STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105885	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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** 39943 Based on interview, and record review, the facility failed to protect the resident's right to be free from neglect by not ensuring staff maintained a secure environment and implemented measures to mitigate the risks to prevent elopement for 1 of 9 residents reviewed for elopement, of a total sample of 10 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury, impairment, and/or death. While resident #1 was out of the facility unsupervised, there was reasonable likelihood he could have fallen, become lost, accosted by a stranger, or been hit by a vehicle. The facility neglected to identify the need for adequate supervision and ensure a secure environment that contributed to resident #1's elopement and placed all residents at risk for elopement at risk. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was determined to be removed on [DATE] after verification of the immediate actions implemented by the facility. The scope and severity of the deficiencies were decreased to a D, no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy. There were a total of 9 current residents at risk for wandering/elopement identified at the time of the survey. Findings: Cross reference F689 On [DATE] at approximately 6:05 PM, the facility's Weekend Supervisor unlocked the door for a visitor to leave and neglected to ensure no residents followed behind the visitor. Resident #1, a vulnerable, severely cognitively impaired male followed the visitor and exited the facility unnoticed and unsupervised. Resident #1 was allowed to exit the building and walked outside on the hot, 90 degree Fahrenheit evening for approximately 30 minutes (retrieved on [DATE] from www.wunderground.com). He traveled approximately 1. 1 miles away from the facility until an off-duty staff nurse noticed him and stopped to call the facility to inquire about him being missing. Resident #1 was admitted to the facility on [DATE], with diagnoses to include right femur fracture, difficulty walking, dementia, anxiety, major depressive disorder, and psychotic disorder with delusions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	

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	The Minimum Data Set (MDS) Admission assessment with reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated he had severe cognitive impairment. The assessment revealed he received antipsychotics, antianxiety, antidepressant, and antibiotic medications, but did not show any documentation of behaviors towards others or rejection of care. Review of the medical record revealed resident #1 had a physician's order for an electronic wander monitoring bracelet to be applied beginning [DATE]. Review of resident #1's medical record revealed he had a care plan for potential for elopement related to his behaviors such as wanders, ambulatory, has confusion, and exit seeking initiated on [DATE]. The goal described the resident would remain safe and would refrain from leaving the facility unsupervised was initiated on [DATE] and revised on [DATE]. Interventions included enhanced supervision, initiated on [DATE], provide redirection when observed going towards exit doors, initiated on [DATE]. A revision was added to the care plan on [DATE] which indicated resident #1 had eloped from building. On [DATE] at 11:48 AM, the Weekend Supervisor stated the receptionist was on duty until 5:00 PM on the weekends and after hours any staff could let visitors in or out. She said she was the on-duty supervisor the day resident #1 eloped. The Weekend Supervisor stated she was sitting at receptionist desk charting assessments sometime after 5:00 PM on Saturday, [DATE] when a visitor approached the door to leave the facility. The Weekend Supervisor said she unlocked the door with a remote electronic key fob from where she was sitting, the visitor then pushed the door open and walked out. The Weekend Supervisor stated she did not see resident #1 behind the visitor nor see him exit out the door. The Weekend Supervisor explained no one realized resident #1 was missing from the facility until about 30 minutes later when she received a phone call from an off-duty nurse at 6:35 PM, who asked if he was a resident at the facility. On [DATE] at 1:05 PM, the Administrator shared a video on his cell phone he made of the incident from the facility's video system when he arrived to the facility the evening of [DATE]. The video from the same date, [DATE], showed the visitor pause at the door, while the Weekend Supervisor unlocked the door with the remote key at 6:05 PM, the visitor then pushed the door handle and opened the door. The Weekend Supervisor was seen lowering her head back to look at her computer and resident #1 came a few seconds later behind the visitor and exited out the door. The video showed him returning to the facility at 6:49 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	

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	On [DATE] at 2:26 PM, Licensed Practical Nurse (LPN) G said she worked the day shift at the facility on [DATE]. She explained that evening she went to the store with her husband and as they were leaving the parking lot, she noticed an older gentleman walking down the street because he kept looking toward the back of him as if he was looking for a ride from someone. He was walking east on the opposite side of the highway from her. LPN G recalled she asked her husband to make a U-turn because it looked like the man had an electronic wander monitoring bracelet on. LPN G explained that they caught up with the man in front of a jewelry store. She said they pulled over on the side of the road, then she got out of the car and asked the man if he needed a ride. He said yes and she asked where he was going? He replied he was going to the [military] base. LPN G recounted the man was not familiar to her, so she asked his name, which sounded familiar. She described it was hot, so she asked him to sit in the shade while she made a phone call, and he agreed. She called the Weekend Supervisor to check if he was a resident of the facility. She said a sheriff's department vehicle pulled up at this time and inquired about resident #1. Another officer arrived and both stayed until the supervisor came. LPN G stated resident #1 did not recognize her, but when the supervisor came, she thought he recognized her. The supervisor got out and talked to him and he walked to the car with her. On [DATE] at 3:20 PM, LPN B stated she was familiar with resident #1. She said she went with the supervisor