

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

Printed: 12/04/2024
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 09/13/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50401 Based on observation, interview and record review, the facility failed to treat residents courteously, fairly and with dignity by using labels such as feedersto identify them, by standing over residents while assisting with their meals, and by leaving their meal at the bedside for an extended time before they were to be assisted with dining for 2 of 7 residents reviewed for dependent dining, of a total sample of 57 residents, (#130 and #54). Findings: 1. On 9/09/24 at 1:15 PM, Certified Nursing Assistant (CNA) A was observed bringing a meal tray into resident #130's room. She then fed the resident lunch while standing up, leaning over the resident's meal and bedside tray, while she spooned food items into the resident's mouth. CNA A was observed going in and out of several resident's rooms and at 1:26 PM, another resident asked her for assistance to get back to bed. CNA A replied, she had two feeders she needed to help, and she would help him when she finished. CNA A was then observed entering resident #130's room to assist the roommate, resident #54, with their lunch. CNA A also stood over this resident while feeding them. A few minutes later, the Key [NAME] Unit Manager (UM) came into the room and walked over to resident #54 and CNA A. She whispered into CNA A's ear, and CNA A then took a seat in a chair and continued assisting resident #54 with their lunch. On 9/09/24 at 1:40 PM, CNA A stated the UM whispered to her to sit down and be comfortable as she assisted the resident with her meal, and she realized she had used the word, feeders when she referred to these 2 residents previously. She stated it was important for aides to sit while assisting residents because it made them both more comfortable and it was important to not use labels when referring to residents to maintain their dignity as an individual. On 9/09/24 at 1:48 PM, the Key [NAME] UM, stated CNA A was a newer CNA and she advised her to sit down while assisting residents to eat. She stated it was important to sit while assisting residents with their meals to maintain good eye contact and ensure the resident did not feel rushed. The Key [NAME] UM confirmed staff should not identify residents by labels such as feeders, because it was a dignity issue. She explained staff should call residents who required assistance to eat, assisted diners. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 9/11/24 at 12:55 PM, a lunch tray was brought to resident #54's room and left at her bedside while the resident slept. Almost an hour later, at 1:45 PM ,CNA B indicated resident #54 was a feeder and she would feed her in a minute. CNA B stated she was not aware residents should not be called feeders and stated, I just call them that. On 9/11/24 at 2:29 PM, the Key [NAME] UM, stated residents who needed assistance with dining, were supposed to receive their meals after the residents who could feed themselves, when the staff were able to assist them. She stated staff should be educated not to leave trays next to the bedside to get cold and instead should bring the tray with them when they were ready to assist the resident. When she learned of CNA B calling resident #54 a feeder, she stated, Not again! She stated, I'm going to have to do some education. On 9/12/24 at 1:02 PM, the Assistant Director of Nursing (ADON) stated residents were not to be labeled, feeders and were to be treated with dignity. The facility's policy on Activities of Daily Living (ADL) Care and Services dated April 2020 and revised on January 2024, indicated appropriate care and services would be provided for residents who were unable to carry out ADL's independently including appropriate support and assistance with dining. The policy on Residents Rights dated September 2021 and revised on January 2024 stated Federal and State law guaranteed certain basic rights to all residents of this facility including being treated with respect, kindness, and dignity. CNA training documents including competency questionnaires for CNAs provided by the facility both undated and from October and November 2023, indicated education to ensure staff were aware it was inappropriate to use labels when referring to residents, such as feeders. The training program documents also indicated when staff assisted a resident with meals, they should be seated next to the resident.