

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB

No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2025
NAME OF PROVIDER OR SUPPLIER Indian River Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7201 Greenboro Dr West Melbourne, FL 32904	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to prevent physical abuse of a vulnerable resident by another resident on the memory care unit, (#1), and failed to prevent neglect of a cognitively impaired resident exhibiting worsening behavior, (#2), for 2 of 6 residents reviewed for abuse/neglect, of a total sample of 6 residents. This failure contributed to resident #1 sustaining a fractured jaw which led to his transfer to an acute care hospital where he died 6 days later. On [DATE] at 9:40 PM, Certified Nursing Assistant (CNA) A witnessed resident #2 enter resident #1's room. Shortly after, resident #1's roommate approached the nurses' station and said resident #2 was in his room on top of resident #1. CNA A said when he got to resident #1's room, resident #2 was coming out with resident #1's sheets in his hands. CNA A explained he saw resident #1 lying on the bed in the dark with his feet hanging off the bed. The next morning, on [DATE] at approximately 7:30 AM, Registered Nurse (RN) F was notified by CNA E that she had observed discoloration to resident #1's face. The Advanced Practice Registered Nurse (APRN) was at the facility and assessed the resident at 11:40 AM. The APRN ordered x-rays of resident #1's face as well as labs. Mobile x-rays were done and the results revealed resident #1 had suffered an acute fracture of the left and right lower jaw with soft tissue swelling. The APRN ordered resident #1's transfer to an acute care hospital at approximately 7:00 PM on [DATE]. The hospital Emergency Department (ED) physician assessment dated [DATE] indicated resident #1's injuries were suspicious for non-accidental trauma, physical abuse or neglect. Resident #1 was not a candidate for surgery due to his advanced age and complex medical history. The resident was transferred to an inpatient hospice unit for comfort care on [DATE] and passed away five days later on [DATE]. The facility failed to prevent resident-to-resident physical abuse for a vulnerable, cognitively impaired resident, (#1), failed to ensure medical care was provided in a timely manner for an emergent injury, failed to ensure incidents of abuse were accurately documented in the medical record, and failed to ensure a cognitively impaired resident, (#2) with history of aggressive behaviors was appropriately monitored and supervised to help him attain his highest practicable level of mental health. These failures contributed to an unsafe environment and put all residents that resided in the memory care unit at risk for physical abuse, and neglect. These failures resulted in Immediate Jeopardy starting on [DATE]. There were a total of 60 residents residing in the facility's memory care unit. Findings: Cross Reference F610 and F835 (continued on next page)		

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #1, an [AGE] year-old male, was initially admitted to the facility from an acute care hospital on [DATE] with diagnoses that included repeated falls, and adult failure to thrive. He was transferred to the hospital from the facility on [DATE] due to unresponsiveness and was treated for pneumonia and admitted to hospice services for senile degeneration of the brain. He was readmitted to the facility on [DATE] with additional diagnoses including palliative care, congestive heart failure, dementia, pain, and long-term use of anticoagulants. Review of the Discharge Minimum Data Set (MDS) dated [DATE], revealed resident #1 had severe cognitive impairment, required supervision for eating, and substantial to maximum assistance for all activities of daily living (ADLs). For bed mobility he required partial to moderate assistance. The physician order summary for [DATE] revealed physician orders including: Apixaban (blood thinner), 5 milligrams (mg) twice a day for clot prevention; Donepezil 5 mg, once a day, and 10 mg at bedtime, for dementia; Haloperidol tablet, 2 mg three times a day for brief psychosis; Lorazepam (Ativan) gel, 1 mg every 6 hours as needed for anxiety; Mirtazapine 15 mg for depression daily; Quetiapine Fumarate 25 mg at bedtime for brief psychotic disorder; and Trazodone, 100 mg every 8 hours for depression with restlessness. Review of a psychiatric note dated [DATE] revealed resident #1 suffered with anxiety but denied depressive symptoms. The note indicated he slept well, ate well, had no manic symptoms, no agitation, and his moods were better. He was noted to be confused and restless, but no other behaviors were noted by the provider. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 4:38 PM, resident #1's wife stated her husband was admitted to the facility because she was unable to care for him at home due to his dementia. She explained he was initially admitted to the facility on [DATE] but was hospitalized again shortly afterwards. Resident #1's wife explained she requested the hospital not return him to the facility, but he had to return on [DATE], as they were unable to find a suitable bed elsewhere. She said she and the resident's brother would visit him almost daily. Resident #1's wife recalled on [DATE] she received a call from an unknown nurse at approximately 8:30 AM, informing her of discoloration found on her husband's face. She was told at that time they did not know what might have happened but believed it might have been caused by the bedrail. She recalled she had not seen her husband's injuries yet so did not argue with their explanation at that time. Resident #1's wife said she arrived at the facility around noon on [DATE] and he was sitting in his chair in the dining room. She remembered she was surprised when she saw the extent of the bruising on her husband's face and neck because it was worse than she imagined. She said the APRN, his nurse, and another female staff member whose name she could not recall were there when she saw him and the APRN said she would order an X-ray of his face and lab work. She said she told them at that time she did not believe this was caused by the bed rails because of how bad his face looked. Resident #1's wife explained she was told they did not know what happened to him, but they would investigate. She stated at approximately 1:00 PM, she tried to feed her husband his lunch, but he could not even open his mouth to chew, so he did not eat. She said she left the facility around 4:00 PM, and received a phone call at approximately 8:30 PM informing her the x-ray showed he had a broken jaw and lab work indicated he had an elevated white blood count (WBC) so he would be transferred to the hospital by non-emergency transport. She recalled the nurse told her it seemed another resident might have attacked him. Resident #1's wife recalled she went right away to the hospital and when she arrived, he was unresponsive, and he never opened his eyes to look at her again. She said she was unable to talk to him again and he passed away six days later on [DATE]. Resident #1's wife recalled the hospital physician told her that surgery and recovery could be complicated, so the best option for him was hospice to keep him comfortable, so he was transferred to inpatient hospice. She conveyed his death certificate said his death was undetermined and per the law enforcement detective she spoke with a few weeks ago, the autopsy report was still not released as it was still an active investigation. Review of a federal report filed by the facility on [DATE] at 8:24 PM, revealed the facility's Assistant Nursing Home Administrator (NHA). reported an incident that resulted in an allegation of serious bodily injury (fracture of left and right mandibular bone). The report contained information submitted by the facility which indicated the incident occurred the previous day on [DATE] at 9:40 PM, but staff became aware of the incident on [DATE] at 7:00 PM. The description of the incident/allegation included resident #1's roommate reported to the CNA that resident #2 was in the resident's room and had made contact with resident #1. The report described the CNA went to the room and observed resident #2 leaving the room with sheets from resident #1's bed. The document detailed that resident #1 was observed with skin discoloration the following morning, an x-ray was completed, and head-to-toe assessments were completed on both residents. Resident #2 was placed on one to one supervision and a psychiatric consult was ordered as well as lab work. Resident #1 was sent to the hospital by the physician for further evaluation and treatment. The summary of relevant records was added to the report on [DATE] at 11:39 AM, which revealed per review of the relevant resident records related to the incident, that resident #2 had behavior of wandering in and out of other residents' rooms. The facility noted both residents were cognitively impaired, and they did not verify the allegation as the facility reported there were no signs of mental anguish from either resident and no signs of pain upon assessment. The facility reported resident #2 lacked cognitive capacity so therefore could not have willful intent. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:06 PM, CNA A confirmed he was assigned to care for resident #1 on [DATE] on the 3 PM to 11 PM shift. He recalled on [DATE] he was sitting at the nurses' station on the locked Caring Way unit (400 hall) and LPN B was sitting near him. He conveyed that at approximately 9:40 PM, he observed resident #2 enter resident #1's room and shortly after that resident #1's roommate approached the nurses' station and said resident #2 was in his room on top of resident #1. CNA A said when he got to the room resident #2 was coming out with resident #1's sheets in his hands and kept walking towards his own room. CNA A explained he saw resident #1 lying on the bed with his feet hanging off, and he remembered the room was dark, so he had to use his phone light to see resident #1's face because the room lights were not working. He said he reported what happened to LPN B and asked her to go check on the residents. CNA A stated the nurse did not go to check on the residents, she scoffed and, kept doing what she was doing. He said he did not report this to anyone else such as a supervisor because he thought the LPN would report it. CNA A said he left the facility at the end of his shift around 11:00 PM that evening. He acknowledged he did not report the incident to anyone until his shift the next day on [DATE], when he was asked to provide a statement to the Director of Nursing (DON) and Assistant NHA. CNA A recalled he did not see resident #1 again on [DATE], but he noticed resident #2 had a swollen hand and was not on one to one supervision. CNA A said he wanted to make sure the true details of what happened to resident #1 were known. He said he believed some staff members disliked him for telling the truth and because he, actually did his job and cared for the residents. Review of resident #1's medical record revealed there were no progress notes, or nursing assessments documenting the incident on [DATE] or [DATE], in either resident #1 or resident #2's medical record. A change in condition note was completed on [DATE] at 7:55 AM, by RN F and the Assistant Director of Nursing (ADON) which noted a change in skin color or condition, notification to APRN, and an order for STAT (without delay) labs and x-ray of face and cervical spine. A skin check with an effective date [DATE] at 8:12 AM, noted the resident had discoloration on both sides of his jaw, right side of his neck, and multiple discolorations in different stages on both arms. A pain assessment was also documented by late entry by the ADON and RN F with an effective date of [DATE] at 8:10 AM, which revealed the resident was, cognitively intact and has reported their acceptable or baseline level of pain, on a scale of ,d+[DATE], was a 0. The nurses documented resident #1 was unable to specify or could not answer the questions regarding his pain. A hospital transfer form was completed by RN F on [DATE] at approximately 6:31 PM, (almost 24 hours after resident #1 was sent to the hospital). The form noted he was transferred to the hospital on [DATE] at around 8:53 PM, due to abnormal x-ray, he required a proxy, was non ambulatory, had no active infections, and incorrectly noted no wounds or bruises present. An undated SBAR (Situation, Background, Appearance, and Review/Notify) Communication Form completed by RN F inaccurately noted the physician was notified of the transfer on [DATE] at 12:00 AM. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:17 AM, LPN B said in a phone interview that on [DATE] she worked a double shift from 7 AM to 11 PM, on the locked Caring Way unit with resident #1 and resident #2. She said she was familiar with both residents. LPN B recalled resident #2 was known to walk into other residents' rooms and caused problems with the other residents. LPN B said resident #2 was known to become aggressive, get into people's faces and grab things from other residents, especially after his family left from visiting. She explained between herself and the other nursing staff they would have to distract him when they saw him going into other resident rooms, but he was not easily redirected. They had to constantly watch him. LPN B recounted on [DATE] at about 9:40 PM, she was passing medications on the unit and was not at the nurses' station. She said she did not witness resident #2 enter or exit resident #1's room nor did she see resident #1's roommate come to the nursing station. LPN B denied that CNA A reported any incidents to her at any time during the shift. LPN B said she saw resident #1 a few times that night and he received medications sometime around 10 PM with no issues. She said she did not notice any injuries and he did not appear to be in any discomfort. LPN B confirmed she did not know of the incident until she received a call from the Assistant NHA asking for her statement sometime later on [DATE]. She stated for any incident suspicious for abuse, staff were supposed to follow the process and report it to the on-call supervisor, perform a head-to-toe assessment and document the findings. LPN B acknowledged she worked with one other nurse to cover the memory care unit that night, and did not explain how she could see everything that happened on the unit if she was passing medications or working on the other side of the Caring Way unit. Review of resident #1's Medication Audit Report for [DATE] and according to LPN B's documentation, he received Trazadone 100 mg at 9:47 PM. No other medications were given to resident #1 by LPN B that evening. On [DATE] at 10:58 AM, RN F, in an interview conducted in Spanish per RN F's request, she stated that on [DATE] she worked a double shift from 7 AM to 11 PM on the locked memory care unit. RN F stated she felt it was difficult to perform her job safely because they were not able to provide enough supervision of the residents. She explained they typically had five CNAs working on the unit for 60 confused residents and when residents had behaviors like entering other residents' rooms they tried to offer them snacks or food to distract them but many of them were not redirectable. RN F recalled at the start of her shift that morning she was informed by CNA E of the bruise on resident #1's face. She remembered she assessed the resident along with CNA E and the overnight nurse, LPN D and noticed he had bruising around his face and on his neck. RN F said she notified the APRN at approximately 7:30 AM of the bruises but acknowledged at that time she was not aware of CNA A's observation and allegation of possible resident-to-resident abuse. She said she began to complete her usual assessments and documentation and was unsure what time she called resident #1's wife to tell her about the bruise on his face. RN F stated the resident's wife arrived around the same time as the APRN, and x-rays were ordered. She said she believed this occurred because there was not enough staff working on that unit to provide supervision for the residents who were constantly wandering. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:18 AM, CNA E recalled that on [DATE] resident #1 had difficulty eating and opening his mouth during morning care that day. She remembered when she started doing room rounds at approximately 7:15 AM, she went to resident #1's room, which was the last room at the end of the hall. She recalled resident #1's bed was by the window, but she could see the bruise on his cheek from the doorway. She said she did not recall seeing the bruise when she left the previous day on [DATE]. She informed RN F and the night shift nurse, LPN D, and they went to see him. CNA E recalled the resident had bruises on both sides of his face, by his chin area and on his neck, (see photo evidence obtained). LPN D told them she had not witnessed any incidents during her shift and had not seen any bruising on his face previously. CNA E said she was unable to put resident #1's dentures in his mouth that morning because he could not open his mouth, and he did not want to eat all day. She recalled that on [DATE], resident #1's brother was at the facility during lunch time and resident #1 did not want to eat and was very tired. His brother asked for him to be put to bed so she brought his lunch tray into the room and his brother offered to try to feed him. She said when the brother left, the tray was still untouched. Review of the Documentation Survey Report for [DATE], revealed that on [DATE] the assigned CNA documented resident #1 was not available for breakfast and lunch but for dinner he had 0% intake of food and refused fluids. On [DATE] at 12:50 PM, LPN D said she was the assigned nurse for resident #1 on [DATE] on the 11 PM to 7 AM shift. She said she received report from the nurse that resident #2 was doing his usual wandering in and out of rooms all night, but was not told of any incidents. She did not recall any issues with resident #1's face and said she did not give him any medications during her shift. LPN D said she became aware of the bruising to the resident's face at the end of her shift by CNA E. She recalled at approximately 7:30 AM she went to see him with CNA E and RN F, and he had bruises on both sides of his face and neck. She acknowledged resident #2 was not placed on one to one supervision until the late afternoon of [DATE] after the facility was made aware of the allegation by CNA A of resident-to-resident assault towards resident #1. LPN D recalled resident #2 continued to be on one to one supervision until [DATE] when he was transferred to the hospital. LPN D acknowledged if she had been told of the incident during report that night she would have known to provide closer supervision for resident #2 to prevent any further incidents. On [DATE] at 12:39 PM, the APRN said in a phone interview that she received a call sometime in the morning of [DATE] from RN F saying that she found a bruise on resident #1's cheek. She said she evaluated resident #1 at approximately 11:40 AM and his wife was at the bedside. The APRN recalled he had a small bruise to the left cheek and another to the right cheek and neck, but said he did not appear to be in distress. She ordered an x-ray of his face, blood work, and UA to rule out infection. She said she called the East Coast UM to inform her of resident #1's bruising and x-ray order but was not aware of any reported incident of abuse at that time. She did not recall having any other conversations about resident #1, until she received a call later that day from the nurse reporting the fractured jaw and elevated WBCs. The APRN said she gave orders to transfer him to the hospital for further evaluation due to elevated WBCs, but she knew they would not be able to do anything about his broken jaw. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's radiology report dated [DATE] at 3:53 PM, reviewed on [DATE] at 9:44 PM, revealed an x-ray of the facial bones and cervical spine had been done at around 2:45 PM and results were reported at around 3:53 PM. The reason for the exam was due to swollen cheek and neck. The cervical spine showed scoliosis, mild degenerative osteoarthritic changes but no acute fractures. The face showed an acute fracture of the right and left mandible (lower jaw) at the junction of the body and symphysis with mild distraction but without significant angulation, accompanied by soft tissue swelling and possible acute bilateral frontal sinusitis. Review of the hospital radiology report dated [DATE] for a computed tomography (CT) of the facial bones revealed the reason for the exam was unknown trauma and jaw bruising. The findings included moderately displaced bilateral (both sides) anterior (towards the back) mandibular ramus fracture which appeared acute, without evidence of underlying lesion or callus. A CT of the head performed the same day included findings of no lytic (localized loss of bone tissue) or blastic (new bone growth) abnormalities were demonstrated. The hospital Emergency Department (ED) physician assessment dated [DATE] indicated resident #1's injuries were suspicious for non-accidental trauma, physical abuse or neglect. The ED physician's note indicated he was told by the resident's wife on [DATE] that she was informed that another facility resident physically assaulted her husband last night in bed. The mandible is the largest and strongest bone of the face, which forms the lower jawline. Mandibular fractures typically occur in two places, the parasymphysis (front of the jaw) and the condylar neck (the portion of the jaw that connect to the joint of the jaw). A mandibular ramus fracture is a fracture to the flat part of the jaw bone located at the back portion on each side of the face. This type of fracture is usually due to trauma including interpersonal violence/assault, motor vehicle accident, falls, and sports activities. A mandibular ramus fracture is rare, and a pathological (due to underlying disease) mandibular fracture is even more rare, accounting for less than 2% of all mandibular fractures. Pathological fractures usually follow surgical interventions such as third molar removal, infection of the jaw bones, tumors or severe bone loss due to certain medications called bisphosphonates or radiation. External signs of a fracture in this area include a displaced or elongated mandible and the skin may show hematoma or ecchymosis (bruising). A two-dimensional x-ray may not give an accurate picture of the fracture, but a CT scan is better at identifying fractures and provided a better image quality to decrease the chance of an interpretation error. The most common complication of this type of fracture was infection, especially if there was a prolonged time prior to treatment, (retrieved on [DATE] from www.ncbi.nlm.nih.gov). Broken lower jawbones are painful and may affect your breathing. You need immediate medical care if you break your jaw, and you may need surgery if it is a severe fracture. A broken jawbone is a medical emergency regardless of what part of your jawbone is broken. You may notice your jaw or cheek are bruised, or swollen, and you may not be able to close your mouth or open it wide. It would be painful when you chew food or talk, it may look like you have swelling or bruising to the jaw or cheek. A broken jaw may affect your ability to eat, speak or breathe, and may take weeks to heal even if surgery is not required (retrieved on [DATE] from www.mycllevelandclinic.org). (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:46 PM, the facility's reportable log for [DATE] was reviewed with the NHA, Assistant NHA, and DON. The NHA stated she was the facility's Risk Manager but at the time of the reportable incident, on [DATE], the Assistant NHA performed the role, and the DON was the Abuse Coordinator. The Assistant NHA said she first learned of the incident on [DATE] at about 3:30 PM, when she was notified by staff that an x-ray result for resident #1 showed he had sustained a fractured jaw. She said she alerted the DON, who was not at the facility that day, but arrived at approximately 4:00 PM. The Assistant NHA said although she was the Risk Manager, she was not made aware of the discoloration found on resident #1's face that morning by CNA E and RN F. The DON and Assistant NHA said they became involved in the investigation at that point, when the DON arrived and started gathering witness statements from the previous night's staff. They said CNA A worked the 3 PM to 11 PM shift on [DATE] and was interviewed in person by the DON and Assistant NHA on [DATE]. They said at that time they learned of his allegation of a possible resident-to-resident incident that occurred the previous evening of [DATE]. They said, CNA A's statement indicated he, ran down the hallway to escort [resident #2 name] personally. When I arrived to the room [resident #1's name] legs were halfway off the bed and I