to pick him up the day he eloped. She said she thought they were keeping a close eye on him that day due to his behaviors. LPN B said, He was sitting on the sidewalk on the curb with a police officer talking to him near the jewelry store. She stated when she got out of the car resident #1 was apologetic and said he knew he did something he should not have done. The LPN said resident #1 could not recall when or why he left. She explained, he told me he drove himself from the facility in a car. On [DATE] at 3:53 PM, by telephone, Certified Nursing Assistant (CNA) C stated she worked a double shift from 3:00 PM to 7:00 AM, on the day resident #1 eloped. She said that day was not unusual that he was wandering around and was asking questions about when he was going to leave and could he go home. What was different was the frequency in which he asked. CNA C said usually he would ask the questions about his wife maybe every few hours or so, but the day he eloped he kept asking about every 10 minutes. She said resident #1 also packed his bags about an hour and a half into her shift and asked why his wife left him there. CNA C explained he was walking around the facility with his bag, carrying a picture of his wife. She recalled the staff knew what he was doing that day, they had to frequently redirect him. The CNA stated everyone knew he had increased behaviors and was more persistent that day. She recounted resident #1 went up to LPN E who was at her medication cart, and talked to her, then she saw him drop his bag on her medication cart. CNA C said she let the other CNAs on the unit, and his nurse know to redirect his behaviors. The CNA said he even asked her where [city where he previously lived] was. CNA C said the supervisor called her around 5:00 PM to come and get resident #1 from the front lobby. She explained resident #1 was sitting next to the supervisor at the front desk, with his bag and a picture of his wife in his hand when she arrived at the lobby. The CNA said the supervisor asked her to take him back to his unit and keep him distracted until dinner. CNA C said she took resident #1 back to the nurse's station and stayed until she had to help deliver dinner trays which was the last time she saw him until after he returned to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	

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	On [DATE] at 4:35 PM, LPN D stated she usually took care of resident #1. She said he was very forgetful, and you had to remind him over and over where he was. The LPN stated she would call his wife, and he would talk to her but forget that he talked to her shortly after. She said, He was physically independent but very forgetful, only oriented to himself. LPN D stated resident #1 was eating in his room when she went to give him his medications around 5:30 PM. The LPN said resident #1 had come to the nurse's station earlier and asked for her to call his wife. LPN D said she would call later, but he came back asking her again to call his wife. The LPN stated when she administered his medications, she told him she would call his wife before he went to bed, and he said okay. She explained resident #1 usually walked around the building, but she did not see him again that night after he got his medications. LPN D stated another staff told her resident #1 had gotten outside, but they were not sure how he got out. She said when he returned, she asked him how he got out of the building and he said, I was very careful, and asked her if he was going to get in trouble. On [DATE] at 5:04 PM, LPN E stated she worked on the day resident #1 eloped but was not his nurse. She said she had taken care of him in the past. The LPN said he wandered a lot, and he asked the same questions over and over, Why is my wife not here? She explained even when his wife had just left, he would ask about her. She continued, we would tell him his wife just left, and he would not remember she was just there. LPN E said she saw resident #1 earlier that evening and he put a bag of garbage on her medication cart, and she told him not to put trash on her cart. I think it was trash, I thought I saw a brief in it. I did not look in the bag. The LPN stated resident #1's CNA came to get him, and she was not aware he thought the bag was his belongings he was taking with him to go home. On [DATE] at 5:55 PM, the Administrator stated when he arrived at the facility that night, he started watching the videos. He said he watched a couple hours prior to the elopement and saw resident #1 wandering down the hall. The Administrator explained not all the cameras were live, some were dummies, and were not in all of the hallways. He said he saw CNA C walk resident #1 back to his room for dinner. The Administrator confirmed resident #1 came out of his room shortly after and came straight back to the front hall. He acknowledged the front hall did not have a live camera, but shortly after resident #1 was seen on video going out the front door. The Administrator stated the video showed the Weekend Supervisor returned to working on her computer and did not look up when resident #1 left the building behind the departing visitor. He said he saw the Weekend Supervisor was still at the desk when she received the phone call about resident #1 being out of the building. Review of resident #1's medical record revealed limited nursing progress notes describing resident #1's behaviors until a week before his elopement. These progress notes revealed escalating exit seeking behaviors in the week preceding the elopement. A nursing progress note dated [DATE], read, The resident removed the electronic wander monitoring bracelet on his right ankle. The bracelet was located [in] the trash can in his room. New bracelet applied on the left ankle. A nursing progress note the next day, [DATE] documented the resident was wandering up and down the unit, packed his belonging and told others he was going home. The nurse charted she notified the charge nurse and the as needed anti-anxiety medication was given. On the day he eloped, [DATE], the nurse documented the resident's behavior remained unchanged. He continued to wandering the unit, and she noted resident #1, constantly needs to be redirected without success. The nurse indicated resident #1 was again medicated for anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	