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview, and record review, the facility failed to ensure completion and accuracy of Level I Preadmission Screening and Resident Review (PASARR) documents on admission and/or failed to make referrals for newly evident or possible mental disorders/diagnoses to evaluate the need for specialized services or alternative placement for 6 of 7 residents reviewed for PASARRs, of a total sample of 57 residents, (#30, #34, #1, #41, #94, and #84). Findings: 1. Review of the medical record revealed resident #30, a [AGE] year old female was admitted to the facility from an acute care hospital on 6/26/24 with diagnoses that included history of stroke, metabolic encephalopathy (brain dysfunction), epilepsy, dementia, insomnia, major depressive disorder, generalized anxiety disorder, and psychotic disorder. The Minimum Data Set (MDS) Admission assessment with an Assessment Reference Date (ARD) 7/03/24 indicated during the look-back period, resident #30 was rarely/never understood and staff assessed her cognition as severely impaired. The assessment noted the resident had continuous signs of delirium and sometimes had social isolation. The Functional Abilities and Goals noted the resident required moderate assistance from staff to complete Activities of Daily Living (ADL). She was frequently incontinent of bladder and bowel functions, had a history of falling, and received high-risk anti-psychotic, anti-anxiety, anti-depressant, antibiotic, and anti-platelet medications. The overall goal for discharge showed the resident was to remain in the facility. The Order Summary Report showed active physician's orders that included: behavior and psychotropic medication side effect monitoring every shift, and psychiatric consultation. Medications included: Keppra 750 Milligrams (MG) twice daily for seizures, Lacosamide 200 MG every twelve hours for epilepsy, Depakote 250 MG three times daily for mood disorder, Lorazepam 0.5 MG tablet every eight hours as needed for anxiety, Sertraline 100 MG once daily for depression, Trazodone 50 MG three times daily for depression, and Lorazepam gel 1 MG applied to skin every 8 hours as needed for restlessness, agitation, and trying to stand. The Comprehensive Care Plan's focuses included: anticonvulsant anti-psychotic, anti-anxiety, and anti-depressant medications, seizure disorder, staff assisted ADL care, staff dependency for emotional, intellectual, physical, and social stimulation, impaired cognitive functions and thought processes, and dementia with secured unit placement. The Preadmission Screening and Resident Review Level I Screen Form (AHCA MedServ Form 004 Part A, March 2017) (PASARR) Section I completed by the hospital on 6/25/2024 documented resident #30 did not have any possible MI or SMI. On 9/13/24 at 9:16 AM, the Social Services Director said she did not complete the PASARR screens. She explained, the Admissions Coordinator ensured a form was received for all new admissions and the Interdisciplinary Team (IDT) discussed any required changes or revisions every morning during clinical meetings. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/24 at 9:26 AM, the East Coast Unit Manager (UM) said she had recently assisted with PASARR Level I Screen revisions and updates. The Registered Nurse (RN) explained, she understood a new screen was required if the form was incorrect, or if new psychiatric diagnoses were later added. She checked resident #30's medical record and confirmed the Level I PASARR from her admission in June was not marked, so she needed a new one because it didn't list the diagnoses. On 9/13/24 at 10:30 AM, the Director of Nursing (DON) explained there was not a policy for the facility's PASARR process and, it keeps going back and forth for who is responsible. 2. Review of the medical record revealed resident #34, a [AGE] year old female was admitted to the facility from another nursing home on 4/25/23. The resident's active diagnoses included: nervous system degeneration, dementia, cerebrovascular (brain vessels) disease, pain, anxiety disorder, major depressive disorder, repeated falls, and schizoaffective disorder. The MDS Quarterly Assessment with ARD 8/29/24 showed during the look-back periods, resident #34 scored 2 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated she was severely cognitively impaired. The assessment noted the resident had continuous inattention and disorganized thinking that did not fluctuate. The Functional Abilities and Goals noted the resident required substantial/maximal assistance from staff to complete ADLs. The resident was always