STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to appropriately record and investigate a grievance to ensure resolution in a timely manner for 1 of 1 resident reviewed for grievances, of a total sample of 35 residents, (#17). Findings: Resident #17 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included end-stage renal disease, cardiac pacemaker, depression, and oxygen dependence. The Minimum Data Set (MDS) Admission assessment dated [DATE] revealed resident #17 had a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated moderate cognitive impairment. She presented with a depressed mood, no behaviors, and dependent for mobility and personal care. Resident #17 was received dialysis and pain management services. On 05/13/24 at 11:53 AM, resident #17 was observed in her room sitting up in bed. She stated she had moved to Florida to live with her family but when she got sick, they could no longer care for her. She complained that some of her belongings were missing, and she reported it to the nurse and aide. She was aware the grievance officer was the Social Service Director (SSD), and that she could report her issues to a staff member who would complete the grievance form on her behalf. Resident #17 stated she had reported other issues to staff in the past and Social Services followed up with her. Review of resident grievances from 10/23/23 through 5/1/24 showed several grievances for resident #17 regarding care, customer service, and call lights. There were no grievances about missing items. On 05/15/24 at 9:32 AM, resident #17 stated she had lost a watch and a black jacket with her initials, that her sister gave her. She stated that when she reported the missing items to multiple staff members, they told her they would look for the items, but a grievance was not filed. Resident #17 looked tearful when she said, there is no point telling them anything because they don't care. Review of the resident's medical record revealed an inventory of personal effects sheet signed by staff member and the resident on 9/27/22. There was evidence of the resident having a watch, blouses/shirts, dresses, shoes, dentures, and a cell phone with charger. There was a note indicating a suitcase with winter clothes and 3 other dresses. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 at 9:43 AM, Certified Nursing Assistant (CNA) B stated she had worked at the facility for over [AGE] years. CNA B said she was aware of the lost jacket but was not aware of the missing watch. She had searched the laundry room and resident #17's room for the jacket but did not find it. CNA B did not fill out a grievance form to report the missing jacket. CNA B stated that grievances were generally completed when residents had care complaints such as abuse or neglect but not for missing items. When a resident reports a lost item, we look for it. She was aware who the grievance officer was and had been educated on how to file a grievance. She further explained that a grievance form could be completed by either the resident or the staff member taking the report. The form was then given to the grievance officer, who would complete an investigation. On 05/16/24 at 9:49 AM, laundry staff stated when the unit lets them know resident clothes or personal items were missing, they looked for it in the dirty laundry. They explained they reported back to the unit if the item was not found, and the unit was responsible for filing a grievance with the SSD. On 05/16/24 at 9:51 AM, Registered Nurse (RN) C stated she had seen resident #17 wearing a black jacket but did not know it was missing. She was not aware of the lost watch but stated she would search the resident's room. RN C said if she knew resident #17 had missing items, she would have looked for them and filled out a grievance form. She explained a grievance can be completed by the resident, family member, or staff member on behalf of the resident. The completed form was then given to the grievance officer, the SSD who would initiate an investigation. RN C noted all staff members were responsible for filling out grievance forms. On 05/16/24 at 12:21 PM, an interview with the Unit Manager (UM) revealed she was not aware resident #17 had missing items. She stated that when a resident reported a lost item to a staff member, that staff member was responsible for filling out a grievance form. The UM explained there were blank grievance forms in her office, and once completed, they were given to the grievance officer, SSD. The grievance officer was responsible for communicating with the resident and completing the investigations. On 05/16/24 at 1:31 PM, an interview with the Social Service Director (SSD), who was also the Grievance Officer, revealed she had been employed at the facility for over 3 years and was very familiar with resident #17. She visited resident #17's room at least twice per week to talk. During their visits, resident #17 would talk to her about how she was feeling and any issues she might have had. She said the resident had reported some care issues for which the SSD filed grievances and completed investigations. The SSD stated she was not aware of any missing items for resident #17 and had she known, she would have filed a grievance. She explained at admission, residents and their family were educated on the grievance process and how to file a grievance. Education was provided to staff upon hire. The SSD indicated grievance forms were kept in the UM offices on both units and all staff members were responsible for completing them. A grievance