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 Medication Administration Record (MAR) dated for [DATE] revealed resident #1 had an as needed (prn) order for anti-anxiety medication every 8 hours for restlessness/agitation that was in effect for 14 days starting on [DATE]. The resident received the medication one time on [DATE], once on [DATE] and again once on [DATE]. The order was not renewed, and it was discontinued after the 14 days were completed. On [DATE], the day after resident #1 cut off his electronic wander monitoring bracelet the nurse noted in the progress notes he was wandering up and down the unit and an anti-anxiety prn medication was given. This medication was restarted that same day, [DATE] as a renewal of the previous 14-day as needed anti-anxiety medication that had expired on [DATE]. Over the course of the week before the elopement resident #1 received one dose of the as needed anti-anxiety medication on [DATE], two doses on [DATE], a dose on [DATE], a dose on [DATE] and another dose on [DATE] both prior to and after the elopement. On [DATE] at 1:58 PM, the 200 Unit Manager (UM) acknowledged the prn anti-anxiety medication was restarted on [DATE] after resident #1 cut his electronic wander monitoring bracelet off the previous day. She was asked why resident #1 did not have additional interventions added to his care plan when this occurred, and his behaviors escalated the days prior to the elopement. The UM could not answer but acknowledged again the resident took his wander monitoring bracelet off on Sunday [DATE] and placed it in the garbage. She continued the bracelet was replaced on the other limb. The UM said she was notified of the incident when she came to work on Monday. She was sure it would have been discussed in morning meeting but could not answer why the interdisciplinary team (IDT) did not add interventions at that time. The 200 UM was unable to say whether psychiatric services was consulted when resident #1 was having increased episodes of behaviors and anxiety that warranted use of the prn anti-anxiety medication, and after she was given the opportunity to check the electronic record she still did not answer the inquiry. The 200 UM was not able to say why no additional interventions were put in place for resident #1 after the incident when he cut off his wander monitoring bracelet, increase in anxiety and unsuccessful attempts at redirection by staff. The UM said, There is a behavior documentation tool on the MAR and the nurse should be documenting the behavior if [prn anti-anxiety medication] was given. Review of the behavior documentation on the MAR for [DATE] revealed no behaviors documented. On [DATE] the resident received the prn anti-anxiety medication at 12:07 PM, with no behavior documented, he received it again at 9:01 PM with screaming behavior noted. He received it again on [DATE], [DATE], and in the afternoon of [DATE] with no behaviors documented by nursing staff. On [DATE] at 3:00 PM, the Administrator acknowledged he was the Risk Manager for the facility. He stated the clinical team met every morning, and discuss abnormal situations then add any interventions needed. He said he would expect the IDT team to inform him of events like when resident #1 removed his electronic wander monitoring bracelet. He said he would expect them to add some new or more effective interventions if there was a change in the resident like increased behaviors. He stated interventions were primarily the responsibility of the MDS team. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	

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	On [DATE] at 4:29 PM, the MDS Coordinator stated she attended the clinical meetings in the morning. She said the team discussed risks, like falls, reviewed events that happened the day before, and the 24-hour report sheet. She stated the team decided what interventions needed to be added or updated and then they would add the interventions to the care plan. She recalled the team did speak about resident #1 wearing a wander guard and said he was usually easily redirected. The MDS Coordinator added that changes in behavior also should be reported to the physician. She acknowledged resident #1 should have had a new intervention in his care plan after cutting off his wander monitoring bracelet. The MDS Coordinator said, I was not aware he cut off his wander guard, this is the first time I am hearing this. The MDS Coordinator explained if there was a new behavior whoever was in the meeting should update the care plan. She explained that enhanced supervision meant basically to supervise resident #1 so staff always knew where he was. In a telephone interview on [DATE] at 3:33 PM, resident #1's wife stated she was notified of her husband's elopement on [DATE] between 9:00 and 9:30 PM when facility staff called her. She said they called her after he was back in the facility. She said, I was kind of upset because he had a bracelet on his leg, and he still got out. She said they told her the bracelet was put on her husband so he would not leave the facility. Resident #1's wife stated he has Alzheimer's Dementia. She said the day he got out of the nursing home their son who lives in another state came to visit her husband. She stated they brought her husband lunch and were able to eat with him. She wondered if it triggered her husband when they left the facility after lunch, because he had seen his son earlier that day and had been told he was only visiting for the day. She cried and said, My heart almost fell out of my chest when they said he was on [highway name] when they found him. Resident #1's wife said it was very scary to think that he walked that far and was on that busy road alone. On [DATE] at 12:35 PM, the Director of Nursing stated neglect was if a resident's needs were not met by the facility. She gave examples of neglect such as if residents were not bathed, not given hydration or not supervised appropriately, and said all of these things were neglect. Review of the facility policy and procedure for Abuse, Neglect Exploitation, and Investigations dated [DATE] revealed the facility would honor the resident's rights by addressing with employees the seven components including neglect in accordance with Federal law. The policy defined neglect as the failure of the facility, or its employees to provide services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of immediate actions to remove the Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team: *On [DATE], Resident #1 was returned to the facility and re-evaluated by the licensed nurse. Full body assessment of resident completed. One to one supervision initiated. Physician and resident representative notified of event. *On [DATE], the facility filed an immediate federal report related to allegation of neglect of resident #1 to Agency for Healthcare Administration, notified Department of Children and Families and initiated a full investigation. Physician and resident