STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105463	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Courtenay Springs	1100 South Courtenay Parkway Merritt Island, FL 32952

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview and record review, the facility failed to provide the appropriate notices of financial liability for 2 of 3 resident reviewed for Skilled Nursing Facility (SNF) Beneficiary Protection Notification, out of a total sample of 43, (#50 and #54). Findings: 1. Resident #50 was admitted to the facility on [DATE], with diagnoses of Parkinson's disease, protein-calorie malnutrition, hypotension, mild cognitive impairment of unknown etiology. Review of resident #50's financial record revealed he began a Medicare Part A skilled nursing stay starting on 1/01/24, with the last day of coverage on 3/08/24. A SNF Beneficiary Protection Notification Review revealed resident #50 received a Notice of Medicare Non-Coverage (NOMNC) at the end of her Medicare Part A stay but did not receive a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN). 2. Resident #54 was admitted to the facility on [DATE], with diagnoses of traumatic ischemia of muscle, rhabdomyolysis, hypertension, cognitive communication deficit, and polyneuropathy. Review of resident #54's financial record revealed he began a Medicare Part A skilled nursing stay on March 1, 2024, with last covered day on 3/08/24. A SNF Beneficiary Protection Notification Review revealed resident #54 received a Notice of Medicare Non-Coverage (NOMNC) at the end of her Medicare Part A stay but did not receive a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN). Interview with the Social Services Director on 3/08/24, at 11:23 AM, revealed Social Services did not handle the ABN and the business office was in charge of that notification. Interview with the Business Office Manager on 3/08/24, at 11:45 AM, revealed no ABNs had been issued by her while being employed at the facility. She explained she thought the Social Service department handled the ABN notifications. She also confirmed no SNF ABNs were issued for residents #50 or #54 who had remained in the facility following a Medicare Part A stay without exhausting their benefit days.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review the facility failed to report an alleged violation of neglect to the State Agency (SA) as required for 1 of 2 residents reviewed for abuse/neglect, of a total sample of 39 residents, (#435). Findings: Review of the Reportable Events 2024 log revealed resident #435 self-reported neglect on 1/27/24. Review of resident #435's medical record revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and intervertebral disc degeneration. Review of resident #435's Minimum Data Set 5-day assessment with Assessment Reference Date of 1/31/24 revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated she was cognitively intact. On 5/30/24 at 12:04 PM, the Director of Nursing (DON) stated resident #435 called the Department of Children and Families (DCF) and an investigator came to the facility on [DATE] to investigate her concerns. The DON explained she was only responsible for reporting adverse events to the SA, but this was not considered one. She indicated the Nursing Home Administrator (NHA) was responsible to submit the required immediate and 5-day reports for allegations of abuse and/or neglect. On 5/30/24 at 12:29 PM, the Social Services Assistant indicated she was the Abuse coordinator when resident #435 called DCF. She explained the DCF investigator came in and she was notified the same day. She stated she did not talk to resident #435 that day and might have done it the following day but could not provide evidence of her interview. She stated she did not speak to nor collect witness statements from staff assigned to resident #435 or other residents. She stated her, Superiors made the decision, to not report to the SA. She confirmed this was considered an allegation of neglect. Review of an email dated 1/28/24 at 1:04 PM, revealed the DON forwarded the message received from the DCF investigator to the NHA and Social Services. The DON added resident #435 called DCF alleging, She had to wait 30 minutes to be changed on 1/27/24. The DON indicated she met with the DCF investigator and law enforcement. The message read, We will discuss as a team how to proceed. On 5/30/24 at 1:15 PM, the NHA stated resident #435 made a self-report to DCF. He indicated the Social Services Assistant interviewed the resident, but she did not report any concerns. He stated he did