should be filed for any resident issue. She noted the staff member would then turn in the completed form to SSD and an investigation would be opened. She reported grievances were to be filed immediately per facility policy and she would communicate with the resident or resident representative either verbally or in writing of the investigation results. She said residents completed an inventory sheet on admission, and they were encouraged to report any new items brought to the facility. If the item was on the inventory sheet and was not found, then we would replace it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 at 2:37 PM, the Director of Nursing stated that a grievance form should be filled out for any resident issue or complaint including missing items. It is the responsibility of all staff members to complete the grievance form and give it to the SSD, grievance officer. All residents and family members are educated on completing a grievance. The DON explained the grievance process was important because it showed what the facility did to resolve a resident's complaint. On 05/16/24 at 03:57 PM the facility's Administrator stated that when a resident reported a missing item, staff were instructed to own the investigation for 10 minutes and look for the item before completing a grievance form. If the item was not found within 10 minutes, the staff were instructed to complete a grievance form. She said she had not heard about resident #17's missing items. She added it was important for staff to follow the grievance policy because they want to do what is right for the resident by finding their lost item or replace it if possible. Review of the facility's Grievance Program Policy and Procedure dated 4/1/22 and revised 6/6/23 revealed that a grievance was a concern that could not be resolved to the satisfaction of the person making the objection at the bedside and or immediately. Immediately was defined as within four or less hours. The process for filing a grievance was to document it, route to the grievance officer, discuss with appropriate individuals, investigate accordingly, and report to state or local law enforcement as needed. When a grievance was received by a staff member, they would notify their supervisor and complete the grievance or forward the completed report to the Grievance Officer. Furthermore, concerns related to alleged abuse, neglect, exploitation, or misappropriation of funds or belongings would be handled according to the state and federal guidelines.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to ensure a resident who was prescribed anti psychotic medications had appropriate diagnosis for its use for 1 of 5 residents reviewed for Unnecessary Medications, of a total sample of 35 residents, (#36). Finding: Review of the medical record revealed resident #36, an [AGE] year old female was admitted to the facility on [DATE] from an acute care hospital. The resident had diagnoses that included Parkinson's Disease and Paranoid Schizophrenia. The Minimum Data Set (MDS) Quarterly Assessment with Assessment Reference Date (ARD) 2/25/24 showed the resident scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated she was severely cognitively impaired. She had no indicators of psychosis (hallucinations/delusions) or behavioral symptoms. The assessment noted she was dependent on staff to complete Activities of Daily Living (ADL), and she had active diagnoses of Parkinson's Disease and Schizophrenia. The resident did not require the use of restraints or alarms, and she received high risk anti-psychotic medications with a noted indication during the look-back period. The Preadmission Screening and Resident Review (PASRR) (AHCA MedServ Form 004, Part A, March 2017) form completed by the hospital on 11/17/21 documented the resident did not have a Mental Illness (MI) or Suspected Mental Illness (SMI). The Comprehensive Care Plan included focus for Parkinson's Disease, behaviors related to Parkinson's Disease, cognitive impairment, Dementia, adverse effects of psychotropic and Parkinson's medications, and read, The resident uses psychotropic medications related to Parkinson's psychosis, paranoid schizophrenia Date initiated: 8/22/23 Revision on: 11/29/23. The Order Summary Report noted active physician's medication orders for Nuplazid (anti-psychotic) 34 milligrams for diagnoses of Neuroleptic Induced Parkinsonism, Other Hallucinations, and Paranoid Schizophrenia. On 5/15/24 at 11:59 AM, the [NAME] 1 Unit Manager explained, once a month she participated in meetings that included Psychiatric providers and Director of Nursing (DON). She said residents' care plans were discussed, and they reviewed medication changes and orders. She stated, we go over all the diagnoses to make sure they are still active. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 11:48 AM, the Lead MDS Coordinator explained that SOC (Standards of Care) meetings were conducted with nurse managers, the Advanced Practice Registered Nurse (APRN), and Medical Director where residents' psychiatric plans of care were discussed, appropriate diagnoses, and medications were determined. She said MDS coding was expected to adhere to the instructions of the Resident Assessment Instrument (RAI) manual. She said she was aware the Centers for Medicare and Medicaid (CMS) focused on misuse of Schizophrenia diagnoses for anti-psychotic medications, and the effort was a focus in their meetings. She explained, the process for determination of active diagnoses was by review of the psychiatric provider's progress notes where it included anti-psychotic medication use indications. She checked resident #36's medical record and said there was a diagnosis of Schizophrenia entered by the DON on 8/21/23 with an effective date of 11/23/21. She stated, we code what it specifically says by the psych (psychiatric) provider; if the physician has not said Schizophrenia, we do not use it, we go by what is in the notes. She checked the record and said the diagnosis for the resident's anti-psychotic medication use was Parkinson's Induced Psychosis and stated, that's not Schizophrenia. Review of the Psychiatric progress notes completed by the Physician Assistant, Certified (PA-C) from 8/24/23 to 3/29/24 included diagnoses of Recurrent Major Depressive Disorder, Delusional Disorders, and Psychosis due to Parkinson's Disease. All notes read, Nuplazid 34 mg 1 capsule by mouth once a day for parkinsonian induced psychosis. In an interview on 5/16/24 at 1:09 PM, the DON recalled she had entered a Schizophrenia diagnosis for resident #36 after she became aware the resident had increased visual and auditory hallucinations. The DON said the Psychiatric APRN later assessed the resident and determined the hallucinations were attributed to the diagnosis of Parkinson's Disease with Psychosis. She said she was aware that CMS focused on misuse of Schizophrenia diagnoses. The DON explained that the medical record was incorrect and said, I should have inactivated it. Review of the CMS RAI version 3.0 Manual read, . Steps for Assessment 1. Medical record sources for physician diagnoses include the most recent history and physical . , progress notes, and other resources as available. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice related to limited range of motion and contracture care, for 1 of 3 residents reviewed for limited range of motion and positioning (#25), out of a total sample of 35 residents. Findings: Resident #25 was admitted to the facility on [DATE] and readmitted from the hospital on 02/28/24 with diagnoses that included hemiplegia/hemiparesis following cerebral infarction, altered mental status, diabetes type II, contracture of left hand, vascular dementia, epilepsy, schizophrenia, and psychotic disorder. The Minimum Data Set (MDS) Annual assessment dated [DATE] revealed resident #25 was unable to complete the Brief Interview for Mental Status (BIMS) but was severely cognitively impaired for daily decision making. She presented with no moods, no behaviors, dependent for personal care and mobility, left upper and lower extremity impaired mobility, and no refusal of care. On 05/13/24 at 12:22 PM, resident #25 was lying in bed with knees bent to one side and eyes open. Her left arm was bent at the elbow onto her chest with left hand closed. She was unable to answer questions clearly but seemed to understand some words. She did not respond when asked to open her left hand or if she wore any devices on that hand. There was no brace, splint, or palm guard observed on her left hand or in the room. On 05/14/24 at 10:26 AM, the resident was observed lying in bed with no palm guard on her left hand. On 05/15/24 at 1:21 PM, Registered Nurse (RN) A stated she had been working at the facility for a few months and had not seen resident #25 with a splint or palm guard. RN A indicated resident #25 used to receive Occupational Therapy (OT) for the left hand but services had stopped a few months ago when the resident started hospice services. She said the facility did not have a Restorative Nursing Program (RNP) but some residents had orders for hand splints and the Certified Nursing Assistant (CNA) would assist with applying them. She added the resident did not normally refuse care. Review of the order summary report dated 05/16/24 revealed resident #25 had orders for OT to evaluate and treat resident #25 after hospital re-admission to facility on 02/28/24. Review of resident #25's comprehensive care plan revealed there was no care plan addressing limited range of motion, positioning, or palm guard use and/or refusal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/24 at 3:16 PM, the Therapy Director stated resident #25 used to be on OT case load prior to being admitted to the hospital on 02/23/24. She noted the resident was readmitted on [DATE] and a new OT evaluation was ordered by the physician. The Director explained Resident #25 was evaluated on 03/03/24 for OT services and was to receive services related to her left-hand contracture daily. She recalled she was discharged from OT on 03/19/24 because she refused to wear the palm guard, was not making improvement, and there were recommendations for hospice evaluation by the physician. The Therapy Director explained the facility did not have RNP but instead had Functional Maintenance Program (FMP). The FMP was used by therapists to educate the direct care staff on how to prevent worsening contractures and skin breakdown. She further indicated staff were educated on palm guard use, but she failed to enter an order. The Director acknowledged she failed to communicate with the Minimum Data Set (MDS) coordinator, who was responsible for developing care plans. She stated she attended care plan meetings and provided therapy recommendations for all residents who received or were being discharged from therapy. Review of OT notes for resident #25 revealed an evaluation for services starting on 03/03/24 through 05/01/24. Treatment diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and contracture of left hand. The treatment plan included manual therapy