representative notified. *On [DATE], the Elopement Risk Alert Binder was reviewed to ensure the resident's picture and demographics were in place. Plan of care and Kardex was reviewed to ensure accuracy of resident's current condition. Increased monitoring related to exit seeking behaviors verified in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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	*On [DATE], Risk Evaluation related to elopement was conducted for resident #1. *On [DATE], facility conducted head count of residents currently residing in the facility; all were accounted for and safe. *On [DATE], doors were assessed by Administrator and Maintenance Director to ensure proper functioning; no issues or concerns were identified. It was identified through Root Cause Analysis (RCA) process that the electronic wander monitoring alarm was deactivated during the remote door opener activation to allow visitors out. Systemic changes listed below to prevent occurrence. *By [DATE], residents residing in the facility were re-evaluated/reviewed for elopement risk. *By [DATE], residents identified at risk for elopement were reviewed by Unit Managers/designee for: Elopement Screen, Car plan in place related to wandering risk, CNAs Kardex reflective of resident status and Resident(s) present in Elopement Binder. *On [DATE], the Director of Nursing (DON) /designee reviewed elopement binders to ensure residents at risk for elopement were present and identified. *On [DATE], Resident #1 was evaluated by psychiatry. *On [DATE], DON/designee educated staff on: a. Components of the regulation: F689 b. Elopement Policy and Procedure c. 1:1 supervision d. Door/Egress checks e. Responding to an alarm f. Response to a missing resident g. Elopement Triggers h. Proactive interventions for residents at risk for wandering/elopement i. In an abundance of caution, abuse and neglect education completed. *On ,d+[DATE], DON/designee carried out elopement drills. Education provided as indicated based on Elopement Drill findings. the facility has completed 35 elopement drills that includes 185 staff members out of 186 (the staff member not included is out of the State). *By [DATE], ,d+[DATE] facility staff members were re-educated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8050 Spyglass Hill Rd Viera, FL 32940	

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	*By [DATE], ,d+[DATE] facility staff members were re-educated, no staff worked without receiving in-person education. Newly hired employees will receive education on above in orientation. *On [DATE], the facility removed the automatic door opener. *On [DATE], the facility adjusted the alarm delay from 15 seconds to 5 seconds to prevent tailgating. *Beginning [DATE], the facility Administrator/designee/DON/designee will ensure the safety and well-being as it relates to elopement is maintained by continued participation, evaluation, and intervention through: a. Clinical standup review of the 24-hour report to identify change in condition. b. Monitoring of egress systemic changes c. Maintaining QA/PI process. *On [DATE], anti-tailgate device was added to the front door along with antennae moved to improve field of frequency. *Beginning [DATE], the facility Administrator/designee, and the DON/designee will ensure the components of F600 compliance with an emphasis on neglect to include monitoring of facility systems during administrative/clinical standup and standdown to identify areas that may rise to the level of investigating ANEMMI to ensure residents receive the necessary care and services. Areas of service include: *Review of Concern/Grievance log *Review of ,d+[DATE] hour report log *Resident/Family Council Meeting(s) *Facility Compliance/Complaint Line *Skin integrity review for any trending *Risk Management Portal *Electronic Health Record (Point Click Care) Alert Reporting-e.g. SBAR, Stop and Watch. *By [DATE], skin evaluations for residents with a BIMS score of 11 or lower were evaluated to identify abuse or neglect. *By [DATE], residents with a BIMS score of 12 or higher were interviewed to identify abuse or neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105885	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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	From [DATE] to [DATE], interviews were conducted with 28 staff members who represented all shifts. Staff included 8 CNAs, 8 LPNs, 4 RNs, 2 Housekeepers, 1 Receptionist, 1 MDS Coordinator, 2 Dietary personnel, 1 Maintenance Director, and 1 Physical Therapy Assistant who verbalized their understanding of the education provided. The resident sample was expanded to include all 8 additional residents identified as at risk for elopement/neglect. Interviews with 3 alert and oriented residents regarding interviews conducted by facility staff regarding feeling safe and no neglect and chart reviews for 9 residents to ensure elopement risk evaluations and skin checks were completed on [DATE]. Observations, interviews, and record reviews revealed no concerns related to elopement for the expanded sample residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105885	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on interview, and record review, the facility failed to ensure a thorough investigation was conducted/completed in response to possible neglect for a resident elopement for 1 resident of 9 residents reviewed for elopement, of a total sample of 10 residents, (#1). Findings: Resident #1 was admitted to the facility on [DATE], with diagnoses to include right femur fracture, difficulty walking, dementia, anxiety, major depressive disorder, and psychotic disorder with delusions. The Minimum Data Set Admission assessment with assessment reference date of 6/24/24 revealed resident #1 had a Brief Interview for Mental Status score of 03/15 which indicated he had severe cognitive impairment. The assessment read he received the following medications, antipsychotics, antianxiety, antidepressant, and antibiotics. On 8/03/24 at 11:48 AM, the Weekend Supervisor stated she was sitting at the receptionist desk on Saturday, 7/20/24 sometime after 5:00 PM, charting assessments when a visitor came to the door to leave. The supervisor said from where she was seated, she unlocked the door with the remote, the visitor pushed the bar on the door, opened the door and walked out. The supervisor stated she returned to her work and did not see anyone behind the visitor go out the door. She explained no one knew resident #1 was missing from the facility until she got a phone call from an off-duty nurse at 6:35 PM, who asked if he was a resident and explained she has seen him walking down