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	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor Healthcare and Rehabilitation Center	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 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** Based on observation and interview, the facility failed to promote a dignified existence related to standing over a resident while assisting with eating for 1 of 1 resident reviewed for dignity, out of a total sample of 40 residents, (#9).Findings: Resident #9 was admitted to the facility on [DATE] with diagnoses including dysphagia, hemiplegia and hemiparesis, need for assistance with personal care, and major depressive disorder. Review of the Quarterly Minimum Data Set assessment with assessment reference date of 3/26/26 revealed resident #9 had a Brief Interview for Mental Status (BIMS) score of 06/15 which indicated she had severe cognitive impairment. The assessment indicated she had impairments to her upper and lower extremities on both sides and was dependent on staff for eating. During meal observation on 4/06/26 at 12:34 PM, resident #9 was in bed with the head of the bed elevated. Her meal tray was located on her overbed table positioned on the left side of the bed. Certified Nursing Assistant (CNA) B was observed as she stood on resident #9's left side, scooped meal with a spoon and assisted resident #9 with her meal. On 4/08/26 at 10:46 AM, CNA B approached surveyor and identified herself as the staff member who assisted resident #9 with her meal on 4/06/26. She acknowledged she stood over the resident beside the bed while she assisted her. CNA B explained she knew she was not supposed to stand over the resident and should have been seated beside her. On 4/08/26 at 12:13 PM, the Director of Nursing (DON) stated she was aware a staff member was observed standing over resident #9 as she assisted her with eating. The DON clarified her expectation was for staff to sit at eye level when assisting with meals to ensure each resident's dignity was respected. Review of the facility's policy and procedure for Administration - Resident Rights revised 11/11/25 indicated each resident would have the right to be treated courteously, fairly and with the fullest measure of dignity.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure coordination of Level I Preadmission Screening and Resident Review (PASRR) findings with the resident assessment process to identify, communicate, and incorporate a diagnosis of Post-Traumatic Stress Disorder (PTSD) into the resident's assessment documentation for 1 of 1 resident reviewed for PASRR, resident #4, from a total sample of 40 residents.Review of resident #4's medical record revealed the initial PASRR dated 11/24, did not identify a diagnosis of Post-Traumatic Stress Disorder (PTSD).Review of resident #4's record further revealed an updated PASRR completed on 4/07/2026, documented as PASRR UPDATED.pdf, which identified a diagnosis of PTSD and required update to the resident's assessment documentation.The record also showed an annual Minimum Data Set (MDS) assessment dated [DATE] that included a diagnosis of Post-Traumatic Stress Disorder (PTSD). The PASRR was not updated to reflect this diagnosis until April 2026.The record included a psychiatric evaluation dated 2/20/25 which identified PTSD as part of the resident's mental health diagnoses.On 4/8/2026 at 10:13 AM, the Social Services Director stated the PTSD diagnosis identified on the updated PASRR was not recognized or acted upon prior to review of the facility matrix in April 2026. The Social Services Director stated the diagnosis was present in the record since July when the MDS coordinator added it to the diagnosis section of the MDS. She said to her knowledge the new diagnosis was not discussed or identified by any of the Interdisciplinary Team (IDT) except the MDS Coordinator.On 4/8/2026 at 12:14 PM, the MDS Coordinator stated she entered new diagnoses into the Minimum Data Set assessment and that diagnoses were reviewed and discussed in morning interdisciplinary meetings, with updates made to the medical record as needed. The MDS Coordinator did not explain why the PTSD diagnosis for resident #4 was not identified or addressed through the established review process. On 4/8/2026 at 10:35 AM, the Director of Nursing (DON) stated the PTSD diagnosis documented on the PASRR was not reflected in the resident's assessment documentation and was not incorporated into the interdisciplinary process when initially identified. The DON stated the PASRR findings were not acted upon until later review and confirmed the issue was identified during matrix review in April 2026 while preparing for survey. The DON acknowledged this was an oversight.Review of the facility's policy and procedure titled Social Services - Trauma Informed Care, effective 4/1/2022 and revised 3/12/2026, read, expectations for identification and response to trauma-related needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or revise a comprehensive, person-centered care plan to address a diagnosis of Post-Traumatic Stress Disorder (PTSD) for 1 of 1 resident reviewed for care planning of a total sample of 40 residents, (#4).Resident #4 was admitted to the facility on [DATE] from an acute care hospital.A psychiatric evaluation dated 2/20/25 identified PTSD as part of the resident's mental health diagnoses. Behavioral health progress notes dated 3/28/25, 7/14/25, 7/31/25, 8/21/25, 9/17/25, 9/23/25, 10/1/25, 10/14/25, and 10/28/25 documented a diagnosis of Post-Traumatic Stress Disorder (PTSD). A comprehensive Minimum Data Set (MDS) assessment dated [DATE], a quarterly MDS assessment dated [DATE], and a quarterly MDS assessment dated [DATE] identified PTSD in Section I (Active Diagnoses).Review of resident #4's care plans revealed no care plan for trauma until 4/08/26.On 4/8/26 at 10:13 AM, the Social Services Director stated the PTSD diagnosis was present in the record but was not addressed in care planning prior to identification of the diagnosis on 4/06/26. The Social Services Director acknowledged the care plan omission was not identified until that time. On 4/8/26 at 12:14 PM, the MDS Coordinator stated diagnoses were entered into the MDS, reviewed in interdisciplinary meetings, and was unable to explain why the PTSD diagnosis was not incorporated into the resident's care plan. On 4/8/26 at 10:35 AM, the Director of Nursing stated the PTSD diagnosis was not incorporated into the interdisciplinary care planning process and was not reflected in the resident's care plan prior to April 2026. She acknowledged this was an oversight.Review of the facility's policy titled Care Planning and Interdisciplinary Team Process, effective 4/1/22 and revised 3/12/26, indicated requirements for development and revision of individualized care plans based on resident assessments and changes in condition.

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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** Based on observation, interview and record review, the facility failed to ensure a physician's order was obtained prior to the administration of oxygen therapy for 1 of 1 resident reviewed for oxygen (O2) therapy out of a total sample of 40 residents, (#89).Findings: Resident #89 was admitted to the facility on [DATE] with diagnoses of respiratory failure with hypoxia, chronic obstructive pulmonary disease, congestive heart failure, and dependence on supplemental oxygen. On 4/06/26 at 8:47 AM, the resident was observed in bed with a nasal cannula that delivered oxygen (O2) at 2.5 liters per minute (L) . He commented that he just got back from the hospital the previous night. He said he was there for shortness of breath, swollen legs and pneumonia. A review of resident #89's medical record revealed there was no physician's order for oxygen. The Minimum Data Set from 3/18/26 indicated he was cognitively intact, dependent on staff for moderate assistance, and used continuous oxygen. A care plan for resident #89 dated 2/26/26 indicated he used O2 for pneumonia and respiratory failure, and instructed staff to monitor him for difficulty breathing. On 4/8/26 at 9:15 AM, Licensed Practical Nurse (LPN) A explained when they get a hospital admission, the nurses help each other put orders into the system, or the unit managers assist. She said having an order in the medical record would ensure a resident received the correct liter of oxygen. On 4/07/26 at 9:48 AM, the Registered Nurse (RN) Unit Manager (UM) of [NAME] 1 said audits are completed on oxygen orders often to ensure they are accurate. On 4/08/26 at 9:37 AM, resident #89 was observed using 3 L of O2. He was measuring his oxygen saturation using a finger oxygen sensor meter. His blood oxygen level was at 96%. He explained he checked it often to be certain it stayed above 90%, because he depended on oxygen to breathe comfortably. On 4/08/26 at 9:43 AM, the UM of [NAME] 1 was unable to find an order in the computer for resident #89 for oxygen. She confirmed the resident was on oxygen and had no order. On 4/08/26 at 10:42 AM, The Director of Nursing confirmed that if a resident is on O2, it should be documented in the order set and the care plan. She said they performed chart audits in their morning meetings so no orders from the hospital were missed, especially after an admission. On 4/09/26 at 10:21 AM, The Administrator stated if a resident is on oxygen, it should be reflected in an order. She also remarked they have a mock survey process; the leaders each have a group of residents, and they check their oxygen concentrators. She added they will now verify that the orders are in the computer as well. A review of the facility's Oxygen Administration Policy dated 1/26/26 instructed staff to verify the provider order prior to administration of O2. It affirmed that oxygen was supposed to be delivered at a flow rate prescribed by a physician.