proceeded to fix him and ask if he was ok because [resident #2 name] took his blankets and dragged them, which he also put me in a headlock where I had to receive help from a co-worker to get him off of me which I reported to the nurse. The Assistant NHA said that LPN B assessed resident #1 that evening and did not notice any injuries. The Assistant NHA was unable to provide documentation of any assessment completed by LPN B that evening. The DON acknowledged there was no documentation of the incident, or report of the allegations made by the CNA, nor any head-to-toe assessment documented by the nurse. The DON said the nurse did not document because she did not notice any injuries to resident #1, and resident #2 was at his baseline always going in and out of other resident rooms. She explained it was normal for residents in the locked unit to wander in and out of other residents' rooms because they had dementia. The DON said, Because the fracture was not treatable there was no need to send the resident out [to the hospital] but because of his elevated blood count he was sent out and the wife agreed. They were unable to provide documentation to show any assessments completed that night for resident #1 or #2. They said they interviewed LPN B by phone, who had worked a double shift on [DATE] from 7 AM to 11 PM. LPN B told them that on the morning of [DATE] there had been no issues with resident #1 except he was sleepy during lunch and his family asked for him to be put in bed. She said his family stayed until early to mid-evening and she gave him medication at approximately 10:00 PM. He did not complain of pain, was not in any distress, and fell back to sleep. They explained LPN B checked on him again at around 10:30 PM and he was still sleeping comfortably. The Assistant NHA said the 11 PM to 7 AM staff were interviewed and both the CNA and LPN gave the same statement. CNA C and LPN D said they provided incontinence care for resident #1 at approximately 1:00 AM to 2:00 AM on [DATE] and they did not notice any injuries to the resident at that time. LPN D told them resident #1 did not receive any medications during her shift, and she first became aware of the discoloration prior to leaving on [DATE] when she was asked to go to his room by the morning nurse and CNA. She said she noticed that he had a discoloration to the left side of his jaw. The Assistant NHA said that resident #1's roommate was interviewed on [DATE] but he did not recall the incident or what he reported to CNA A. Both the DON and Assistant NHA confirmed they had not been notified on [DATE] regarding CNA A's allegations of a possible resident-to-resident incident. They confirmed LPN B said she did not witness or receive report from CNA A regarding resident #2 coming out of resident #1's room, the roommate's allegation about the attack, nor of him being put in a headlock by resident #2. The Assistant NHA explained CNA E was the first one who noticed resident #1's injuries on [DATE] during her morning rounds at approximately 7:30 AM. She told them in her statement she saw the discoloration to one side of his face and notified RN F and LPN D. They stated RN F called the APRN who was already at the facility doing rounds that morning and called resident #1's wife at approximately 8:30 AM to notify her of the bruises. They said a head-to-toe assessment was done and they started completing the incident report. The Assistant NHA and DON explained at around 11:40 AM (four hours after the bruises were first noticed and reported) the APRN evaluated resident #1 with his wife at the bedside. They said at that time the APRN ordered an x-ray of the resident's face, labs, and a UA to rule out a UTI. The x-ray and labs results were obtained at approximately 3:30 PM which confirmed he had a broken jaw and elevated WBCs. The Assistant NHA and DON said the APRN was notified shortly after that time, and an order was		

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NAME OF PROVIDER OR SUPPLIER Indian River Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7201 Greenboro Dr West Melbourne, FL 32904	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the lab results of [DATE] revealed resident #1's WBCs were 13.49 out of a range of 3.90 (low) to 11.20 (high). Review of resident #1's mobile radiology report revealed the x ray results were reported to the facility on [DATE] at 3:53 PM. On [DATE] at 6:40 PM, a standard phone order was given by the APRN to send resident #1 to the hospital for evaluation and treatment, almost three hours after the jaw fractures were reported to the facility. Review of the hospital's inpatient hospice unit notes dated [DATE] revealed resident #1 was sent to the hospital due to being abused by another resident with cognitive issues. He had two fractures to his jaw and bruising as a result of the abuse and there was an open investigation regarding the lack of supervision to keep him safe. The note indicated his wife was very upset and angry as a result of his injuries because she had been reluctant to send him back to the facility after his last hospital admission but there was no other place that would offer him placement. A hospice note dated [DATE] revealed resident #1 was laying on his left side and had oral secretions draining. His breathing was slightly labored, and his tongue obstructed his airway along with the secretions. The note indicated resident #1 was actively dying and his wife was emotionally distraught by the attack on her husband at the facility by another resident. 2. Review of the medical record revealed resident #2, a [AGE] year-old male was admitted to the facility on [DATE] from an in-patient psychiatric hospital with diagnoses that included Alzheimer's Disease, major depressive disorder, recurrent severe, anxiety disorder, cognitive impairment, mild neurocognitive disorder, hypermobility syndrome, and affective mood disorder with other behavioral disturbance. The Minimum Data Set (MDS) Quarterly Assessment with Assessment Reference Date (ARD) of [DATE] noted resident #2 was rarely/never understood and unable to complete the Brief Interview for Mental Status (BIMS). Staff assessed the resident had short-term and long-term memory problems, his cognitive skills for daily decision making were severely impaired, and no acute mental status changes occurred. For 4 to 6 days, the resident had physical and verbal behaviors directed towards others, other behaviors not directed towards others, rejection [TRUNCATED]		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview and record review the facility failed to conduct an accurate and thorough investigation related to an allegation of resident to resident physical abuse of a vulnerable, cognitively impaired resident, (#1), failed to investigate an injury of unknown origin for the same event when abuse was not substantiated, including completely and thoroughly documenting investigative findings, to ensure the safety of all vulnerable residents on the memory care unit. This failure contributed to resident #1's injury, transfer to a higher level of care where he died 6 days later. Per the facility's 5-Day report to the state agency, on [DATE] at approximately 4:00 PM, Certified Nursing Assistant (CNA) A reported to administrative staff that during his shift, the previous day, on [DATE] at approximately 9:40 PM, resident #1's roommate reported to him he had seen resident #2 in their room, making contact with resident #1. CNA A went to the room and observed resident #2 exiting with resident #1's bed sheets. The next morning on [DATE] staff reported discoloration to resident #1's face to the provider so an x-ray and lab work were ordered. The x-ray revealed fractures of the left and right jaw. Head-to-toe assessments and pain evaluations were reported to be completed on both residents. Resident #2 was put on one-to-one observation, and psychiatry was consulted. Notification to the physician, resident representatives, law enforcement, and Department of Children and Families (DCF) were completed. The facility concluded the allegations were not verified because there was no, mental anguish for either of the residents. The facility reported resident #2 lacked the cognitive capacity for willful intent. The facility's failure to complete a thorough investigation, maintain accurate records of investigative findings, and ensure appropriate corrective actions were implemented, placed resident #1 and other cognitively impaired residents that resided in the memory care unit at risk for physical abuse and neglect. Resident #1 passed away on [DATE] of unknown causes and death is under investigation with DCF and law enforcement at the time of this survey. This failure resulted in Immediate Jeopardy starting on [DATE]. There were a total of 60 current residents that resided in the memory care unit. Findings: Cross Reference F600 and F835 Resident #1, an [AGE] year-old male, was initially admitted to the facility from an acute care hospital on [DATE] with diagnoses that included repeated falls, and adult failure to thrive. He was transferred to the hospital from the facility on [DATE] due to unresponsiveness and was treated for pneumonia and admitted to hospice services for senile degeneration of the brain. He was readmitted to the facility on [DATE] with additional diagnoses including palliative care, congestive heart failure, dementia, pain, and long-term use of anticoagulants. Review of the Discharge Minimum Data Set (MDS) dated [DATE], revealed he had severe cognitive impairment, required supervision for eating, and substantial to maximum assistance for all activities of daily living (ADLs). He exhibited behaviors such as physical and verbal aggression towards others, and rejection of care. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Reportable Incidents Log from [DATE] to [DATE] revealed there was a physical abuse allegation that involved resident #1 and #2 on [DATE]. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:46 PM, the facility's reportable log for [DATE] was reviewed with the Nursing Home Administrator (NHA), Assistant NHA, and the Director of Nursing (DON). The NHA stated she was the facility's Risk Manager but at the time of the reportable incident, on [DATE], the Assistant NHA performed the role, and the DON was the Abuse Coordinator. The Assistant NHA said she first learned of the incident on [DATE] at about 3:30 PM, when she was notified by staff that an x-ray result for resident #1 showed he had sustained a fractured jaw. She said she alerted the DON, who was not at the facility that day, but arrived at approximately 4:00 PM. The Assistant NHA said although she was the Risk Manager, she was not made aware of the discoloration found on resident #1's face that morning by CNA E and Registered Nurse (RN) F. The DON and Assistant NHA said they became involved in the investigation at that point, when the DON arrived and started gathering witness statements from the previous night's staff. They said CNA A worked the 3 PM -11 PM shift on [DATE] and was interviewed in person by the DON and Assistant NHA on [DATE]. They said at that time they learned of his allegation of a possible resident-to-resident incident that occurred the previous evening of [DATE]. They said, CNA A's statement indicated he, ran down the hallway to escort [resident #2 name] personally. When I arrived to the room [resident #1's name] legs were halfway off the bed and I proceeded to fix him and ask if he was ok because [resident #2 name] took his blankets and dragged them, which (when) he also put me in a headlock where I had to receive help from a co-worker to get him off of me which I reported to the nurse. The Assistant NHA said that Licensed Practical Nurse (LPN) B assessed resident #1 that evening and did not notice any injuries. The Assistant NHA was unable to provide documentation of any assessment completed by LPN B that evening. The DON acknowledged there was no documentation of the incident in the medical record, or report of the allegations made by the CNA, nor any head-to-toe assessment documented by the nurse. The DON explained the nurse did not document an assessment because she did not notice any injuries to resident #1 and resident #2 was at his baseline always going in and out of other resident rooms. She did not answer how anyone would know resident #1's assessment was within normal limits or even performed as the nurse alleged, if there was not an assessment documented at all. The DON explained it was normal for residents in the locked unit to wander in