a busy highway about a mile away from the facilty. On 8/03/24 at 1:05 PM, the Administrator shared video footage of the incident from his cell phone taken on 7/20/24 after resident #1's elopement. According to the video, at 6:05 PM, a visitor was seen paused at the door, while the Weekend Supervisor pushed the button, a few seconds later the visitor pushed the door handle and opened the door. Resident #1 came behind the visitor and went out the door 6 seconds later. The video showed him returning to the facility at 6:49 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/03/24 at 3:53 PM, via telephone, Certified Nursing Assistant (CNA) C stated she worked a double shift from 3:00 PM to 7:00 AM the day resident #1 eloped. She recalled the day he eloped he had been wandering around, and asked more frequently questions like when he was going to leave and could he go home, about every 10 minutes. She recounted resident #1 packed his bags about an hour and a half into her shift and asked why his wife had left him there. CNA C stated the staff had to redirect him frequently that day because he had increased behaviors and was more persistent with them. She remembered she let the other CNAs, and his nurse know so they could also redirect him. She said he asked her where [his home] was. CNA C explained the Weekend Supervisor called her around 5:00 PM and asked her to come get him from the front desk and keep him occupied after he wandered up there and set the wander prevention alarm off. CNA C explained when she arrived to the lobby resident #1 was sitting next to the supervisor at the front desk, with his bag and a picture of his wife in his hand. CNA C said she took resident #1 back to the nurse's station and stayed near him until she had to help deliver trays for dinner. She added if resident #1 had been on 1:1 supervision she did not think he would have gotten out. She explained she wrote a statement afterwards and got education for elopement, abuse and neglect. On 8/03/24 at 7:08 PM, CNA F stated she was working on the 200 unit the night resident #1 eloped. She stated was not resident #1's assigned CNA that evening, but she knew him as being confused and needing redirection and supervision sometimes. She recalled resident #1's behavior caught her attention when she arrived to her shift on that Saturday as he kept walking up the hallway in the front of the 200 unit toward the lobby, which was not usual for him. She explained he carried around a bag and a picture of his wife, was carefully watching the staff watching him, and had told her he was leaving and had been doing these type of things all week. CNA F recalled while her and CNA C were passing dinner trays resident #1 approached them and the redirected him back to his room. She stated she told CNA C that resident #1 needed to be on 1 to 1 supervision because of the way he was acting, and CNA C told her he was okay. CNA F explained she did not write a statement after the elopement incident, nor did anyone follow up to interview or ask her questions about what she saw or what happened that evening, nor did she voluntarily go to Supervisory staff to volunteer information about what happened. CNA F stated she told CNA C after the elopement, I told you he needed to be on 1 to 1 [supervision]. On 8/03/24 at 4:34 PM, Licensed Practical Nurse (LPN) D stated she was assigned to resident #1 the night he eloped. She said she was not aware his CNA had to retrieve him from the lobby area. LPN D said she was surprised when the supervisor told her he got out of the building. She said when he returned, she asked him how he he left and he said, I was very careful. The LPN said he then asked her if he was going to get in trouble. LPN D stated the staff got education when the administrative team got to the facility that evening, and she wrote a statement. She explained she talked with the Director of Nursing (DON) that evening about the event, but no one inquired about resident' #1's behaviors that shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8050 Spyglass Hill Rd Viera, FL 32940	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/04/24 at 1:58 PM, the 200 Unit Manager (UM) stated she did not think resident #1 had any new behaviors although she acknowledged nurses needed to reinstate an as needed anti anxiety medication order that week, which he received multiple times. The UM stated he needed the medication because he was more anxious, but did not elaborate further. When asked why he was given the as needed anti-anxiety medication when he cut off his wander monitoring bracelet, packed his clothes to leave and staff were not able to redirect him as these were more behaviors than anxiety, she again stated he got the medication for anxiety not behaviors. The UM stated all of the staff who worked that night were interviewed on the night of the elopement by the DON, UMs, and Assistant DON. She was unable to say who was interviewed, nor how did they know if all of the staff were interviewed. The 200 UM stated they did not have documentation of which staff were interviewed, or what was said during those interviews. On 8/03/24 at 5:55 PM, in joint interviews with the Director of Nursing (DON), the Administrator, the [NAME] President of Clinical Services and the Regional Nurse, the DON stated on the evening of the elopement, she asked all staff in the facility to write a statement regarding interactions with resident #1. She read statements including, LPN E's statement read, The last time I saw resident was at 6:19 PM. CNA J's statement read, he saw him while was passing trays in his room at approximately 5:30 PM. CNA C's statement from 7/20 read, [resident #1's name] left saw him between 6-6:30 PM. The DON acknowledged that two of the staff statements said they saw the resident when he was not in the building per the facility video timeline. The DON stated she did not interview or speak to the staff again personally after she received their statements to clarify or add additional information to her investigation of the incident. She stated she asked for written statements then she and the managers provided verbal education to the staff. The DON could not say why she did not further investigate by clarifying or asking for additional details from staff when some statements were vague or incorrect only saying she did not want to change them. She confirmed the facility had no further written documentation showing further investigation with the staff, and explained she had talked to staff throughout that evening and no one mentioned resident #1's behavior. The Regional Nurse explained, because there was actual video footage that showed what happened