incontinent of bladder and bowel functions, and received high-risk opioid medications. No active discharge planning was in place, and the resident was not expected to return to the community. The Comprehensive Care Plan's focuses included: behaviors, refusals of care/treatment, anti-anxiety medications for restlessness, impaired cognitive function/impaired thought processes, mood disorder, insomnia, depression, staff assisted ADL care, staff dependency for emotional, intellectual, physical, and social stimulation, impaired cognitive functions and thought processes, and dementia with secured unit placement. The Order Summary Report showed active physician's orders that included: resident may not go on LOA (Leave of Absence) from the facility, mechanical lift transfer, and psychotropic medication side effect monitoring. Medications included: Lorazepam 0.5 MG every eight hours as needed for restlessness, and Tramadol (opiate) 50 MG every eight hours as needed for chronic pain. The PASARR's Section I completed by the hospital on 3/27/23 documented resident #34 did not have any possible MI or SMI. The Admission Record noted MI or SMI diagnoses were added after the resident's facility admission that included: major depressive disorder, recurrent mild (5/02/23), other specified anxiety disorders (8/10/23), and schizoaffective disorder (11/02/23). On 9/13/24 at 2:24 PM, the East Coast UM checked resident #34's medical record and said the only PASARR that was completed was by the hospital on 3/27/23 and no MI or SMI diagnoses were marked. She checked the diagnosis record and confirmed they were added after she was admitted to the facility. On 9/13/24 at 9:37 AM, the DON said she could not answer why or how the PASARR revisions/corrections were missed. She stated, We do a really detailed discussion in psych (psychiatric) meetings; it includes the psychiatric providers, social services, and nursing; we do discuss diagnoses in the meetings. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50401 3. Resident #41 was admitted on [DATE] with diagnoses that included speech and language deficits following cerebral vascular accident, dementia moderate with mood disturbance, major depressive disorder, mood disorder, history of falling, and insomnia. The PASARR dated 5/19/23, indicated diagnoses of anxiety and depression but did not include the admission diagnoses of mood disorder nor dementia from 8/16/23. Per the medical record on 8/13/24, a psychiatry consult was ordered to address the resident's mood and cognitive status. The Psychiatry note dated 8/28/24 indicated the resident reported she had been feeling down, had anhedonia (the inability to feel joy or pleasure), low energy, poor sleep and irritability. The Psychiatry Subsequent Note dated 8/30/24 indicated the resident had a diagnosis of bipolar disorder which was not indicated on the admission diagnoses nor on the Level I PASARR. On 9/10/24 at 9:15 AM, the resident stated she had been having horrible dreams that were like torture but could not describe them in detail without emotional distress. She explained she had not told anyone about the dreams but did talk to the Psychiatric Nurse. She said it was very frightening and made her feel like she didn't know if it was real or not. On 9/11/24 at 4:00 PM, the Key [NAME] UM, reviewed the resident's care plan and stated she was unsure why the diagnoses of dementia and mood disorder were not recorded on her PASARR. She was not sure if there was an updated PASARR in Medical Records that had not been uploaded into the computer yet. On 9/12/24 at 10:15 AM, the Medical Record Coordinator stated she was unsure if there were any updated PASARR's not yet downloaded into the resident's medical record. On 9/12/24 at 1:02 PM, the Assistant Director of Nursing (ADON) submitted a Psychiatric consult for a new symptom of nightmares and said the provider would see her tomorrow. On 9/12/24 at 2:42 PM, the facility provided an updated PASARR performed that day, 9/12/24. The newly updated PASARR still indicated the resident did not have a primary diagnosis of dementia even though the medical record indicated she did have the diagnosis of dementia. 