techniques and prosthetic training 15 minutes per day. OT goals included safely wearing a hand roll, a palmar guard or even a carrot on left hand for up to 30 minutes. Assessment notes revealed resident #25 had a palm guard and roll for her left hand but refused to wear it. A progress note dated 03/15/24 showed resident exceeded the goal of wearing palm guard for one hour and maximum improvement was yet to be attained. An OT discharge summary from 03/21/24 showed maximum potential was achieved, and resident referred for FMP. The prognosis, with consistent staff follow-through, would allow the resident to maintain current level of functioning. The FMP plan was to facilitate resident maintaining current level of performance and to prevent decline, development of and instruction in the following FMP had been completed with the Inter Disciplinary Team (IDT): bed mobility, Range of Motion (ROM) (Passive) and splint or brace care. Review of the resident's medical record revealed a progress note from the Physiatrist on 03/18/24 that indicated the resident was observed wearing palm guard in the left hand and tolerates it when on. On 05/16/24 at 10:28 AM, CNA D stated she used to see the resident with a palm guard but had not seen her with it for a few months. CNA D indicated that when OT was discontinued, therapist came to educate them about resident having the palm guard. She further indicated it would be beneficial for resident #25 to have the palm guard because it would prevent her nails from digging in her palms that could cause skin breakdown. On 05/16/24 at 09:58 AM, RN C stated the resident received OT when she returned from the hospital, but it had ended a few months ago. She indicated that nothing was being done for resident #25's left hand to prevent worsening of contractures. She noted the resident used to wear a palm guard, but she had not seen it for a while. She explained she was unfamiliar with FMP but remembered a therapist came to educate staff on the use of the palm guard. She further explained that it was important to wear a palm guard for a resident with contractures because it would prevent skin breakdown as well as worsening contractures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 at 12:21 PM, Unit Manager (UM) for [NAME] 2 unit, stated resident #25 received OT for a few weeks when she returned from the hospital, and she was used a palm guard. I am unsure of why OT ended. She said after a resident was discharged from therapy, an order was usually entered by the Therapy Director for use of a palm guard and FMP. The therapy director would come to the unit and educate the staff on how to apply the palm guard and there would be a care plan created by the MDS coordinator addressing the palm guard. She indicated that resident #25 was unable to verbalize her needs and she had refused care in the past.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on observation, interview and record review, the facility failed to maintain oxygen flow rates as ordered by the physician for 2 of 2 residents reviewed for respiratory care from a total sample of 35 residents, (#100, #366). Findings: 1. Review of the medical record revealed resident #100 was admitted to the facility on [DATE] from the hospital. His diagnosis included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, type 2 diabetes, unspecified dementia, need for assistance with personal hygiene care, and dependent on supplemental oxygen. Resident #100's Admission Minimum Data Set (MDS) with an assessment reference date of 4/12/24 revealed the resident scored 7 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated he had severely impaired cognitive skills for daily decision making. The MDS assessment noted the resident received oxygen therapy and required moderate assistance from staff for transfers, personal hygiene care, dressing, bathing, and toileting hygiene. The MDS noted the resident did not exhibit behavior symptoms or rejection of care that was necessary to achieve the resident's goals for health and well-being. Review of resident #100's medical record revealed a care plan was initiated on 4/17/24 and revised on 4/26/24 which indicated the resident was oxygen dependent for COPD. The interventions included setting the oxygen via nasal cannula (NC) as ordered. Resident #100's physician order showed an active order for oxygen at 2 liters per minute (LPM) via NC continuously every shift for supplemental oxygen. Oxygen can be given to COPD patients but only in controlled amounts .Hypercapnia respiratory failure is when there is too much carbon dioxide in your blood, and near normal or not enough oxygen in your blood, and it can be fatal. It commonly occurs in people with COPD who are given too much or uncontrolled amounts of oxygen. Retrieved on 5/17/24 from drugs.com. On 5/13/24 at 1:30 PM, resident #100 was observed lying in bed with oxygen administered through a nasal cannula. The oxygen concentrator's liter flow rate was set between 4.5 and 5 LPM. He stated he did not adjust the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/24 at 2:52 PM, Registered Nurse (RN) A reviewed resident #100's oxygen order and stated the current order specified the resident was to receive 2 LPM of oxygen continuously via NC. She observed the resident's oxygen concentrator setting and acknowledged it was set between 4.5 and 5 LPM which was incorrect. She confirmed the flow rate should have been set to 2 liters as prescribed. RN A stated it was the nurse's responsibility to set the resident's oxygen flow rate as