they did not feel they needed additional information from the staff. On 8/04/24 at 4:53 PM, the [NAME] President of Clinical Services and the Regional Nurse confirmed the facility did not have a statement documented from CNA F or an interview from 7/20/24, the night of the elopement. They presented a verbal statement signed by CNA F and transcribed on 8/03/24 in which CNA F stated, I felt something wasn't right. On 8/04/24 at 3:01 PM, the Administrator stated he was the Risk Manager for the facility. He explained interviews were part of the investigation process for abuse or neglect allegations as well as taking statements from staff or witnesses. He was unable to say how the facility would know if they had interviewed all of the pertinent players or what had been said if there was no documentation for it. Review of the facility Abuse, Neglect, Exploitation and Investigation policy and procedure issued 4/01/22, read, The facility will conduct their own internal investigation including but not limited to staff.resident, and family/resident representative interviews, medical records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 Spyglass Hill Rd Viera, FL 32940	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to maintain a secure environment and provide adequate supervision to prevent a severely cognitively impaired resident to exit unauthorized, and unsupervised from the facility and the safety of its property, for 1 of 9 residents reviewed for elopement risk, of a total sample of 10 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury, impairment, and/or death. While resident #1 was out of the facility unsupervised, there was reasonable likelihood he could have fallen, become lost, accosted by a stranger, or been hit by a vehicle and died . The facility's failure to identify and provide adequate supervision and ensure a secure environment contributed to resident #1's elopement and placed all elopement risk residents at risk. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was determined to be removed on [DATE] after verification of the immediate actions by the facility. The scope and severity of the deficiencies were decreased to a D, no actual harm with a potential for more than minimal harm, that is not an Immediate Jeopardy. There were a total of 9 current residents identified at risk for wandering/elopement. Findings: Cross reference F600 On [DATE] at approximately 6:05 PM, the facility's Weekend Supervisor unlocked the door for a visitor to leave and neglected to ensure no residents followed out behind the visitor. Resident #1, a vulnerable, severely, cognitively impaired male, followed behind the visitor and exited the safety of the facility unnoticed and unsupervised. Resident #1 was allowed to exit the building and walked outside on the hot, sunny 90 degree Fahrenheit evening for approximately 45 minutes, traveling approximately 1.1 miles away from the facility, (retrieved on [DATE] from www.wunderground.com). Along the route it was noted to have uneven, sloped terrain/pavement, curbs and multiple open retention ponds. He would have crossed a heavily trafficked, six lane highway with speed limit of 40 miles per hour to reach the location where an off-duty staff member spotted him. The facility was unaware of resident #1's whereabouts until 6:35 PM when an off-duty staff member happened to see the resident walking down the street with a wander prevention bracelet and called the supervisor. Resident #1 was admitted to the facility on [DATE], with diagnoses to include right femur fracture, difficulty walking, dementia anxiety, major depressive disorder, psychotic disorder with delusions. The Minimum Data Set (MDS) Admission assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of ,d+[DATE] which indicated he had severe cognitive impairment. The assessment indicated he received antipsychotic, antianxiety, antidepressant, and antibiotic medications. Review of the medical record revealed resident #1 had a physician order for an electronic wander monitoring bracelet to be applied beginning [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Review of resident #1's medical record revealed he had a care plan for potential for elopement related to his behaviors such as wandering, ambulatory, has confusion, and exit seeking initiated on [DATE]. The goal described the resident would remain safe and would refrain from leaving the facility unsupervised was initiated on [DATE] and revised on [DATE]. Interventions included enhanced supervision, initiated on [DATE], provide redirection when observed going towards exit doors, also initiated on [DATE]. A revision was added to the care plan on [DATE] which indicated resident #1 had eloped from building.

On [DATE] at 1:05 PM, the Administrator shared a video from his cell phone recorded on [DATE] from the facility's video monitoring system. The video which started at approximately 6:05 PM, showed a visitor paused at the door, while the weekend supervisor used a remote control to open the front door to exit the facility. The visitor pushed the door handle and opened the front door exiting the facility lobby. Six seconds later resident #1 went out the door after the resident. The weekend supervisor was seen seated at the receptionist desk with her head down, on the computer, totally unaware of resident #1 tailgating behind the visitor she had let out moments before. The video then showed resident #1 returning to the facility at 6:49 PM. The Administrator stated the video camera was positioned above the receptionist desk, and ran on a loop, so he had recorded the video portion of resident #1 leaving the facility on his phone but had no other record of his actions from that day.

On [DATE] at 11:48 AM, the Weekend Supervisor stated the receptionist hours were Monday- Friday 8 AM-8 PM and Saturday and Sunday from 8 AM-5 PM. The Weekend Supervisor stated she worked most weekends and confirmed she was the supervisor in charge [DATE], the day resident #1 eloped. She stated she had been sitting at the receptionist desk charting assessments after the receptionist left the facility. She said she saw the visitor approach and pushed the button on the remote to unlock the door to let her out. She stated she did not see resident #1 follow behind the visitor. The supervisor explained how she had opened the door from where she was seated at the desk using the remote without having to actually get up from her position. She explained no one at the facility knew resident #1 was missing until she received a phone call from off duty Licensed Practical Nurse (LPN) G at 6:35 PM, who asked if [name of resident #1] was a resident at the facility.