4. Resident #1 was admitted on [DATE] with diagnoses that included multiple sclerosis, depression, bipolar I disorder, and anxiety disorder. The Level I PASARR in the medical record, dated 4/01/22, indicated a diagnosis of depression only but did not include the diagnoses of bipolar or anxiety disorders as her records indicated. A Psychiatry Consult note dated 4/10/23 revealed the consult was ordered because the resident was, Acting bipolar. This consult note also indicated the resident had a past medical history of bipolar disorder. An updated PASARR that included this diagnosis was not found. On 9/11/24 at 4:00 PM the Key [NAME] UM, stated she was unsure why bipolar and anxiety disorders were not recorded on the resident's PASARR. She was not sure if there was an updated PASARR had been completed since the diagnoses was discovered. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 10:15 AM, the medical records coordinator stated she did not know if there were any updated PASARR's since the original one dated 4/01/22 and she would look amongst her documents that had not been downloaded into resident records yet. On 9/13/24 at 10:52 AM, the DON confirmed they were not aware the Level I PASARR was incorrect/incomplete when they provided a new, updated PASARR to the surveyor. 40892 5. Resident # 94 was admitted to the facility on [DATE] with diagnoses including mood disorder and post-traumatic stress disorder. Review of the MDS significant change assessment with ARD of 6/10/24 revealed resident #94 had a BIMS score of 15/15, which indicated she was cognitively intact. The assessment revealed her active diagnoses included bipolar disorder and post-traumatic stress disorder. A review of the resident #94's EMR revealed the diagnoses of mood disorder with an onset date of 4/09/23 and bipolar disorder with an onset date of 4/09/23. The medical record contained a level I PASARR screening form dated 2/28/23 which did not indicate resident #94 had a MI or suspected MI. The record did not contain a Level II PASARR screening form. On 9/12/24 at 10:47 AM, the DON stated the PASARR dated 2/28/23 was incomplete. She confirmed there were no diagnoses listed on the form though the resident had diagnosis of bipolar disorder. The DON indicated the PASARR should have listed the MI or suspected MI diagnoses and was therefore incorrect. On 9/13/24 at 10:52 AM, the DON stated the company did not have a policy for which staff was responsible for updating the PASARRs. 48878 6. Review of the medical record revealed resident #84 was admitted to the facility on [DATE]. His diagnoses included paranoid schizophrenia, dementia with behavioral and psychotic disturbance, brief psychotic disorder, major depressive disorder, anxiety disorder, post-traumatic stress disorder, and alcohol abuse. Resident #84's Quarterly MDS with an ARD of 8/20/24 revealed the resident scored 10 out of 15 on the BIMS exam which indicated he had moderate cognitive impairment. Resident #84's Order Summary Report and the Medication Administration Record showed the resident had an order for Oxcarbazepine 300 MG by mouth two times a day for mood, Quetiapine 50 MG by mouth one time a day for paranoid schizophrenia, and Trazodone 25 MG by mouth, three times a day for depression with agitation. Review of resident # 84's medical record revealed behaviors, post-traumatic stress disorder, schizophrenia, and antipsychotic medication care plans that indicated the resident refused care and to monitor and report changes in behavior to the physician. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 1:15 PM, the DON stated it was her and Social Service's responsibility to ensure the residents' Level I and Level II PASARRs were completed and submitted timely. She also stated the residents were to have Level I PASARRs submitted prior to admission, or a new one completed if a resident was diagnosed with a new mental illness, or if there was a change in condition. She verified resident #84 was diagnosed with paranoid schizophrenia, dementia with behavioral and psychotic disturbances, brief psychotics disorder, major depressive disorder, anxiety disorder, post-traumatic stress disorder, and alcohol abuse on 5/17/23, however, only the anxiety disorder, depressive disorder, and substance abuse was listed on the Level I PASARR submitted prior to admission on 6/30/22. The DON acknowledged the resident's paranoid schizophrenia, dementia with behavioral and psychotic disturbance, brief psychotic disorder, and post-traumatic stress disorder should have been included on the Level I PASARR. She confirmed the Level I PASARR was inaccurate and another Level I PASARR should have been submitted with the correct diagnoses upon admission and did not know how it was missed. On 9/13/24 at 10:51 AM, the DON stated the facility did not have a PASARR policy or any guidelines to follow regarding the PASARRs. She stated she was told to follow the regulations but did not know what the regulations were.		