not speak with the DCF investigator, and stated an allegation of neglect was not reported to him. He stated he did not believe he was called in on Sunday, 1/28/24 when the DCF investigator came to the facility. When asked about the email sent by the DON to him and social services on 1/28/24 he stated he did not remember receiving it. He indicated he could not remember when he learned about this and the DCF investigator did not disclose any information. He confirmed he had the appropriate log in to submit the federal reporting and acknowledged the facility failed to report this allegation of neglect. He stated he was waiting for the determination of the DCF report. He explained allegations of abuse or neglect were to be made within 2 hours to DCF and within 24 hours to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse Investigation and Reporting policy and procedure revised on July 2017 read, All alleged violations involving abuse, neglect, . will be reported to the facility Administrator, or his/her designee, to the following persons or agencies: The State licensing/certification agency responsible for surveying/licensing facility . An alleged violations involving abuse, neglect, . will be reported immediately but no later than . twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on interview and record review, the facility failed to provide written Notification of Transfer to the resident or their representative for 2 of 2 residents reviewed for hospitalization s, of a total sample of 39 residents, (#15 and #25). Findings: 1. Resident #25 was admitted to the facility on [DATE] with diagnoses to include multiple sclerosis, chronic obstructive pulmonary disorder, ESBL, diabetes, and major depression. The Minimum Data Set (MDS) Annual Assessment noted that resident #25 scored 9 on the Brief Interview for Mental Status (BIMS) evaluation, which indicated the resident's cognition was moderately impaired. A Nursing Home to Hospital Transfer Form dated 5/27/24 revealed resident #25 had altered mental status. Review of the medical record revealed resident #25 was transferred to the hospital on 5/27/24. On 5/30/24 at 1:51 PM, the Admission Director confirmed resident #25 was still in the hospital but were planned to return to the facility the next day. On 5/30/24 at 2:41 PM, the Social Service Director (SSD) confirmed they could not provide documentation of written notice to the resident and/or the resident's representative. 45646 2. Resident #15 was admitted to the facility on [DATE] with diagnoses including cutaneous abscess of abdominal wall, acute respiratory failure and acute posthemorrhagic anemia. Review of the MDS admission assessment with assessment reference date of 4/09/24 revealed resident #15 had a Brief Interview for Mental Status score of 15 which indicated she was cognitively intact. Review of progress notes for residents #51 revealed she was transferred to the hospital on 4/23/24, 4/25/24, 5/03/24 and 5/20/24 for possible gastrointestinal bleeding. Resident #15 returned to facility after each hospitalization . Review of the Notification of Transfer or Discharge form for 4/23/24 and 4/25/24 revealed the daughter was notified of the transfer verbally; the 5/03/24 form revealed the daughter was notified of the transfer verbally and resident #15 signed the form upon her return 5/07/24; and the form dated 5/20/24 indicated the daughter was notified verbally on 5/24/24 and resident #15 signed on an unknown date. On 5/30/24 at 12:30 PM, the SSD acknowledged only two of the Notification of Transfer or Discharge forms were signed by resident #15. She stated the family was notified verbally each time. The SSD explained copies of the Notification of Transfer or Discharge forms were left in resident #15's room. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 12:33 PM, resident #15 was shown the Notification of Transfer or Discharge forms. She stated the facility had her sign some papers when she returned from the hospital. Resident #15 denied seeing those forms before and stated no one had left any copies for her previously when she had transferred to the hospital. In an interview with the Administrator and SSD on 5/30/24 at 12:45 PM, the SSD stated she had not mailed copies of the Notification of Transfer or Discharge to the resident's representative and could not provide proof she provided them to resident #15. The Administrator recalled copies had been mailed to resident representatives in the past. He explained the SSD and SSA were new, and the process just fell through the cracks. The facility's policy and procedure for Transfer or Discharge Notice revised December 2016 read, The resident and/or representative (sponsor) will be notified in writing of the following information: a. the reason for the transfer for discharge; b. the effective date of the transfer or discharge; c. the location to which the resident is being transferred or discharged .