On [DATE] at 2:26 PM, LPN G said she worked the day shift at the facility on [DATE] then later that evening she went to pick up food at a restaurant not far from the facility with her husband. She explained as they left the parking lot, she noticed an older gentleman walking down the street who kept looking behind him as if he needed a ride or was looking for someone to pick him up. She stated the man was headed east on the sidewalk along the highway, across the intersection from where she had been parked. LPN G recounted it looked like the man had an electronic wander monitor bracelet on his leg and she asked her husband to make a U-turn so she could get a closer look. She explained they caught up with him further down the road in front of another store, so they pulled to the side of the road, and she got out of the car. She asked the gentleman if he needed a ride and where he was going. To which he replied, yes and he was going to the base. LPN G stated she did not know him, so she asked him his name, which sounded familiar. She instructed him to sit in the shade and she called her supervisor at the facility to check to see if the man was ours. Around that time a sheriff's officer pulled up and asked resident #1 where he lived, and she told him he was from the facility and a supervisor was on the way to get him. LPN G said she stayed with him until the Weekend Supervisor and another staff arrived at her location. She explained resident #1 did not recognize her but when the supervisor came, it appeared he recognized her. The supervisor got out of her car and talked to him, then he walked to the car with her.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at approximately 7:25 PM and on [DATE] at 9:18 AM, the likely route was toured by car and by foot (see photo evidence). Per interview the resident left his room on the 200 hall and walked toward the front of the building to the lobby approximately 267 feet away. From there he exited the building through the front door and likely walked approximately 298 feet through the parking lot down a short drive to the sidewalk adjacent to a minimally busy two-lane road. On the short road adjacent the parking lot there were two open retention ponds directly across from the facility. At the sidewalk he would have turned right and walked .3 miles over uneven pavement passing multiple business entrances to where that road intersected a moderately trafficked four lane road and turned left. He continued another 0.4 miles on the moderately trafficked road passing five business entrances, the driveway for a fire station and four unsecured retention ponds. At this point there was a large intersection with busy restaurants/convenience store on three of the four corners of the intersection. Resident #1 then turned left onto the highway which was 6 lanes across at that point with traffic coming from the nearby interstate and busy shopping area a short distance away. He walked another 0.1 miles before he was stopped by LPN G and her husband at the jewelry store. On [DATE] at 3:20 PM, LPN B stated she was familiar with resident #1. She said she went with the Weekend Supervisor to pick him up the day he eloped. The LPN stated she went along with the supervisor to retrieve resident #1 from where LPN G found him in case she needed assistance with him due to possible behavior. LPN B said, He was sitting on the sidewalk on the curb with a police officer talking to him near the jewelry store. She stated when she got out of the car resident #1 was apologetic and said he knew he did something he should not have. The LPN said resident #1 could not recall when or why he left. She said he told her he drove himself from the facility in a car. On [DATE] at 3:53 PM, via telephone, Certified Nursing Assistant (CNA) C stated she worked a double shift from 3 PM to 7 AM on the day resident #1 eloped. She recalled he had wandered around that day, asking questions about every 10 minutes like, when he was going to leave? and could he go home? She said resident #1 packed his bags about an hour and a half into her shift and asked her why his wife had left him there. She recounted all the staff knew of his behaviors that day, and they needed to frequently redirect him. She expressed that everyone knew he had increased behaviors and had been hard to redirect that day. CNA C said she let the other staff, and his nurse know what he was doing so they could redirect him. She said he asked her where [the name of the city where he used to live] was. CNA C explained the Weekend Supervisor called her around 5:00 PM and asked her to come get resident #1 from the front. CNA C explained that resident #1 was sitting next to the supervisor at the front desk, with his bag and a picture of his wife in his hand when she arrived. The CNA said the supervisor asked her to take him back to his unit and keep him distracted until dinner. CNA C said she took resident #1 back to the nurse's station but shortly after the dinner trays arrived and the CNAs had to deliver them to the residents. CNA C stated she left resident #1 and went to deliver the trays and did not see him again until he was returned to the facility with the Weekend Supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105885	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Healthcare and Rehabilitation Center	8050 Spyglass Hill Rd Viera, FL 32940

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:35 PM, LPN D stated she was assigned to care for resident #1 frequently. She recalled he was very forgetful, and staff had to remind him over and over where he was. The LPN stated she would call his wife for him; he would talk to her and only a few minutes later he would already forget that he had just talked to her. She said, He was physically independent but very forgetful, only oriented to himself. LPN D stated resident #1 was eating in his room when she went to give him his medications around 5:30 PM. She said resident #1 had come to the nurse's station earlier and asked her to call his wife, but she told him she would call her later. He came back asking for her to call his wife again. LPN D said when she gave him his medications, she promised him she would call his wife before he went to bed, and he said okay. She explained resident #1 usually walked around the building, but she did not see him that night after she gave him his medications. LPN D stated another staff told her resident #1 had left the building, but they were not sure how he got out. She said when resident #1 returned to the facility, she asked him how he got out of the building and he said, I was very careful. The LPN said he then asked her if he was going to get in trouble. On [DATE] at 5:21 PM, in a second interview, the Weekend Supervisor said, When [resident #1] was talking to me before the elopement, he had a picture of his wife, but I do not recall him having a bag. She said she had seen the picture in his room but did not recall seeing him carry it around with him in the past. The supervisor stated she let him sit with her and talk a little bit because she knew he was an elopement risk, and it would give him a change of scenery. She stated if she knew he was exit seeking she would have put him on one-to-one supervision. She acknowledged it was not likely he would have eloped if he had more supervision such as one to one. She stated she had not been aware his behavior was different that day. Review of resident #1's medical record revealed limited nursing progress notes describing resident #1's behaviors until a week before his elopement. These progress notes revealed escalating exit seeking behaviors in the week preceding the elopement. A nursing progress note dated [DATE], read, The resident removed the electronic wander monitoring bracelet on his right ankle. The bracelet was located [in] the trash can in his room. New bracelet applied on the left ankle. A nursing progress note the next day, [DATE] documented the resident was wandering up and down the