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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** 51023 Based on interview, and record review, the facility failed to obtain a Level I Preadmission Screening and Resident Review (PASARR) for 1 of 6 residents reviewed for PASARRs, of a total sample of 57 residents, (#5). Resident #5's medical record revealed he was admitted to the facility on [DATE] with diagnoses of Parkinsonism, dementia, bipolar disorder, depression, insomnia, and dysphagia. Review of the resident's clinical record revealed no Level I or Level II PASARR. Review of resident #5's physician orders revealed Quetiapine Fumarate 600 milligrams (mg) at bedtime for bipolar disorder with a start date of 7/16/24, Donepezil 10 mg at bedtime for dementia on 7/16/24, Mirtazapine Tablet 30 mg at bedtime for depression with a start date of 7/16/24, Lamotrigine 200 mg at bedtime for bipolar disease with a start date of 8/01/24, Lamotrigine 200 mg in the morning for bipolar disease with a start date of 8/1/24 and Aripiprazole 25mg in the morning for bipolar disorder with a start date of 9/03/24. Review of the resident's care plan from 7/18/24 revealed focuses which included the use of antidepressant medication related to depression, the use of antipsychotic medications related to bipolar disorder, the resident having a mood problem related to a mood disorder listed as bipolar disorder and the resident having impaired cognitive function and impaired thought processes related to a diagnosis of dementia. On 9/11/24 at 1:35 PM, the Nursing Home Administrator confirmed a Level I PASARR should have been completed for resident #5 but they could not provide one. On 9/12/24 at 2:31 PM, the [NAME] President of Operations stated there was no facility policy or procedure for PASARR.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview, and record review of facility documentation, the facility failed to effectively implement Quality Assurance and Performance Improvement (QAPI) policies to ensure thorough monitoring of previously identified areas of concern and adequately track performance to ensure prior improvement measures were realized and sustained. Findings: Review of the facility's policy, Quality Assurance/Performance Improvement Plan revealed the following, All employees will participate in ongoing quality assurance and performance improvement efforts which support our mission by striving to provide excellent service for residents. The document indicated the QAPI committee was ultimately responsible to ensure compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction. In addition the QAPI committee would implement any Performance Improvement Projects (PIP) topics indicated by data analysis. PIPs were, Implemented in accordance with CMS' protocol for conducting PIPs. On 9/11/24 at 1:35 PM, the Nursing Home Administrator revealed the facility had identified a concern related to Preadmission Screening and Resident Review (PASARR) and created a PIP. Review of the PIP revealed it was started on 5/08/24. The first step of the plan was for an audit to be completed on current residents to ensure each had a Level I PASARR completed. When asked for the audit, the Administrator provided a paper with a handwritten list of resident's names. The words, waiver or no waiver, was hand written next to the names. The audit did not include a date to indicate when it was completed, nor did it include what the audit consisted of. Review of the PIP section entitled Monitoring revealed the action step that the Director of Nursing/Designee would conduct audits on new admissions weekly x four weeks, then every two weeks x two months to ensure compliance. Review of the PIP document presented by the facility revealed no documentation under the heading, Status for the new admission audits. The Administrator then provided audits for newly admitted residents starting on 5/11/24. The Administrator was asked about resident #5 who was admitted on [DATE] and did not have a PASARR in their medical record. The Administrator explained as he was not in the facility that week the audit was not done for new residents admitted during that time. Review of the next weeks audit revealed Resident #5 was not added to those audit sheets either. The Administrator did not answer why the facility did not go back and review the new admissions on the off weeks for compliance, nor why 5 additional residents were found during the survey to have concerns with their PASARRs that had not been corrected by the facility. The Five Elements of QAPI include Governance and Leadership, in which the facility designates one or more persons be accountable for QAPI. Another element, the PIP is a concentrated focus on a particular problem and involves gathering information systematically to clarify issues or problems and intervene for improvement, (retrieved on 9/26/24 from www.cms.gov).		