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 Based on interview and record review, the facility failed to complete and submit discharge assessments timely for 6 of 6 residents reviewed for resident assessments, of a total sample of 39 residents, (#12, #40, #53, #55, #73 and #76). Findings: During a review of resident assessments, six residents were identified as having Minimum Data Set (MDS) assessments that were over 120 days past due. 1. Resident #12 was admitted to the facility on [DATE] and discharged [DATE]. Review of the medical record revealed an MDS discharge assessment was not completed or submitted following resident #12's discharge. 2. Resident #40 was admitted to the facility on [DATE] and expired [DATE]. Review of the medical record revealed an MDS death in facility tracking record was not completed or submitted following resident #40's discharge. 3. Resident #53 was admitted to the facility on [DATE] and expired [DATE]. Review of the medical record revealed an MDS death in facility tracking record was not completed or submitted following resident #53's discharge. 4. Resident #55 was admitted to the facility on [DATE] and discharged [DATE]. Review of the medical record revealed an MDS discharge assessment was not completed or submitted following resident #55's discharge. 5. Resident #73 was admitted to the facility on [DATE] and discharged [DATE]. Review of the medical record revealed an MDS discharge assessment was not completed or submitted following resident #73's discharge. 6. Resident #76 was admitted to the facility on [DATE] and discharged [DATE]. Review of the medical record revealed an MDS discharge assessment was not completed or submitted following resident #76's discharge. On [DATE] at 3:52 PM, the Director of Nursing (DON) stated she was not aware any MDS assessments had been missed. She explained the facility switched to a new electronic medical record system on [DATE]. She reviewed the submitted MDS for each identified resident and acknowledged MDS discharge assessments were not submitted for any of the 6 residents. The DON stated they must have gotten missed in the transition. On [DATE] at 1:55 PM, the MDS Coordinator reviewed the medical record for each resident. She verified MDS discharge assessments or death in facility tracking records were not submitted within the required timeframe following discharge. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy and procedure MDS Completion and Submission Timeframes revised ,d+[DATE] read, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The document indicated the assessment coordinator was responsible for ensuring resident assessments were completed and submitted in accordance with current state and federal guidelines.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 51023 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was accurately completed following a new mental health diagnosis for 1 of 1 resident reviewed for PASRR, of a total sample of 77 residents, (#80). Findings: Resident #80's medical record revealed she was admitted to the facility 5/03/24 with diagnoses of type 2 diabetes mellitus, cognitive communication deficit, unspecified dementia, anxiety and depression. The resident's PASRR forms dated 5/03/24 was completed prior to admission to the facility. The form listed anxiety disorder and depressive disorder under Section IA Mental Illness or suspected Mental Illness. Under Section II, it was noted that a secondary diagnosis of dementia was listed. A Psychiatry evaluation note dated 5/10/24 revealed a diagnosis of schizophrenia had been added to the resident's medical record. The resident was noted to have chronic and consistent psychosis. The resident also was noted to have past attempts of suicide by overdose. During the evaluation, no suicidal ideations, paranoia or hallucinations were noted. Another Psychiatry evaluation dated 5/24/24 revealed the resident was having increased paranoid and disorganized thinking. The evaluation noted the resident appeared unstable and required medication changes. Review of the resident medical record revealed no updates had been made to the PASRR form to include the new diagnosis of schizophrenia and history of