unit, packed his belonging and told others he was going home. The nurse charted she notified the charge nurse and the as needed anti-anxiety medication was given. On the day he eloped, [DATE], the nurse documented the resident's behavior remained unchanged. He continued to wandering the unit, and she noted resident #1, constantly needs to be redirected without success. The nurse indicated resident #1 was again medicated for anxiety. Review of the Medication Administration Record (MAR) dated for [DATE] revealed resident #1 had an as needed (prn) order for anti-anxiety medication every 8 hours for restlessness/agitation that was in effect for 14 days starting on [DATE]. The resident received the medication one time on [DATE], once on [DATE] and again once on [DATE]. The order was not renewed, and it was discontinued after the 14 days were completed. On [DATE], the day after resident #1 cut off his electronic wander monitoring bracelet the nurse noted in the progress notes he was wandering up and down the unit and an anti-anxiety prn medication was given. A renewal order for the same as needed anti-anxiety medication every 8 hours for restlessness/agitation was documented as restarted in the record. Over the course of the week before the elopement resident #1 received one dose of the as needed anti-anxiety medication on [DATE], two doses on [DATE], a dose on [DATE], a dose on [DATE] and another dose on [DATE] both prior to and after the elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8050 Spyglass Hill Rd Viera, FL 32940	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:58 PM, the 200 Unit Manager (UM) acknowledged the prn anti-anxiety medication was restarted on [DATE] after resident #1 cut his electronic wander monitoring bracelet off the previous day. She was asked why resident #1 did not have additional interventions added to his care plan when this occurred, and his behaviors escalated the days prior to the elopement. The UM could not answer but acknowledged again the resident took his wander monitoring bracelet off on Sunday [DATE] and placed it in the garbage. She continued the bracelet was replaced on the other limb. The UM said she was notified of the incident when she came to work on Monday. In a telephone interview on [DATE] at 3:33 PM, resident #1's wife stated she was notified by staff of her husband's elopement on [DATE] around 9:00 PM after he was returned to the facility. She said, I was kind of upset because he had a bracelet on his leg, and he still got out. She said they told her the wander monitoring bracelet was put on her husband so he would not leave the facility. Resident #1's wife stated her husband has Alzheimer's Dementia. She said the day he got out of the nursing home their son who lived in another state came to visit her husband. She stated they brought her husband lunch and were able to eat with him. She wondered if it triggered her husband when they left the facility after lunch, because he had seen his son earlier that day and had been told he was only visiting for the day. She cried and said, My heart almost fell out of my chest when they said he was on [highway name] when they found him. Resident #1's wife said it was very scary to think about what could have happened since he walked that far away and was on that busy road alone. Review of the facility's corrective actions were verified by the survey team and included the following: * On [DATE], Resident #1 was returned to the facility and re-evaluated by licensed nurse. Full body assessment of resident completed. One to one supervision initiated. Physician and resident representative notified on event. * On [DATE], the facility filed an immediate federal report related to allegation of neglect of resident #1 to Agency for Healthcare Administration, notified Department of Children and Families and initiated a full investigation. Physician and resident representative notified. * On [DATE], the Elopement Risk Alert Binder was reviewed to ensure resident's picture and demographics were in place. Plan of care and Kardex reviewed to ensure accuracy of resident's current condition. Increased monitoring related to exit seeking behaviors verified in place. * On [DATE], Risk Evaluation related to elopement was conducted for resident #1. * On [DATE], Facility conducted head count of residents currently residing in the facility; all were accounted for and safe. * On [DATE], Doors were assessed by Administrator and Maintenance Director to ensure proper functioning; no issues or concerns were identified. It was identified through Root Cause Analysis (RCA) process that the electronic wander monitoring alarm is deactivated during the remote door opener activation to allow visitors out. Systemic changes listed below to prevent occurrence. * By [DATE], Residents residing in the facility were re-evaluated/reviewed for elopement risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8050 Spyglass Hill Rd, Viera, FL 32940	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* By [DATE], Residents identified at risk for elopement were reviewed by Unit Managers/designee for: Elopement Screen, Care plan in place related to wandering risk, CNAs Kardex reflective of resident status and Resident(s) present in Elopement Binder. * On [DATE], the Director of Nursing (DON) /designee reviewed elopement binders to ensure residents at risk for elopement were present and identified. * On [DATE], Resident #1 was evaluated by psychiatry. * On [DATE], DON/designee educated staff on: a. Components of the regulation: F689 b. Elopement Policy and Procedure c. 1:1 supervision d. Door/Egress checks e. Responding to an alarm f. Response to a missing resident g. Elopement Triggers h. Proactive interventions for residents at risk for wandering/elopement i. In an abundance of caution, abuse and neglect education completed. * On [DATE], DON/designee carried out elopement drills. Education provided as indicated based on Elopement Drill findings. The facility has completed 35 elopement drills that includes 185 staff members out of 186 (the staff member not included is out of the State). * By [DATE], ,d+[DATE] facility staff members were re-educated. * By [DATE], ,d+[DATE] facility staff members were re-educated, no staff worked without receiving in-person education. Newly hired employees will receive education on above in orientation. * On [DATE], the facility removed the automatic door opener. * On [DATE], the facility adjusted the alarm delay from 15 seconds to 5 seconds to prevent tailgating. * Beginning [DATE], the facility Administrator/designee/DON/designee will ensure that the safety and well-being as it relates to elopement is maintained by continued participation, evaluation, and intervention through: a. Clinical standup review of the 24-hour report to identify change in condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Viera Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8050 Spyglass Hill Rd Viera, FL 32940	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Monitoring of egress systemic changes c. Maintaining QAPI process. * On [DATE], anti-tailgate device was added to the front door along with antennae moved to improve field of frequency. From [DATE] to [DATE], interviews were conducted with 28 staff members who represented all shifts. Staff included 8 CNAs,8 LPNs, 4 RNs, 2 Housekeepers, 1 Receptionist, 1 MDS Coordinator, 2 Dietary personnel, 1 Maintenance Director, and 1 Physical Therapy Assistant who verbalized their understanding of the education provided. The resident sample was expanded to include all eight residents identified as at risk for elopement currently in the facility. Interviews with three alert and oriented residents regarding interviews conducted by facility staff regarding feeling safe and no neglect and chart reviews for the other 8 residents to ensure elopement risk evaluations and skin checks were completed on [DATE]. Observations, interviews, and record reviews revealed no concerns related to Elopement.