and out of other residents' rooms because they had dementia. In regard to why resident #1 was not sent out to the hospital immediately when the fractures were known, the DON explained, Because the fracture was not treatable there was no need to send the resident out [to the hospital] but because of his elevated blood count he was sent out and the wife agreed. The DON, and Administrator were unable to provide documentation to show any assessments completed that night on resident #1 or #2. They said they interviewed LPN B by phone, who had worked a double shift on [DATE] from 7 AM to 11 PM. LPN B told them that on the morning of [DATE] there had been no issues with resident #1 except he was sleepy during lunch and his family asked for him to be put in bed. She said his family stayed until early to mid-evening and she gave him medication at approximately 10:00 PM. He did not complain of pain, was not in any distress, and fell back to sleep. They explained LPN B checked on him again at around 10:30 PM and he was still sleeping comfortably. The Assistant NHA said the 11 PM-7 AM staff were interviewed and both the CNA and LPN gave the same statement. CNA C and LPN D said they provided incontinence care for resident #1 at approximately 1:00 AM to 2:00 AM on [DATE] and said they did not notice any injuries to the resident at that time. LPN D told them resident #1 did not receive any medications during her shift, and she first became aware of the discoloration prior to leaving on [DATE] when she was asked to go to his room by the morning nurse and CNA. She said she noticed that he had a discoloration to the left side of his jaw. The Assistant NHA said that resident #1's roommate was interviewed on [DATE] but he did not recall the incident or what he reported to CNA A. Both the DON and Assistant NHA confirmed they had not been notified on [DATE] regarding CNA A's allegations of a possible resident-to-resident incident. They confirmed LPN B said she did not witness or receive report from CNA A regarding resident #2 coming out of resident #1's room, the roommate's allegation about the attack, nor of him being put in a headlock by resident #2. The Assistant NHA explained CNA E was the first one who noticed resident #1's injuries on [DATE] during her morning rounds at approximately 7:30 AM. She told them in her statement she saw the discoloration to one side of his face and notified RN F and LPN D. They stated RN F called the Advance Practice Registered Nurse (APRN) who was already at the facility doing rounds that morning and called resident #1's wife at approximately 8:30 AM to notify her of the bruises. They said a head-to-toe assessment was done and they started completing the incident report. The Assistant		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the lab results of [DATE] revealed resident #1's WBCs were 13.49 out of a range of 3.90 (low) to 11.20 (high). Review of resident #1's mobile radiology report revealed the x ray results were reported to the facility on [DATE] at 3:53 PM. On [DATE] at 6:40 PM, a standard phone order was given by the APRN to send resident #1 to the hospital for evaluation and treatment, almost three hours after the jaw fractures were reported to the facility. In a progress note dated [DATE] at 8:53 PM, RN G documented APRN notified of lab results, resident transferred to the local hospital. Another progress note by RN G dated [DATE] at 9:43 PM, indicated the x-ray results were reviewed with the APRN, and the resident was at the hospital. Broken lower jawbones are painful and may affect your breathing. You need immediate medical care if you break your jaw, and you may need surgery if it is a severe fracture. A broken jawbone is a medical emergency regardless of what part of your jawbone is broken. You may notice your jaw or cheek are bruised, or swollen, and you may not be able to close your mouth or open it wide, (retrieved on [DATE] from www.myclivelandclinic.org). (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 4:38 PM, resident #1's wife stated her husband was admitted to the facility because she was unable to care for him at home due to his dementia. She explained he was initially admitted to the facility on [DATE] but was hospitalized again shortly afterwards. Resident #1's wife explained she requested the hospital not return him to the facility, but he had to return on [DATE], as the hospital was unable to find a suitable bed elsewhere. She said she and the resident's brother would visit him almost daily. Resident #1's wife stated she felt there was a safety issue at the facility. She said in the lunchroom several family members saw a man and a woman fight while two staff members sat on the floor, each looking at their phones instead of observing the residents. She explained she mentioned to staff at least three times to put their phones down and pay attention to the residents before something happened. Resident #1's wife relayed this was why she was trying to transfer her husband to another facility in the area. She recalled on [DATE] she received a call from the facility at approximately 8:30 AM, informing her of discoloration found on her husband's face. She was told at that time they did not know what had happened but believed it might have been caused by the bedrail. She recalled she had not seen her husband's injuries yet, so she did not argue with their explanation at that time. Resident #1's wife said she remembered when she arrived at the facility she was surprised at the extent of the bruising on her husband's face and neck because it was worse than she imagined. She said the APRN, the nurse, and another staff member whose name she could not recall were there and the APRN said she would order an X-ray of his face and lab work. She said she told them at that time she did not believe this was caused by the bed rails because of how bad his face looked. Resident #1's wife explained she was told they did not know what happened to him, but they would investigate. She said she left the facility around 4:00 PM, and received a phone call at approximately 8:30 PM letting her know the x-ray showed he had a broken jaw and lab work indicated he had elevated WBC so he would be transferred to the hospital by non-emergency transport. She recalled the nurse told her it seemed another resident might have attacked him. Resident #1's wife recalled she went right away to the hospital and when she arrived, he was unresponsive, and he never opened his eyes to look at her again. She said she was unable to talk to him again and he passed away six days later on [DATE]. Resident #1's wife recalled the hospital physician told her that surgery and recovery could be complicated due to his age and medical history, so the best option for him was hospice to keep him comfortable. He was transferred to inpatient hospice. She recalled she told the staff present; this was not the bedrails that caused this because of the extent of his wounds. She said she was upset and left the facility but took pictures of his face to keep as proof. On [DATE] at 5:06 PM, CNA A said that on [DATE] he was sitting at the nurses' station on the Caring Way unit (400 hall locked unit) and LPN B was sitting with him. At around 9:40 PM he observed resident #2 enter resident #1's room and shortly after that resident #1's roommate went to the nurses' station and said he saw resident #2 in his room on top of resident #1. CNA A said when he got to the room resident #2 was coming out with resident #1's sheets in his hands and kept walking towards his room. Resident #1 was lying with his feet hanging off the bed and he had to use his phone light to see resident #1's face because the room lights were not working. He said he reported what he saw to the nurse and told her to go check on both residents, but she scoffed and just kept doing what she was doing. He did not go above the nurse and report to a supervisor because he expected her to do it. He reported the incident to the DON and ANHA on [DATE] sometime in the evening. CNA A said he did not recall seeing resident #1 when he returned for his shift on [DATE], but he saw resident #2 had a swollen hand and was not on 1:1 supervision. He recalled other incidents involving resident #2 including him exiting the facility during the ,d+[DATE] PM shift and CNA A and another staff member attempting to get him back, and resident #2 punching a pregnant CNA in the stomach. He said he was not sure if these incidents had been reported but staff had been reporting his aggressive behaviors to administration, but nothing was done. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:06 PM, CNA A confirmed he was assigned to care for resident #1 on [DATE] on the 3 PM to 11 PM shift. He recalled on [DATE] he was sitting at the nurses' station on the locked Caring Way unit (400 hall) and LPN B was sitting near him. He conveyed that at approximately 9:40 PM, he observed resident #2 enter resident #1's room and shortly after that resident #1's roommate approached the nurses' station and said resident #2 was in his room on top of resident #1. CNA A said when he got to the room resident #2 was coming out with resident #1's sheets in his hands and kept walking towards his own room. CNA A explained he saw resident #1 lying on the bed with his feet hanging off, and he remembered the room was dark, so he had to use his phone light to see resident #1's face because the room lights were not working. He said he reported what happened to LPN B and asked her to go check on the residents. CNA A stated the nurse did not go to check on the residents, she scoffed and, kept doing what she was doing. He said he did not report this to anyone else such as a supervisor because he thought the LPN would report it. CNA A said he left the facility at the end of his shift around 11:00 PM that evening. He acknowledged he did not report the incident to anyone until during his shift the next day on [DATE], when he was asked to provide a statement to the Director of Nursing (DON) and Assistant Nursing Home Administrator (NHA). CNA A recalled he did not see resident #1 again on [DATE], but he noticed resident #2 had a swollen hand and was not on 1:1 supervision. CNA A said he wanted to make sure the true details of what happened to resident #1 were known. He said he believed some staff members disliked him for telling the truth and because he actually did his job and cared for the residents. On [DATE] at 10:17 AM, LPN B said in a phone interview that on [DATE] she worked a double shift from 7 AM to 11 PM, on the locked Caring Way unit with resident #1 and resident #2. She said she was familiar with both residents. LPN B recalled resident #2 was known to walk into other residents' rooms and caused problems with the other residents. LPN B said resident #2 was known to become aggressive, get into people's faces and grab things from other residents, especially after his family left from visiting. She explained between herself and the other nursing staff they would have to distract him when they saw him going into other resident rooms, but he was not easily redirected. They had to constantly watch him. LPN B recounted on [DATE] at about 9:40 PM, she was passing medications on the unit and was not at the nurses' station. She said she did not witness resident #2 enter or exit resident #1's room nor did she see resident #1's roommate come to the nursing station. LPN B denied that CNA A reported any incidents to her at any time during the shift. LPN B said she saw resident #1 a few times that night and he received medications sometime around 10 PM with no issues. She said she did not notice any injuries and he did not appear to be in any discomfort, but acknowledged she did not document these findings. LPN B confirmed she did not know of the incident until she received a call from the Assistant NHA asking for her statement sometime later on [DATE]. She stated for any incident of suspicious abuse, staff were supposed to follow the process and report it to the on-call supervisor, perform a head-to-toe assessment and document the findings. LPN B acknowledged she worked with one other nurse to cover the memory care unit that night, and did not explain how she could see everything that happened on the unit if she was passing medications or working on the other side of the Caring Way unit. Review of resident #1's Medication Audit Report for [DATE] and per LPN B's documentation he received Trazadone 100 milligrams for depression at or around 9:47 PM. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:50 PM, LPN D said she was the assigned nurse for resident #1 on [DATE] on the 11 PM to 7 AM shift. She said she received report from the nurse that resident #2 was doing his usual wandering in and out of rooms all night, but was not told of any incidents. LPN D acknowledged resident #2 was not placed on one-to-one supervision, until the late afternoon of [DATE] after the facility was made aware of the fracture and allegation by CNA A of resident-to-resident assault towards resident #1. LPN D recalled resident #2 continued to be on one-to-one supervision until [DATE] when he was transferred to the hospital. The nurse acknowledged if she had been told of the incident during report that night she would have known to provide closer supervision for resident #2 to ensure there were no further incidents. In telephone interviews on [DATE] at 8:57 AM and again on [DATE] at 7:50 PM, resident #2's son recalled he was told by a nurse while visiting his father on Christmas day that his father had attacked another resident. He explained he had spoken with other nurses at the facility after that, and they were all aware of the incident between his father and the other resident (#1), but no one would say they had witnessed anything. He said his father was eventually transferred to the hospital on [DATE]. At the hospital they found bruises on both of his arms and a cut on the elbow that looked infected, which he did not know the origin of. The son recalled other incidents including when his father being attacked after he wandered into another resident's room and took some cookies. Another incident his mother witnessed when his father was grabbed by another resident and choked, and another incident with that same resident, his father was bitten on the hand, which he said he had pictures of. Resident #2's son stated he was not aware of any reports or investigations by the facility related to those incidents even though staff were present. On [DATE] at 11:18 AM, CNA E stated she worked the 7 AM to 3 PM shift on [DATE] and was the first person to see and report the discoloration to resident #1's face. She reported it to RN F at approximately 7:30 AM. During morning care on [DATE], resident #1 was unable to open his mouth for his dentures. He did not want to eat his meals that day but also remembered that he did not want to eat the previous day, [DATE] when his brother and wife visited. In a second phone interview on [DATE] at 12:20 PM, resident #1's wife recalled she had been at the facility Christmas day, [DATE] at approximately 11:15 AM and her brother-in-law arrived a little later. She conveyed that when she arrived, they had her husband sitting up in the dining room of the Caring Way unit and were getting ready to serve him lunch. His lunch tray arrived but he did not want to eat it. She said he did not have any noticeable injuries on his face at that time and was not complaining of any pain but was very sleepy. In a phone interview on [DATE] at 8:41 AM, resident #1's brother explained he visited the facility Christmas day, [DATE] with his brother's wife. He did not notice any injuries on his brother's face at that time. He was sitting in his wheelchair in the dining room of Caring Way unit with lunch tray in front of him. The brother explained the resident usually required only prompting to eat but was able to feed himself. They attempted to feed the resident, but he would not eat the food. They told the assigned CNA to lay him down since he was very sleepy, and she brought the tray to the room to see if he would eat his Christmas lunch at some point. The CNA left the tray at the bedside, but he said his brother was not interested in eating. He said he left the facility at around 5:00 PM. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Documentation Survey Report for [DATE], revealed that on [DATE] the assigned CNA erroneously documented resident #1 was not available for breakfast and lunch but for dinner he had 0% intake of food and refused fluids. On [DATE] the CNA documented that he ate 25% of his breakfast, 50% of his lunch, and 25 % of his dinner, in conflict with resident #1's wife's statement that he did not eat that day. On [DATE] at 10:58 AM, RN F in an interview conducted in Spanish per RN F's request, she stated on [DATE] she worked a double shift from 7 AM to 11 PM on the locked memory care unit. RN F recalled at the start of her shift that morning she was informed by CNA E of the bruise on resident #1's face. She remembered she went to his room and assessed the resident along with CNA E and the overnight nurse, LPN D, and noticed he had bruising around his face and on his neck. RN F said she notified the APRN at approximately 7:30 AM, of the bruises but acknowledged at that time she was not aware of CNA A's observation and allegation of possible resident-to-resident abuse. RN F stated the resident's wife arrived at the facility after she was notified, around the same time as the APRN, and an x-ray was ordered. On [DATE] at 12:39 PM, the APRN said in a phone interview that she received a call sometime in the morning of [DATE] from RN F to report a bruise on resident #1's cheek. She said she evaluated resident #1 at approximately 11:40 AM and his wife was at the bedside. The APRN recalled he had a small bruise to the left cheek and another to the right cheek and neck, but said he did not appear to be in any distress. She ordered an x-ray of his face, blood work, and urinalysis (UA) to rule out infection. She said she called the East Coast Unit Manager (UM) to inform her of resident #1's bruising and x-ray order but was not aware of any reported incident of abuse at that time. She did not recall having any other conversations about resident #1, until she received a call later that day from the nurse reporting the fractured jaw and elevated WBC. The APRN said she gave orders to transfer him to the hospital for further evaluation due to the elevated WBCs, but she knew they would not be able to do anything about his broken jaw. On [DATE] at 4:02 PM, in a second interview with the Assistant NHA, DON, [NAME] President of Operations, and Regional Nurse Consultant (RNC), the Assistant NHA stated that CNA A's allegations were not corroborated by any other staff member. She explained they did not have an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting in person but held a phone conference with the Medical Director to inform him of what they knew at that time. The Assistant NHA said during the scheduled monthly QAPI meeting in January they discussed what happened in December. She explained the Medical Director was made aware of the fracture once they received the results of the x-ray sometime after 3:00 PM on [DATE]. The Assistant NHA stated they concluded the allegations that resident #1 was injured by resident #2 were not verified. She verified no call was made to resident #2's representative to report a change in condition on [DATE] when he was placed on one to one supervision and psychiatry was consulted nor of the allegation resident #2 was the aggressor in the incident with resident #1. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:36 AM, in another interview with the DON, Assistant NHA, NHA, RNC, East Coast UM, and the Assistant DON, the DON stated she was unable to give a timeline of when the events happened because she was not made aware of the allegations until after the x-ray results had resulted. The DON stated that the UM was the first person notified by the nurse of the discoloration on the morning of [DATE]. The UM said that she did not speak with the nurse on [DATE] about the incident because she had spoken to the APRN. The UM recalled she received a call from the APRN at approximately 11:40 AM to inform her of resident #1's discoloration and x-ray order. The UM then called the Assistant DON, who was not at work and the Assistant NHA about the discoloration to resident #1's cheek. The DON explained CNA E, the day shift CNA was not interviewed right away, and she was the first person to see the discoloration. The DON explained the expectation was for all staff to report all incidents to their supervisor in a timely manner. The ADON said she did not remember receiving a call from UM about resident #1's bruises. The UM stated she called the ADON and spoke with her but could not recall the details of the conversation as it had not been documented. The ADON said she was unsure when she learned about the incident and had no documentation about it. The UM stated that RN F started writing the incident report at approximately 7:31 AM, but a resident assessment was not started until 9:00 AM. The UM said she started interviews at approximately 11:40 AM, (approximately 4 hours after the bruising was reported), starting with RN F. The Assistant NHA said they submitted their immediate report after speaking with CNA A, but corrected herself and said they should have just filed immediately for injury of unknown origin. Although the facility was unable to provide a root cause, accurate documentation of the events or a timeline of events, the RNC stated she felt they had done a thorough investigation. On [DATE] at 2:20 PM, in a joint interview with the Assistant NHA and DON, the Assistant NHA explained the APRN spoke to the UM for Key [NAME] Unit and reported the incident to her not to the ADON or the East Coast UM. Her expectation was for staff to notify the Nurse Manager or Staff Coordinator immediately when there were allegations of abuse/neglect or when there was an unknown injury of a resident. The Assistant NHA acknowledged the incident was not reported in a timely manner. She verified resident #2's family was not notified of the allegations. The Assistant NHA stated they unsubstantiated resident-to-resident abuse but acknowledged there was no follow up investigation to explain how resident #1 was injured. The DON verified that looking back the facility should have done another reportable as an injury on unknown origin and said it should have been re-opened. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:48 PM, in a joint interview with the facility's corporate staff including the Director of Compliance and [NAME] President of Risk and Regulatory they stated the investigation into resident #1's injuries would be re-opened (almost three months after the incident occurred) based on inconsistencies with CNA A's statements. They acknowledged the facility submitted a new Federal Immediate Report almost three months after the incident occurred. The Director of Compliance and [NAME] President of Risk and Regulatory did not say why they would re-open an investigation into an event that occurred in December of last year, if as they said, the original investigation was accurate. The Director of Compliance said he was not with the company in [DATE] and the [NAME] President was in a different position. They acknowledged that mandatory Federal one- and five-day reports were reviewed by corporate staff before they were sent to the State Agency. When asked why they would re-open this case when their predecessors approved the original investigations and Federal reports, they said they re-interviewed CNA A and found inconsistencies with his statement. The statements were regarding resident #2 having punched a pregnant staff and put CNA A in a headlock. However, neither of the corporate staff had concerns with CNA A's allegation that he saw resident #2 coming out of resident #1's room with the bedding. The Director of Compliance said the new investigation would focus on the injury of unknown origin. He could not say why the facility did not investigate resident #1's jaw fractures as an injury of unknown origin when		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) Level II Evaluation was completed for 2 of 3 residents, (#2, #4); and failed to complete Level I screen after significant change in condition for 1 of 3 residents, (#2) reviewed for PASARR, of a total sample of 6 residents. Findings: 1. Review of the medical record revealed resident #2, a [AGE] year-old male was admitted to the facility on [DATE] from an in-patient psychiatric hospital with diagnoses that included Alzheimer's Disease, major depressive disorder, recurrent severe, anxiety disorder, cognitive impairment, mild neurocognitive disorder, hypermobility syndrome, and affective mood disorder with other behavioral disturbance. The Minimum Data Set (MDS) Quarterly Assessment with Assessment Reference Date (ARD) of 12/29/24 noted during the look-back periods, resident #2 was rarely/never understood and unable to complete the Brief Interview for Mental Status (BIMS). Staff assessed the resident had short-term and long-term memory problems, his cognitive skills for daily decision making were severely impaired, and no acute mental status changes occurred. For 4 to 6 days, the resident had physical and verbal behaviors directed towards others, other behaviors not directed towards others, rejection of evaluation or care, and he wandered. The assessment showed the resident required staff supervision/moderate assistance to complete Activities of Daily Living (ADL), and for Functional Mobility. The resident received 3 injections, high-risk anti-psychotic, anti-anxiety, anti-depressant, hypnotic, and anti-convulsant medications, and no psychological therapy or active discharge planning occurred. The Physician's Determination of Resident's Capacity to Make Medical Decisions Based on Informed Consent dated 12/10/24 noted the physician determined resident #2 was unable to make his own decisions. The Care Plan Report initiated on 10/05/24 noted the resident required secure dementia unit with new surrounding adjustment difficulties and impaired safety awareness, cognitive deficits, high fall risk, nurse monitoring of adverse medication effects, history of non-compliance/refusal of care, behaviors including impulsivity, combativeness with staff, wandering in/out of other resident's rooms, getting into other resident's beds, exit-seeking, and re-direction resistance/difficulty with an intervention initiated on 12/26/24 for 1:1 staff observation/re-direction of resident's behaviors including going into other resident's rooms. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Order Summary Report included physician ordered medications for Citalopram (anti-depressant) 20 Milligrams (MG) each day at bedtime for depression, Depakote (anti-convulsant) 875 MG every 8 hours for affective mood disorder, Dextromethorphan (anti-tussive) 15 MG twice daily for behaviors, Haldol Decanoate (anti-psychotic) 75 MG injection every 21 days for dementia psychosis, one time Haldol injections for agitation on 12/04/24, 12/17/24, 12/26/24, 12/27/24, 12/28/24, and 12/29/24, Lorazepam (anti-anxiety) 0.5 MG twice daily for anxiety and wandering and 1 MG once on 12/13/24 for anxiety and insomnia, Mirtazepine (anti-depressant) 7.5 MG once daily at bedtime for sadness/depression, Paroxetine (anti-depressant) 20 MG once daily at bedtime for depression, and Temazepam (sedative-hypnotic) 15 MG once daily at bedtime for insomnia. The State of Florida Agency for Health Care Administration (AHCA Med/Serv Form 004 Part A, March 2017) completed by the in-patient psychiatric facility on 9/09/24 prior to resident #2's admission to the facility read, . Individual may not be admitted to a Nursing Facility. Use this form and required documentation to request a Level II PASRR (Pre-admission Screening and Resident Review) because there is a diagnosis of or suspicion of Serious Mental Illness. In a joint interview with the Nursing Home Administrator (NHA) and Assistant NHA on 3/11/25 at 10:40 AM, the NHA conveyed the facility was not aware of resident #2's Level II evaluation results until after they obtained a copy the same day from the in-patient psychiatric facility. Review of a progress note completed by the Psychiatric Mental Health Nurse Practitioner on 12/26/24 noted resident #2 had paranoid thoughts and read, . staff documented assaultive and aggressive behaviors. On 3/15/25 at 12:45 PM, the Director of Nursing (DON) said there were discussions in clinical meetings to determine if new PASARR screens or evaluations were needed, and she was responsible for ensuring they were completed. She did not explain why a new screen was not completed for resident #2 after he showed assaultive behaviors. 2. Review of the medical records revealed resident #4, a [AGE] year old male was admitted to the facility on [DATE] from Hospice with diagnoses including chronic pancreatitis, dementia with other behavioral and psychotic disturbance, brief psychotic disorder, major depressive disorder, moderate, primary insomnia, generalized anxiety disorder, affective mood disorder, Post-Traumatic Stress Disorder (PTSD), alcohol abuse, and persistent mood disorder. The MDS Quarterly Assessment with ARD of 2/20/25 noted resident #4 scored 4 out of 10 on the BIMS that indicated he was severely cognitively impaired. The assessment showed the resident had physical, verbal, behavioral symptoms directed towards others, other behavioral symptoms towards himself, rejection of evaluation or care for 4 to 6 days, and for 1 to 3 days, he wandered. The Care Plan Report initiated on 5/30/23 included secured dementia unit placement to meet individual needs for ADL care, impaired safety awareness, dementia, impaired cognitive function/thought processes, Long Term Care services, Hospice Services, nurse adverse medication effects monitoring, ADL self-care deficits, behaviors including nutritional supplement and medication declinations, and read, (Does not want nurse to touch any part of arm/shoulder/fingers). Care Plans initiated on 6/07/24 included: PTSD, resistive/refusals of care, anxiety, depression, and Paranoid Schizophrenia like behaviors and initiated 7/07/24: Incapacity. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Determination of Resident's Capacity to Make Medical Decisions Based on Informed Consent dated 12/23/24 noted the physician determined resident #4 was unable to make his own decisions. A progress note completed by the Psychiatric Mental Health Nurse Practitioner on 1/02/25 noted resident #4 reported he had been in a physical altercation with a peer who entered his room and took his property. In a telephone interview on 3/13/25 at 1:40 PM, the Psychiatric Mental Health Nurse Practitioner said he knew resident #4 well and recalled evaluating him on 1/02/25. He checked the medical record and explained the assessment occurred after the resident was moved to a new room and with a new roommate. He said he believed the resident confabulated the story and the resident's memory was very impaired and unreliable. He stated he was not aware of resident #2's involvement in any resident to resident physical altercations that were verified. On 3/13/25 at 12:30 PM, resident #4 was observed sitting on the bed in his room. The resident said, I had no fights or arguments with anybody. On 3/15/25 at 1:43 PM, resident #4 was observed sitting in a wheelchair in his room. He said he did not recall telling the Psychiatric Mental Health Nurse Practitioner that he hit someone and said, they pissed me off taking all my clothes; I just stood there and watched them. On 3/13/25 at 2:18 PM, the East Coast Unit Manager checked resident #4's medical record and said she completed a new PASARR screen on 1/06/25 that indicated a Level II Evaluation was required. She was unable to locate a completed evaluation. Review of the State Agency PASARR vendor records noted on 1/13/25, resident #4's case was administratively closed when the additional medical records required from the facility to process the Level II Evaluation were not received. The record showed on 3/13/25, the facility submitted a new request. On 3/15/25 at 12:45 PM, the DON said resident #4's Level II evaluation wasn't completed due to lack of consent. The DON explained she was not aware additional medical records were required and conveyed the facility missed conducting follow-up measures to ensure the Level II evaluation was completed. On 3/15/25 at 1:26 PM, the Regional Director of Operations said the facility did not have company policy for PASARR and they followed regulatory guidelines.		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13252 Based on record review, and interview, the facility failed to promote a culture of safety on the locked memory care unit to ensure residents' dementia and/or behaviors were free of abuse/neglect. The facility Administration's lack of active involvement and their deficient behavioral monitoring, reporting and investigative standards contributed to negative resident-to-resident interactions, which ended, at times, with physical fights, battery, and/or life altering injuries for 2 of 6 residents reviewed for abuse, neglect and behaviors of a total sample of 6 residents, (#1, and #2). On 12/25/24 at 9:40 PM, Certified Nursing Assistant (CNA) A witnessed resident #2 enter resident #1's room. Shortly after, resident #1's roommate approached the nurses' station and said resident #2 was in his room on top of resident #1. CNA A said when he got to resident #1's room, resident #2 was coming out with resident #1's sheets in his hands. CNA A explained he saw resident #1 lying on the bed in the dark with his feet hanging off the bed. The next morning, on 12/26/24 at approximately 7:30 AM, Registered Nurse (RN) F was notified by CNA E that she had observed discoloration to resident #1's face. The Advanced Practice Registered Nurse (APRN) was at the facility and assessed the resident at 11:40 AM. The APRN ordered x-rays of resident #1's face as well as labs. Mobile x-rays were done and the results revealed resident #1 had suffered an acute fracture of the left and right lower jaw with soft tissue swelling. The APRN ordered resident #1's transfer to an acute care hospital at approximately 7:00 PM on 12/26/24. The hospital Emergency Department (ED) physician assessment dated [DATE] indicated resident #1's injuries were suspicious for non-accidental trauma, physical abuse or neglect. Resident #1 was not a candidate for surgery due to his advanced age and complex medical history. The resident was transferred to an inpatient hospice unit for comfort care on 12/27/24 and passed away five days later on 1/01/25. The facility Administration failed to prevent physical abuse for a vulnerable, cognitively impaired resident (#1), failed to ensure medical care was provided in a timely manner for an emergent injury to ensure minimal pain and suffering, failed to ensure incidents and allegations of abuse were accurately documented in the medical record, and failed to ensure a cognitively impaired resident, (#2) with known aggressive behaviors received needed mental health services; was appropriately monitored and supervised; and had a comprehensive person-centered care plan with appropriate behavioral interventions. These failures contributed to an unsafe environment and put all residents residing in the memory care unit at risk for physical abuse and delays in care. These failures resulted in Immediate Jeopardy starting on 12/26/24. There were a total of 60 residents residing in the facility's memory care unit. Findings: (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #1, an [AGE] year-old male, was initially admitted to the facility from an acute care hospital on 10/26/24 with diagnoses that included hypertensive chronic kidney disease stage 3, repeated falls, and adult failure to thrive. He was transferred to the hospital from the facility on 11/16/24 due to unresponsiveness after his wife witnessed him slump over on his chair during dinner. He was treated for community acquired pneumonia and admitted to hospice for senile degeneration of the brain. He was readmitted to the facility on [DATE] with additional diagnoses including encounter for palliative care, congestive heart failure, syncope and collapse, dementia with behavioral disturbances, anxiety, major depressive disorder, pain, and long-term use of anticoagulants. In a telephone interview on 3/10/25 at 4:38 PM, resident #1's wife stated her husband was admitted to the facility because she was unable to care for him at home due to his dementia. She explained he was initially admitted to the facility on [DATE] but was hospitalized again shortly afterwards. Resident #1's wife explained she requested the hospital not return him to the facility, but he had to return on 11/27/24, as the hospital was unable to find a suitable bed elsewhere. She said she and the resident's brother would visit him almost daily. Resident #1's wife stated she felt there was a safety issue at the facility. She said in the lunchroom several family members saw a man and a woman fight while two staff members sat on the floor, each looking at their phones instead of observing the residents. She explained she mentioned to staff at least three times to put their phones down and pay attention to the residents before something happened. Resident #1's wife relayed this was why she was trying to transfer her husband to another facility in the area. She recalled on 12/26/24 she received a call from the