suicide attempt. Interview with the Director of Nursing (DON) on March 29, 2024, at 3:31 PM, revealed the Admissions department was responsible for making sure a resident had a PASRR completed when admitted . Afterwards, the DON and unit managers performed the chart checks to ensure the information was accurate. The DON stated she handled any changes that needed to be made to the form. The DON confirmed no updates had been made to Resident #80's PASRR form to include the new schizophrenia diagnosis. Facility policy titled, Behavioral Assessment, Intervention and Monitoring revised on March 2019, indicated new onset or changes in behavior that indicated newly evident or possible serious mental disorder, intellectual disability, or a related disorder would be referred for a PASRR Level II evaluation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to implement fall prevention interventions for 1 of 3 residents reviewed for accidents, of a total sample of 39 residents, (#63). Findings: Review of the medical record revealed resident #63, an [AGE] year-old female was admitted to the facility from an acute care hospital on 3/17/23. The resident had diagnoses that included spinal stenosis (narrowing), blindness, muscle weakness, anxiety, stroke, urinary tract infection, and adult failure to thrive. The Minimum Data Set (MDS) Annual Assessment with Assessment Reference Date (ARD) 3/11/24 noted the resident's vision was severely impaired, and she scored 10 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated she had moderate cognitive impairment. The assessment showed the resident had difficulty focusing attention and disorganized thinking that fluctuated and changed in severity. She was incontinent of bladder and bowel functions and received high-risk anti-depressant medications during the look back period. The MDS did not note the resident's functional abilities. The Task Description records documented the resident was dependent on staff to complete Activities of Daily Living (ADL). for mobility, and to transfer in and out of bed. The Comprehensive Care Plan included focuses for staff total assistance with daily ADL care, and high risk of falls related to debility, impaired mobility, blindness, and medication side effects with a goal that the resident would remain free of falls causing hospitalization s. An intervention was entered on 5/20/24 that read, Bolsters to mattress to define mattress perimeters. The Order Summary Report included active physician's medication orders for Escitalopram Oxalate 10 milligrams (MG) once daily for depression, and Gabapentin 300 MG three times daily for spinal stenosis. On 5/28/24 at 11:17 AM, resident #63 was observed awake, lying in bed in her room. The resident's daughter said her mother had fallen from her bed about a week prior, and she was supposed to get a new bed to keep her from falling out. She stated she was concerned because her mother sometimes forgot she was in bed, and it hadn't been changed yet. Review of the Nurses Notes on 5/17/24 indicated resident #63 was observed by a Certified Nursing Assistant (CNA) in her room lying on the floor next to her bed. It was noted that the CNA informed the nurse that the resident had likely fallen out of bed. In a joint observation with Registered Nurse (RN) A on 5/28/24 at 12:26 PM, the RN checked resident #63's bed and confirmed there was a regular mattress without bolsters. She recalled the resident was observed on the floor next to her bed about a week prior, and staff believed she fell out. (continued on next page)

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	105463	A. Building B. Wing	05/30/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/24 at 12:32 PM, in a joint observation, the [NAME] Unit Manager checked resident #63's bed and confirmed a bolster mattress was not in place. She said all resident falls were discussed during Interdisciplinary Team (IDT) meetings every morning and afternoon. She explained, bolster mattresses were used as a fall prevention intervention because they created a perimeter around the bed and helped to prevent falling out of bed. She said the Central Supply Coordinator arranged and implemented bolster mattresses. She said she didn't know why the intervention was delayed for 8 days. On 5/29/24 at 1:35 PM, the Assistant Director of Nursing (ADON) said she also served as the facility's Risk Manager. The ADON explained that the IDT discussed all resident falls in morning meetings, and together they decided what interventions were needed. She stated, If somebody needs reminders, I