prescribed and to routinely monitor the oxygen settings every shift to ensure the flow rates align with the physician's order. She reiterated it was important to have the oxygen set at the correct flow rate and not have it set at a higher rate than prescribed to prevent the resident from becoming more oxygen dependent. She also stated it was imperative residents diagnosed with COPD should not be administered oxygen at a higher flow rate than prescribed because it can cause the resident's Carbon Dioxide (CO2) to increase and suppress their respirations. On 5/15/24 at 1:44 PM, Director of Nursing (DON) acknowledged it was the nurse's responsibility to check the oxygen (O2) concentrator every shift to ensure the flow rate matched the physician order. She stated it was imperative the resident receive the prescribed oxygen to prevent respiratory complications from occurring. She also stated if a resident diagnosed with COPD was administered oxygen at a higher rate than prescribed, it could increase the resident's CO2 and interfere with the O2 and CO2 exchange. 2. Review of the medical record revealed resident #366 was admitted to the facility on [DATE] from the hospital. His diagnosis included rhabdomyolysis, cerebral infarction, type 2 diabetes, cirrhosis of liver, muscle wasting and atrophy, need for assistance with personal care, and heart failure. Resident #366's Admission Minimum Data Set (MDS) with an assessment reference date of 5/3/24 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated he did not have any cognitive impairment. The MDS assessment noted the resident received oxygen therapy and required maximal assistance from staff for transfers, bathing, and dressing. The MDS also noted the resident did not exhibit behavior symptoms or rejection of care that was necessary to achieve the resident's goals for health and well-being. Review of resident #366's medical record revealed a care plan was initiated on 5/9/24 which indicated the resident had congestive heart failure with interventions that included setting the oxygen per physician orders. Resident #366's physician order showed an active order for oxygen at 3 LPM via NC continuously every shift for supplemental oxygen. Oxygen is a medication that requires a prescription from a healthcare provider .If you take in more oxygen that your body needs, it can slow your breathing and heart rate to dangerous levels. Too much oxygen can lead to oxygen toxicity or oxygen poisoning. Retrieved on 5/17/24 from my.clevelandclinic.org. On 5/13/24 at 1:45 PM, resident #366 was observed lying in bed with oxygen administered through a nasal cannula. The oxygen concentrator's liter flow rate was set between 4.5 and 5 LPM. He stated he did not adjust the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/24 at 2:52 PM, RN A reviewed resident #366's oxygen order and stated the current order specified the resident was to receive oxygen 3 LPM continuously via NC. She observed the resident's oxygen concentrator setting and acknowledged it was set between 4.5 and 5 LPM which was incorrect. She confirmed the oxygen flow rate should have been set to 3 liters as prescribed. RN stated it was the nurse's responsibility to set the resident's oxygen flow rate as prescribed and to routinely monitor the oxygen settings every shift to ensure the flow rates align with the physician's order. She reiterated it was important to have the oxygen set at the correct flow rate and not have it set at a higher rate than prescribed to prevent the resident from becoming more oxygen dependent. She also stated it was imperative residents diagnosed with COPD should not be administered oxygen at a higher flow rate than prescribed because it can cause the resident's CO2 to increase and suppress their respirations. On 5/15/24 at 1:44 PM, Director of Nursing (DON) acknowledged it was the nurse's responsibility to check the oxygen concentrator every shift to ensure the rate matches the physician order. She stated it was imperative the resident receive the prescribed oxygen to prevent respiratory complications from occurring. The facility's oxygen policy read, The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there are physician's orders for this procedure. Review the physician's orders or facility protocol for oxygen administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 13252 Based on observation, and interview, the facility failed to ensure staff donned facial hair restraints correctly and failed to ensure dishware was allowed to air dry before storing. Findings: On 5/16/24 at 11:45 AM, the facility's lunch tray line was observed. The Dietary Aide at the end of the line had his facial hair restraint below his bottom lip and his mustache was exposed. He received plates of food from the cook and placed them on a tray while he conversed with his co-workers. When asked why his hair restraint did not cover his mustache, he replied, I forgot. Neither the cook, who was directly across from the Dietary Aide or the Area Manager explained why they had not instructed the Aide to correctly don the facial hair restraint. During kitchen inspection on 5/16/24 at 2:24 PM, the facility's cookware and serveware were observed. A metal storage rack, with various sizes of pans and cookware was noted next to the three compartment sink. There were 5 large hotel pans, 6 inches deep, that were stacked on top of each other. The pans were noted to be wet (wet nesting). The facility's Food Service Director said the pans should have been allowed to air dry before they were stored.