facility at approximately 8:30 AM, informing her of discoloration found on her husband's face. She was told at that time they did not know what had happened but believed it might have been caused by the bedrails. She recalled she had not seen her husband's injuries yet, so she did not argue with their explanation. Resident #1's wife said she remembered when she arrived at the facility she was surprised at the extent of the bruising on her husband's face and neck because it was worse than she imagined. She said the APRN, the nurse, and another staff member whose name she could not recall were there and the APRN said she would order an x-ray of his face and lab work. She said she told them at that time she did not believe this was caused by the bed rails because of how bad his face looked. Resident #1's wife explained she was told they did not know what happened to him, but they would investigate. She stated at approximately 1:00 PM, she tried to feed her husband his lunch, but he could not even open his mouth to chew, so he did not eat. She said she left the facility around 4:00 PM, and received a phone call at approximately 8:30 PM letting her know the x-ray showed he had a broken jaw and lab work indicated he had elevated white blood count (WBC) so he would be transferred to the hospital by non-emergency transport. She recalled the nurse told her it seemed another resident might have attacked him. Resident #1's wife recalled she went right away to the hospital and when she arrived, he was unresponsive, and he never opened his eyes to look at her again. She said she was unable to talk to him again and he passed away six days later on 1/01/25. Resident #1's wife recalled the hospital physician told her that surgery and recovery could be complicated due to his age and medical history, so the best option for him was hospice to keep him comfortable. He was transferred to inpatient hospice. She recalled she told the staff this was not the bedrails that caused this because of the extent of his wounds. She said she was upset and left the facility but took pictures of his face to keep as proof. (continued on next page)		

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The DON and Assistant NHA said they became involved in the investigation at that point, when the DON arrived and started gathering witness statements from the previous night's staff. They said CNA A worked the 3 -11 PM shift on 12/25/24 and was interviewed in person by the DON and Assistant NHA on 12/26/24. They said at that time they learned of his allegation of a possible resident-to-resident incident that occurred the previous evening of 12/25/24. They said, CNA A's statement indicated he, ran down the hallway to escort [resident #2 name] personally. When I arrived to the room [resident #1's name] legs were halfway off the bed and I proceeded to fix him and ask if he was ok because [resident #2 name] took his blankets and dragged them, which he also put me in a headlock where I had to receive help from a co-worker to get him off of me which I reported to the nurse. The Assistant NHA said that Licensed Practical Nurse (LPN) B assessed resident #1 that evening and did not notice any injuries. The Assistant NHA was unable to provide documentation of any assessment completed by LPN B that evening. The DON acknowledged there was no documentation of the incident, or report of the allegations made by the CNA, nor any head-to-toe assessment documented by the nurse. The DON said the nurse did not document because she did not notice any injuries to resident #1 and resident #2 was at his baseline always going in and out of other resident rooms. She explained it was normal for residents in the locked unit to wander in and out of other residents' rooms because they had dementia. The DON said, Because the fracture was not treatable there was no need to send the resident out [to the hospital] but because of his elevated blood count he was sent out and the wife agreed. They were unable to provide documentation to show any assessments completed that night on resident #1 or #2. They said they interviewed LPN B by phone, who had worked a double shift on 12/25/24 from 7 AM to 11 PM. LPN B told them that on the morning of 12/25/24 there had been no issues with resident #1 except he was sleepy during lunch and his family asked for him to be put in bed. She said his family stayed until early to mid-evening and she gave him medication at approximately 10:00 PM. He did not complain of pain, was not in any distress, and fell back to sleep. They explained LPN B checked on him again at around 10:30 PM and he was still sleeping comfortably. The Assistant NHA said the 11 PM-7 AM staff were interviewed and both the CNA and LPN gave the same statement. CNA C and LPN D said they provided incontinence care for resident #1 at approximately 1:00 AM to 2:00 AM on 12/26/24 and said they did not notice any injuries to the resident at that time. LPN D told them resident #1 did not receive any medications during her shift, and she first became aware of the discoloration prior to leaving on 12/26/24 when she was asked to go to his room by the morning nurse and CNA. She said she noticed that he had a discoloration to the left side of his jaw. The Assistant NHA said that resident #1's roommate was interviewed on 12/26/24 but he did not recall the incident or what he reported to CNA A. Both the DON and Assistant NHA confirmed they had not been notified on 12/25/24 regarding CNA A's allegations of a possible resident-to-resident incident. They confirmed LPN B said she did not witness or receive report from CNA A regarding resident #2 coming out of resident #1's room, the roommate's allegation about the attack, nor of him being put in a headlock by resident #2. The Assistant NHA explained CNA E was the first one who noticed resident #1's injuries on 12/26/24 during her morning rounds at approximately 7:30 AM. She told them in her statement she saw the discoloration to one side of his face and notified RN F and LPN D. They stated RN F called the APRN who was already at the facility doing rounds that morning and called resident #1's wife at approximately 8:30 AM to notify her of the bruises. They said a head-to-toe assessment was done and they started completing the incident report. The Assistant NHA and DON explained at around 11:40 AM (four hours after the bruises were first noticed and reported) the APRN evaluated resident #1 with his wife at the bedside. They said at that time the APRN ordered an x-ray of the resident's face, and labs. The x-ray and labs results were obtained at approximately 3:30 PM which confirmed he had a broken jaw and elevated WBCs. The Assistant NHA and DON said the APRN was		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/14/25 at 2:07 PM, the facility's investigation was again reviewed, with the Assistant NHA. She said the Key [NAME] Unit Manager notified her of the resident #1's x-ray results. The Assistant NHA said she did not observe resident #1 on 12/26/25 and therefore would not be able to speak about the resident's discoloration/bruising except what was conveyed to her by other staff and their documentation or lack thereof. The facility's investigation showed that CNA A, as the lone staff, observed resident #2 leaving resident #1's room with a blanket on the evening of 2/25/25 at approximately 9:40 PM. The Assistant NHA could not say where the other staff who were working on the unit were at the time of the incident. She did not explain if the other staff were assisting other residents, at lunch or even on a break per the facility investigation. Review of staff statements that were provided by the Assistant NHA lacked dates, time stamps and objective descriptions such as the location of the staff member when the alleged altercation between resident #1 and resident #2 occurred. There was no evidence that the Administrative staff that led the investigation made any effort to determine why CNA A was the only witness, or why he did not report the incident to other staff or a supervisor when he did not receive an appropriate response from the nurse he informed. The Assistant NHA acknowledged CNA A's statement did not include the observation of resident #2 coming out of resident #1's room, she added that information was only obtained verbally. The Assistant NHA explained, going into other resident rooms was just part of the behaviors, for resident #2 in regard to whether resident #2's unwanted entry to resident #1's room, removing resident #1's bedding or entering any other resident's room was a concern that should have been documented or reported to the nurse or a manager. The Assistant NHA said the resident-to-resident abuse was not substantiated in the facility's Federal 5-day report because CNA A was the only witness. The Assistant NHA relayed the facility had opened a new investigation related to resident #1's fractured jaw since the start of the complaint survey. She explained the new investigation was to focus on injury of an unknown origin. The Assistant NHA did not provide an answer if the allegation should have been considered an injury of unknown origin since the facility did not substantiate the Federal 5 Day Report for resident-to-resident abuse. The Assistant NHA did not provide an explanation or a Root Cause Analysis (RCA) as to why resident #1's jaw was fractured. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/14/25 at 4:48 PM, the facility's corporate staff including the Director of Compliance and [NAME] President of Risk and Regulatory discussed why they re-opened the investigation into the incident of resident #1's bilateral fractured jaw almost three months after the incident occurred. They acknowledged the facility submitted a new Federal Immediate Report almost three months after the incident occurred as well. The Director of Compliance and [NAME] President of Risk and Regulatory did not say why they would re-opened an investigation into an event that occurred in December of last year if as they said, the original investigation was accurate. The Director of Compliance said he was not with the company in December 2024 and the [NAME] President was in a different position. They acknowledged that mandatory Federal one- and five-day reports were reviewed by corporate staff before they were sent into the State Agency. When asked why they would re-open this case when their predecessor approved the original investigations and Federal reports, they said they re-interviewed CNA A and found inconsistencies with his statement. The concerned statements noted resident #2 punched a pregnant staff and put CNA A in a headlock. However, neither of the cooperate staff had concern with CNA A's allegation that he saw resident #2 coming out of resident #1's room with the bedding. The Director of Compliance said the new investigation would focus on the injury of unknown origin. The Director of Compliance introduced a new theory at that time, that resident #1's injury was the result of a pathological fracture due to osteoporosis. The Director of Compliance said on 3/12/25 the facility requested a review of resident #1's x-ray results and osteoporosis was now added to the report. He agreed osteoporosis was not on the original x-ray reading report. Corporate staff voiced statements indicating the facility wanted to re-litigate the facts of the incident but still maintain their original investigation was complete and thorough. The facility's Administration and Corporation's lack of involvement of the locked unit led to the acceptance/culture of demented residents' inappropriate and often unsafe behaviors such as fighting and wandering into other resident's rooms/space was normal and accepted versus implementing appropriate interventions for staff to utilize to maintain the safety of residents on the locked unit. The facility Administration and Corporate staff did not say why they had not placed the same urgency into their original investigation of resident #1's injuries from the onset, as they were now with the re-opening of a new investigation. 