communicate whatever is to be put in place; for equipment, it's central supply; in SOC (Standards of Care) we communicate whether or not the equipment came in or not. On 5/29/24 at 3:14 PM, the MDS Coordinator said she attended morning and afternoon IDT meetings where care plans were discussed. She explained she updated care plans, Per the intervention decided in meetings. In an interview with the Central Supply Coordinator on 5/30/24 at 11:18 AM, she explained Unit Managers made her aware when supplies or equipment were needed for fall interventions. She said she wasn't aware resident #63 had fallen until earlier that day when the Unit Manager told her the resident needed a bolster mattress. She stated, I do have one and when they get her up, we will get it switched out. On 5/29/24 at 1:35 PM, the Director of Nursing (DON) said the ADON was responsible for follow up to ensure fall interventions were implemented. She explained, MDS updated the care plan from what was determined in meetings. The DON checked the Electronic Health Record and said resident #63 was observed on the floor beside her bed on 5/17/24. She said the care plan was updated on 5/20/24 with an intervention for a bolster mattress. She explained ample time had passed, it was important, and the intervention should have been implemented. The DON stated, She could have a fracture if she fell out of bed. Review of the facility's standards and guidelines titled, Falls - Clinical Protocol dated March 2018 read, . Monitoring and Follow-Up . 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to ensure a Midline intravenous (IV) dressing was changed in accordance with professional standards to prevent the potential for infection for 1 of 1 resident reviewed for IVs, of a total sample of 39 residents, (#384). Findings: Resident #384, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included sepsis, urinary tract infection, metabolic encephalopathy, chronic obstructive heart disease, and chronic obstructive pulmonary (lung) disease. Review of the Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form (3008) dated 5/23/24 revealed the resident's primary diagnosis was acute metabolic encephalopathy with catheter-associated urinary tract infection. Documentation indicated the resident was alert, oriented, followed instructions, and had a Midline IV inserted on 5/22/24. A midline catheter is a small tube used to give treatments and to take blood samples. The catheter is inserted into a vein in your arm. The end of a midline, inside your body, does not go past the top of your armpit (retrieved on 6/09/24 from www.drugs.com). On 5/30/24 at 9:54 AM, resident #384 was observed in bed in her room with a right upper arm midline IV. Resident #384 stated, I get IV antibiotics for a bladder infection in the midline. The hospital put it in. The midline IV dressing was lifted up at the edges and dated 5/22/24. On 5/30/24 at 10:00 AM, Registered Nurse (RN) B, responsible for resident #384's care, was in her room and confirmed the midline IV with a transparent dressing dated 5/22/24. RN B stated the antibiotic was given at 9:00 PM so that shift would be responsible for changing the dressing every 7 days and as needed. RN B searched the electronic medical records and stated, There are no dressing change orders. A review of the physician orders revealed no orders for dressing changes for the resident's midline. On 5/30/24 at 10:36 AM, the [NAME] Wing Unit manager stated that new admissions records were reviewed by the clinical team the day after admission to ensure all orders were in place. She said the facility would change IV dressings as needed, but at least every seven days. She confirmed there were no orders in place to change the midline IV dressing, which should have been changed on 5/29/24, the previous day. On 5/30/24 at 2:43 PM, the Director of Nursing (DON) stated the resident was admitted to the facility from an acute care hospital on 5/24/24 with a midline IV inserted on 5/22/24. She stated the protocol was for the nurse to review the admitting orders with the physician, make the physician aware of the midline, and obtain an order for the midline dressing to be changed as IV antibiotics were to be administered. (continued on next page)

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	105463	A. Building B. Wing	05/30/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Central Venous Catheter Dressing Change policy, revised on 4/2016, read, Change transparent semi-permeable membrane dressings at least every 5-7 days and when wet, soiled, or not intact.

