigerator. During a tour of the unit pantry at the 100-200 unit nurse's station, accompanied by the Dietary Manager, there was a carton of eggs in a plastic grocery bag in the reach in refrigerator. It was noted that there was no label on the bag or the carton to designate which resident the eggs were for and when the eggs were placed in the refrigerator.

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	105300	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Coast Center for Rehabilitation and Healthc	9555 SE Federal Hwy Hobe Sound, FL 33455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, interview, and policy review, the facility failed to ensure appropriate use of Personal Protective Equipment (PPE) during the use of a tracheostomy (artificial opening in the neck) and percutaneous endoscopic gastrostomy (PEG/surgical placement of a feeding tube) use for 1 of 1 sampled resident (Resident #95); and failed ensure timely contact isolation for 1 of 1 sampled resident (Resident #57). The findings included: 1) Review of the policy Enhanced Barrier Precautions revised 04/01/24 documented, in part, Enhanced Barrier Precautions (EBP) consists of the use of gowns and gloves for high-contact care activities which include but may not be limited to Device care or use: . feeding tube, tracheostomy . Review of the record revealed Resident #95 was admitted to the facility on [DATE] to received care and services, in part, related to a tracheostomy and PEG tube. A care plan initiated on 06/14/24 documented the resident required EBPs related to the tracheostomy and PEG tube. This care plan instructed staff to wear a gown and gloves for high contact resident care areas to include the use of the tracheostomy and the feeding tube. During a medication pass observation on 11/06/24 beginning at 12:44 PM, Staff K, Licensed Practical Nurse (LPN) obtained liquid Ferrous Sulfate to be administered via Resident #95's PEG tube, and Ipratropium Albuterol, a nebulizer treatment, to be administered via his tracheostomy tube. The LPN donned a mask and gloves, gave the medication through the PEG tube, and then removed her gloves and washed her hands. The LPN then proceeded to put the nebulizer medication into the medication holder of the nebulizer machine, and hooked the nebulizer to the resident's tracheostomy. The LPN had not donned another pair of gloves after hand hygiene between procedures, and failed to don a gown during either of the processes. During an interview on 11/07/24 at 10:03 AM, when asked when she would expect staff to utilize PPE with Enhanced Barrier Precautions, the Infection Control Preventionist (ICP) stated whenever staff were providing direct care. When asked if this would include during the provision of medications via a tracheostomy and or a PEG, the ICP stated yes. During an interview on 11/07/24 at 10:23 AM, when asked to explain EBP, Staff K, LPN, appropriated explained the use of gloves and gowns whenever she needed to do something with one of the tubes. When asked why she did not use gloves during the nebulizer treatment or a gown during the entire medication pass observation for Resident #95 the previous day, the LPN did not have a response. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the policy Transmission-Based (Isolation) Precautions, implemented 02/115/24 documented, in part, 10. Contact Precautions - a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE, C. difficile, .) . e. Residents experiencing wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, should be placed on contact precautions even before a specific organism has been identified. Review of the record revealed Resident #57 was admitted to the facility on [DATE]. Review of the orders indicated the need for a stool sample to rule out C. difficile as of 10/02/24. The positive results were reported to the facility on [DATE], at which time contact precautions were implemented as per the order dated 10/07/24. During an interview on 11/07/24 at 9:32 AM, when asked about the implementation of contact precautions for C. difficile, the ICP stated the contact precautions should be initiated when symptoms start, and if tested positive should be kept on precautions until the resident has a formed bowel movement. The ICP agreed that since the order for the C. difficile test was given on 10/02/24, Resident #57 would have had symptoms of 3 or more loose stools within 24 hours, and the contact precautions should have been initiated as per order on that date. The ICP agreed the order was initiated on 10/07/24, five days after the initiation of symptoms.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide an appropriate mattress for 1 of 26 sampled residents (Resident #309). The findings included: Review of Resident #309's record revealed the resident was admitted to the facility on [DATE] and moved to her current room and bed on 10/11/24. According to the resident's most recent complete assessment, a Medicare 5-day Minimum Data Set (MDS), dated [DATE], Resident #309 had a Brief Interview for Mental Status score of 14, indicating that the resident was 'cognitively intact'. The assessment documented that Resident #309 required 'substantial/maximal assistance' for transferring and required 'partial/moderate assistance' for bed mobility. Resident #309's diagnoses at the time of the assessment included: Hypertension, UTI (Urinary Tract Infection) (last 30 days), Diabetes Mellitus, Hyponatremia, Hyperlipidemia, Malnutrition, Anxiety disorder, Depression, Polyneuropathy, Immunodeficiency, Muscle weakness, Dysphagia, Abnormalities of gait and mobility, Need for assistance with personal care, Constipation, Adjustment disorder with mixed anxiety and depressed mood, Muscle wasting and atrophy, necrotic bilateral lower legs (heels) and that the resident was at risk for pressure development with none present upon admission. During an interview, on 11/05/24 at 8:46 AM, with Resident #309 and the resident's family member, Resident #309 stated that the mattress was not comfortable and that she can feel the bars of the bed frame in the middle of the mattress. She also stated that the controls for the bed did not work. During the interview, and with permission from Resident #309, this Surveyor placed a hand on the mattress and pressed down with minimal force and was resting the hand directly on the frame of the bed. This Surveyor used the remote control that was attached to the mattress and it was observed that the bed did not move up and down when the buttons were pushed. Resident #309 stated that she had spoken with Maintenance and the Wound Care Nurse about the mattress. During an interview, on 11/05/24 01:56 PM, with the Maintenance Director and the Administrator, this Surveyor demonstrated that the resident was resting in the bed and mattress with her body in contact with the metal bed frame and that the mattress would not support the resident's weight (189 pounds) and keep her from resting on the bed frame. On 11/05/24 at 2:03 PM, the Maintenance Director confirmed that the mattress was a standard mattress. When asked about conducting audits on the mattress, the Maintenance Director was not able to provide details or documentation of any audits conducted by the facility. During an interview, on 11/05/24 at 2:05 PM, with the Wound Care Nurse, when asked about the mattress provided to Resident #309, the Wound Care Nurse replied, she never said anything to me about the mattress. (continued on next page)

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 11/06/24 at 10:34 AM, with Staff M, Unit Clerk, when asked about ensuring residents have an appropriate mattress, Staff M replied, the unit manager receives the information from the hospital for what the resident needs - air mattress, specialty mattress - and the UM (Unit Manager) will make sure that they have it. On 11/07/24 at approximately 8:30 AM, the Administrator provided documentation in the form of an email from the mattress company that documented the mattress should support 300 pounds. During an interview, on 11/07/24 at 1:03 PM, with the Housekeeping/Laundry Supervisor, when asked about checking the mattresses prior to residents being placed or moved into a room, the Housekeeping/Laundry Supervisor replied, 'I check the mattress myself when a resident moves out and right before a resident is admitted . When asked about checking the mattress in preparation of a room change, the Housekeeping/Laundry Supervisor stated that the mattresses were not checked at the time of a room change. When asked for documentation of the rooms and mattresses being checked, the Housekeeping/Laundry Supervisor provided this Surveyor with documentation of quarterly audits that included bed functionality, receptacles, and lights. The most recent was completed on 09/20/24 with no documentation of any concerns related to Resident #309's bed.