2. Resident #2 was admitted to the facility on [DATE] from a psychiatric hospital. His diagnoses included Alzheimer's disease, dementia with behaviors, anxiety, major depression and unspecified mood disorder. Medical record review revealed a Level I, Preadmission Screening and Resident Assessment (PASARR) dated 10/01/24 was completed at the hospital and a Level II PASARR was required. There was not any evidence in the medical record that a Level II PASARR was completed on or about the time of admission for resident #2, or that one had been requested by the facility. The State of Florida Agency for Health Care Administration (AHCA Med/Serv Form 004 Part A, March 2017) form completed by the in-patient psychiatric facility on 9/09/24 prior to resident #2's admission to the facility read, . Individual may not be admitted to a Nursing Facility. Use this form and required documentation to request a Level II PASARR (Pre-admission Screening and Resident Review) because there is a diagnosis of or suspicion of Serious Mental Illness. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The medical record contained progress notes which provided some insight to the resident's past behaviors prior to the alleged physical abuse of resident #1. A progress note dated 10/03/24 indicated resident #2 was admitted to the facility after having been previously Involuntarily admitted (Florida [NAME] Act) to a psychiatric facility for attacking his own family. Progress notes dated 10/10/24, 10/14/24, 10/18/24 and 11/09/24 respectively depicted a resident that was excessively exit seeking, setting off door alarms, restless, wandering in and out of other residents' rooms, and waking other residents up. The notes indicated the resident was often resistive to redirection. One particular progress note dated 11/24/24, which was struck out but still in the medical record for review, revealed resident #2 wandered into the room of a resident he did not get along with, got into the bed which upset the other resident, and ultimately lead to a fight between the two residents. The facility staff noted on several occasions that redirection of resident #2 was ineffective. The Situation Background Assessment and Recommendation (SBAR) note dated the next day, 11/25/24, indicated a nurse noticed two minor skin openings and discoloration to the back of resident #2's left hand. The next day, 11/26/24, an Interdisciplinary Team (IDT) note revealed the resident wandered in and out of other residents' rooms, refused care and at times was resistant to redirection. This note indicated the resident continued to be anxious/restless and attributed the discoloration to the back of the resident's hand, to a lab draw that was earlier in the week. The author of the IDT note did not provide any insights as how a resident-to-resident altercation was ruled out as the etiology for the wound/discoloration since the resident was noted to freely wander into other resident's rooms. On 3/11/25 at 10:17 AM, LPN B said in a phone interview that on 12/25/24 she worked a double shift from 7 AM to 11 PM on the locked Caring Way unit with resident #1 and resident #2. She said they were assigned to her previously and she was familiar with both residents. LPN B recalled resident #2 was known to walk into other resident's rooms and caused problems with the other residents. LPN B said resident #2 was known to become aggressive, get into people's faces and grab things from other residents, especially after his family left from visiting. She explained between herself and the other nursing staff they would have to distract him when they saw him going into other resident's rooms, but he was not easily redirected. They had to constantly watch him. Resident #2 had behaviors care plan initiated on 10/05/24. The interventions included administer medications, encourage/assist resident to develop appropriate coping methods, encourage resident to express feelings, explain procedures prior to doing them, and intervene or redirect resident as necessary. The care plan interventions were never updated despite the staff's frequent inability to redirect him, monitor him and/or prevent him from wandering into other resident's rooms, in conflict with other residents on the locked unit, until after the alleged incident on 12/25/24. The care plan was not updated until the reported incident on 12/26/24, after the alleged assault of resident #1, who sustained a bilateral jawbone fracture. Nursing home Administration did not intervene to identify and attempt to prevent resident #2's inappropriate behaviors until the life altering injury of resident #1 was identified. On 3/11/24 at 10:58 AM, RN F in an interview conducted in Spanish per RN F's request, she stated she often worked on the memory care unit. RN F stated she felt it was difficult to perform her job safely because they were not able to provide enough supervision of the residents there. She explained they typically had five CNAs working on the unit for 60 confused residents and when residents had behaviors like entering other residents rooms they tried to offer them snacks or food to distract them but many of them were not redirectable. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a joint interview on 3/11/25 at 10:40 AM, with the Nursing Home Administrator (NHA) and Assistant NHA, the Assistant NHA stated they had requested a level II PASARR) from the psychiatric hospital but never received it. They were not able to provide documentation they had attempted to obtain the level II screening prior to 3/11/25, when it was brought to their attention during the survey. The NHA and the Assistant NHA said they never submitted their own level II screening because they expected to receive it from the psychiatric hospital. They continued, resident #2 already received all of the services he needed to manage his mental health, such as visits with the Psychiatrist who provided medication management. The Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date of 12/29/24 noted during the look-back period, resident #2 was rarely/never understood and unable to complete the Brief Interview for Mental Status. Staff assessed the resident had short-term and long-term memory problems, his cognitive skills for daily decision making were severely impaired, and he had no acute mental status changes. The assessment indicated that for four to six days, the resident had physical and verbal behaviors directed towards others, other behaviors not directed towards others, rejection of evaluation or care, and he wandered. The MDS detailed the resident received three medications by injection, received high-risk anti-psychotic, anti-anxiety, anti-depressant, hypnotic, and anti-convulsant medications. The assessment indicated resident #2 received no psychological therapy and no active discharge planning had occurred. Resident #2's Order Summary Report for December 2024, included the physician ordered medications: Citalopram (an anti-depressant) 20 Milligrams (MG) each day at bedtime for depression; Depakote (anti-convulsant) 875 MG every 8 hours for affective mood disorder; Dextromethorphan (anti-tussive) 15 MG twice daily for behaviors; Haldol Decanoate (anti-psychotic) 75 MG injection every 21 days for dementia psychosis; one-time Haldol injections for agitation received on 12/04/24, 12/17/24, 12/26/24, 12/27/24, 12/28/24, and 12/29/24; Lorazepam (anti-anxiety) both 0.5 MG twice daily for anxiety and wandering, and 1 MG once on 12/13/24 for anxiety and insomnia; Mirtazapine (anti-depressant) 7.5 MG once daily at bedtime for sadness/depression; Paroxetine (anti-depressant) 20 MG once daily at bedtime for depression; and Temazepam (sedative-hypnotic) 15 MG once daily at bedtime for insomnia. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/11/25 at 8:57 AM, in a telephone interview resident #2's son stated the family was not happy with how the facility handled many situations with his father. He recalled when his father was at the psychiatric hospital, they stabilized his mental health with medications and treatment, so there were not any issues. Resident #2's son said when he came to the nursing home, the facility changed his father's medications constantly, without discussing it with his family, and they did not understand why. He said he believed the facility did not have enough staff to supervise the residents on the locked unit and gave examples. He recalled an incident when his father was attacked after he wandered into another resident's room and took some cookies. Another time last November his mother witnessed his father being grabbed by another resident on the unit and choked until his father was able to push the other resident off of him. In another incident with that same resident, he recalled his father was bitten on the hand, which he had pictures of. Resident #2's son stated he was not aware of any reports or investigations by the facility related to those incidents even though staff were present. He said he had recordings of care plan meetings he attended, where the staff promised to do different things to ensure his father's safety, but they never followed through with any of the interventions. The son recalled he was told by a nurse at the facility that his father attacked another resident on or about 12/25/24. He explained he had spoken with other nurses at the facility, and they were all aware of the incident, but no one would say they had witnessed anything. He said his father was eventually transferred to the hospital on 12/29/24. At the hospital they found bruises on both of his arms and a cut on the elbow that looked infected. The son said they took his father out of the nursing home for no reason, and he was never given a reason why his father needed to go to the hospital. In interviews on 3/14/25 at 11:52 AM and 1:25 PM, the Social Service Director stated she was responsible for creating and updating care plans for any behaviors exhibited by the residents. She said she did this by attending clinical meetings and speaking to the psychiatric provider when residents had issues. The Social Services Director did not say why resident #2 had no new interventions in his care plan after the behaviors noted by nurses and by the psychiatric provider. She stated she did not recall any incidents with resident #2 and denied knowledge of any incidents between resident #2 and any other residents. She acknowledged care plans should be revised when issues occurred but said there was no policy for it. The Social Services Director said they looked at what worked and would continue to use that intervention. Review of a progress note completed by the Psychiatric Mental Health Nurse Practitioner dated 12/26/24 revealed resident #2 had paranoid thoughts and read, . staff documented assaultive and aggressive behaviors . Review of the facility's Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) policy revised 10/2022 noted, All events reported as possible ANEMMI will be investigated to determine whether ANEMMI occurred. The policy included, Residents who are suspected of initiating abusive behavior toward other residents will be immediately separated from the suspected victim. The immediate actions to remove the Immediate Jeopardy by the facility were reviewed and revealed the following which was verified by the survey team: *12/26/24 resident #1 no longer resides in the facility, discharged on [DATE]. *12/29/24 resident #2 no longer resides in the facility, discharged on [DATE]. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*12/26/24 at 7:30 AM staff noticed discoloration to resident #1's jaw/neck and notified APRN per orders for anticoagulant monitoring. Upon examination APRN ordered a facial x-ray at 12:44 PM. Resident #1 transferred to hospital at 8:09 PM for evaluation related to lab results. *12/26/24-12/27/24- 200 of 200 current staff across all departments were provided education on abuse, neglect, exploitation, misappropriation, mistreatment, and injury of unknown source. *12/26/24 at 3:53 PM x-ray results received by facility. The Unit Manager notified the APRN and the facility Risk Manager of the x-ray results. An internal investigation was initiated, and a federal immediate report was submitted. *3/14/25, the NHA and DON were re-educated by the Registered Nurse Consultant (RNC) on the components of F835 with an emphasis on taking immediate action on ensuring person centered care and interventions are in place for residents with a history of dementia and behaviors for effectiveness, thoroughly investigating and reporting allegations in a timely manner and appropriate interventions for behavioral dementia residents and timely medical treatment. *3/14/25, a quality review was conducted by the RNC/designee of 57 current residents who reside on the memory care unit to ensure appropriate interventions for behavioral dementia residents are in place and timely medical treatment is rendered within the previous 30 days. No like residents were identified. *3/14/25, a quality review was conducted by the RNC/ [TRUNCATED]		