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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** 46665 Based on observation, interview, and record review, the facility failed to ensure safe supplemental oxygen administration for 1 of 1 resident reviewed for respiratory care, of a total sample of 39 residents, (#54). Findings: Review of the medical record revealed resident #54, an [AGE] year-old female was admitted to the facility from an acute care hospital on 1/26/24. The resident had diagnoses that included traumatic muscle ischemia (lack of blood or oxygen), muscle weakness, cognitive communication deficit, thyroid disorder, neuropathy (nerve impairment), repeated falls, depression, and shortness of breath. The Minimum Data Set Quarterly Assessment with Assessment Reference Date 3/02/24 noted the resident scored 15 out of 15 on the Brief Interview for Mental Status that indicated she was cognitively intact. The assessment showed the resident did not have any indicators of psychosis, behavioral symptoms, rejection of evaluation or care, and she required staff supervision or set-up assistance to complete Activities of Daily Living. Resident #54 received high-risk anti-depressant medications and did not require oxygen therapy during the look back period. On 5/28/24 at 11:26 AM and 1:56 PM, and 5/29/24 at 12:12 PM, resident #54 was observed awake in her room sitting in a wheelchair beside the bed. She was receiving supplemental oxygen via a nasal cannula at a flow rate of 3.5 liters per minute from an oxygen concentrator device. The oxygen tubing was undated. Review of the Comprehensive Care Plan included focuses for: staff assistance for daily care needs, risk for falls, and communication and cognitive deficits. The care plan did not include supplemental oxygen therapy. Review of the Order Summary Report on 5/28/24 revealed active physician's medication orders for resident #54 but contained no physician's orders for supplemental oxygen. The Weights and Vitals Summary report documented that from 1/26/24 to 4/10/24, resident #54 did not receive supplemental oxygen therapy and from 4/11/24 to 5/28/24, the resident received supplemental oxygen via a nasal cannula; the report did not note the oxygen delivery flow rates, for 48 days. The May 2024 Medication Administration Record (MAR) was reviewed. The May 2024 MAR did not have documentation entries by nurses for oxygen administration, monitoring, tubing or supply changes. In an interview on 5/29/24 at 12:17 PM, Registered Nurse (RN) A explained, nurses were responsible for entering physician's orders and monitored supplemental oxygen administration where it was recorded on the MAR. She said she was very familiar with resident #54 who she was assigned to multiple times over the past few weeks. She said the resident had been receiving oxygen therapy as needed and the RN stated, She's sick. (continued on next page)

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	105463	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Courtenay Springs	1100 South Courtenay Parkway Merritt Island, FL 32952

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:23 PM on 5/29/24, in a joint observation with RN A, she checked resident #54's oxygen flow rate, confirmed it was set at 3.5 liters per minute, and the nasal cannula tubing was undated. The RN reset the flow rate to 2 liters per minute and said she received report from the outgoing 11:00 AM to 7:00 PM nurse. She checked the MAR and confirmed the medical record did not include physician's orders for oxygen and stated, It's supposed to be 2 liters. On 5/29/24 at 12:33 PM, in a joint observation, the [NAME] Unit Manager checked resident #54 and confirmed the resident was now receiving supplemental oxygen at a flow rate of 2 liters per minute and stated, She has been on O2 (oxygen); there should be an order. The Unit Manager checked the medical record for physician's orders and stated, You're right; it's not there and it should be, and I vaguely remember it was 2 liters. I will contact the Nurse Practitioner to clarify the orders. In an interview on 5/29/24 at 1:12 PM, with the Director of Nursing (DON), she explained that nurses entered doctor's orders into the Electronic Health Record (EHR) which included care and maintenance of oxygen, oxygen supplies, and tubing changes which showed up on the MAR. She said Unit Managers completed a check system as part of morning meetings to ensure nurses knew how to monitor oxygen administration and maintain supplies. She said it was important because tubing changes and supplies were required weekly, and if they were undated there was no way to track it, so they may not be changed out. She said too much oxygen could lead to toxicity and other complications. She checked resident #64's medical record and said nurses had entered oxygen orders the same morning. The DON conveyed that nurses must have missed the orders. Review of the facility's standards and guidelines dated October 2010 and titled Oxygen Administration read, . 