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	08/15/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents reviewed for Care Planning were offered participation in plans or revisions to their care, of a total sample of 40 residents, (#65). Findings: Review of the medical record revealed resident #65, a [AGE] year old female was admitted to the facility on [DATE], and readmitted from an acute care hospital on 5/26/24 with diagnoses of malnutrition, type 2 diabetes mellitus, adjustment disorder with anxiety and depressed mood, gastrostomy (feeding tube) status, and acute duodenal (intestine) ulcer with perforation. The most recent Minimum Data Set (MDS) Admission 5-day Assessment with an Assessment Reference Date (ARD) of 6/02/24 noted during the look back periods, the resident scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated her cognition was moderately impaired. There were no signs and symptoms of delirium or rejection of care necessary to achieve health and well-being goals. The resident scored 13 out of 27 on the PHQ-2 to 9(C) (Resident Mood Interview) that indicated moderate depression, and she felt down, depressed, or hopeless nearly every day. The assessment showed the resident's customary routines and activities preferences were very important to her, and she required a feeding tube to sustain nutrition and hydration. The Order Summary Report included active physician's orders for nothing by mouth (NPO) diet, regular diet, regular texture, thin consistency, meat cut into bite size, sandwiches with lunch/dinner, no straw, and J (small intestine) tube/surgical site care. On 8/12/24 at 10:53 AM, resident #65 was observed sitting in a wheelchair in her room while her family representative visited. The resident was visibly upset when she said although she had asked staff on multiple occasions, they hadn't kept her updated about having her feeding tube removed. She stated, Maybe it's going to happen on Wednesday. Review of the Comprehensive Care Plan included focuses, goals, and interventions that included nutrition and hydration with a mechanically altered diet and tube feeding. The care plan showed resident #65 was at the facility for short term placement, and the resident/representative clearly expressed a desire to discharge from the facility. It was noted the resident had an alteration in mood as evidenced by adjustment disorder with mixed anxiety and read, endorses depressed mood. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/24 at 10:54 AM, the resident's representative conveyed the resident had been anxiously awaiting having the feeding tube removed as she had greatly improved and was eating regular food again. She stated, We need to know when it's happening. Review of the Care Plan Calendar Schedule provided by the MDS Coordinator documented a Care Plan Meeting had been scheduled for the resident on 5/21/24 and noted the resident had been discharged on [DATE]. On 8/15/24 at 10:59 AM, the MDS Coordinator checked the care plan meeting schedule and explained that resident #65 had been scheduled for a care plan meeting on 5/21/24 however, she was discharged to the hospital before the meeting was held. She said when the resident returned on 5/26/24, a meeting to include the resident and/or her representative wasn't rescheduled and she stated, She should have been put back on the schedule and she was missed; we just missed it. On 8/15/24 at 2:38 PM, the Director of Nursing (DON) explained the MDS department was responsible for scheduling regular care plan meetings. She said it was important to include the resident and representative so the facility could ensure their needs were met and they understood their plan of care and discharge plans. The DON stated, It's an opportunity for us to all meet together so they understand what's going on; it can cause depression and anxiety and it's important for everybody to feel like they're heard, and things change; it's an opportunity for those to be shared. Review of the facility's standards and guidelines titled Comprehensive Assessments and Care Plans dated 4/01/22 read, . the plan of care should be created in consultation with the resident and the resident's representative (s)- (i) The resident's goals for admission and desired outcomes. (ii) The resident's preference and potential future discharge. (iii) . The facility shall maintain the right to participate in the development and implementation of his or her person-centered plan of care.