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing: . After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for PRN [as needed] administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45646 Based on observation and interview, the facility failed to store and serve food in a manner to prevent foodborne illness in the resident population that received dietary services from the facility kitchen. Findings: During the Initial Brief Tour of the kitchen with the Food Service Director on 5/28/24 at 11:05 AM, a lunch bag was observed on one of the shelves inside the walk-in refrigerator. The Food Service Director stated the bag belonged to an employee who must have put it down by accident and forgot to take it to the employee break room. He stated he would have the employee remove it. Dietary Server C entered the walk-in refrigerator and removed her lunch bag. Food Service Director was informed the bag was on a wire shelf above two containers of raw chicken in marinade that were not fully covered with plastic wrap. On a shelf opposite the chicken was a container of cubed potatoes that were uncovered. The Food Service Director acknowledged employees should not store person items inside the walk-in refrigerator and the containers should have been covered to prevent contamination. During a follow up visit to the kitchen on 5/29/24 at 11:07 AM, Dietary Server C was observed walking toward the walk-in refrigerator carrying the lunch bag observed in the walk-in refrigerator the previous day. She reached for the door to the walk-in refrigerator and stopped when she saw the surveyor to the side. Dietary Server C then released the door handle, turned and left the kitchen. When she returned, Dietary Server C verified she had stored her lunch bag in the walk-in refrigerator the day before and was about to do it again when she saw the surveyor. She acknowledged she was not supposed to store personal items in the walk-in refrigerator. Dietary Server C was unable to explain why she had put her personal lunch inside the walk-in refrigerator previously or why she was about to do it again. During Tray Line Observation on 5/29/24 at 12:11 PM, [NAME] D was observed at a steam table as she prepared to serve lunch. She was observed with gloves on both hands. [NAME] D pulled a tray cart closer to the area and reached into the plate storage container and picked up a stack of plates with fingers on the bottom of the stack and thumbs on the top plate which touched the eating surface of the plate. She arranged the plates on the shelf to begin service when the phone rang. [NAME] D answered the phone while still wearing her gloves. She went to deliver a message and was observed as she pulled off the glove on her right hand and scratched her bare hand with her gloved left fingers. She returned to the steam table and arranged items for service when the phone rang again. [NAME] D again answered the phone and returned to the tray line. She pulled the cart closer and resumed plating food without cleaning her hands or changing gloves. [NAME] D turned and grabbed several unwrapped rolls from another table and placed them on plates, covered the plates and placed them on the tray cart for delivery. Head Chef E arrived back in the kitchen after he delivered items to the nursing units. He was informed of the observation and the surveyor asked for the staff member to change gloves due to potential for cross contamination. No supervisor was present in the kitchen to observe tray line. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy and procedure, Preventing Foodborne Illness - Food Handling revised July 2014 read, Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. The document indicated gloves were considered single-use items and must be discarded after completing the task for which they were used.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43192 Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee implemented effective Performance Improvement Plans to correct and monitor previously identified deficiencies and ensure sustained improvements. Findings: The facility had deficiencies at F609 for failure to report abuse/neglect allegations, F623 for failure to provide written notice of transfer to residents who were transferred out of the facility, and at F812 for failure to ensure kitchen sanitation/cleanliness in the last recertification survey conducted on 11/09/22. Review of the Plan of Correction, which served as the facility's allegation of compliance, approved by the QAPI committee on 12/29/22 revealed the facility would monitor corrective actions to prevent re-occurrence of the concerns identified in their recertification survey. During the current survey, the following deficiencies were again identified, F609, F623, and F812 for similar concerns. As a result of these repeat citations, it was identified there was insufficient auditing and oversight of the concerns identified in the previous citations. On 5/30/24 at 2:42 PM, the Nursing Home Administrator (NHA) explained the QAPI committee worked on identified deficiencies anywhere between 90 days to 6 months. He mentioned they performed audits and discussed findings during QAPI meetings. He stated he was under the impression the repeat deficiencies were corrected. Review of the facility's QAPI Program policy revised on 10/2022 revealed the facility would develop, implement, and maintain an ongoing, facility wide QAPI program, That builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. The policy contained QAPI Action Steps to follow which included, Areas that may be appropriate to monitor and evaluate include: . State Surveys and deficiencies.