STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview and record review, the facility failed to report possible neglect for 1 of 3 residents reviewed for neglect, of a total sample of 4 residents, (#1). Findings: Review of the medical record revealed resident #1, an [AGE] year old female was admitted to the facility from an acute care hospital on 7/12/24 with diagnoses including acute respiratory failure, sepsis (blood infection), primary thrombocytopenia (slow blood clotting), urinary tract infection (UTI), muscle weakness, major depressive disorder, dementia with behavioral disturbance, need for assistance with personal care, and difficulty in walking. Hospital medical records dated 10/05/24, indicated resident #1 sustained a fall with a head injury that required emergency transport to the hospital. While at the hospital, the resident received emergency physician assessments, monitoring, treatment, diagnostic laboratory blood work, prescription medication orders, and Computed Tomography (CT) imaging. The CT imaging found the resident sustained a possible nondisplaced nasal bone fracture. Review of the most recent Minimum Data Set (MDS) Admission 5-day assessment with Assessment Reference Date (ARD) 7/16/24 revealed during the look-back period, resident #1 scored 4 out of 15 on the Brief Interview for Mental Status (BIMS) exam that indicated she was severely cognitively impaired. The assessment showed she had no behavioral symptoms or rejection of care necessary to achieve goals for health and well-being noted. The Preferences for Customary Routine and Activities interview completed with the resident noted it was somewhat important for her to go outside for fresh air. The Functional Abilities and Goals assessment showed the resident required a wheelchair and walker, substantial/maximum staff assistance to complete Activities of Daily Living (ADL), mobility functions, and to wheel a wheelchair. Walking was not assessed due to her medical condition/safety concerns. The resident was incontinent of bladder and bowel functions, short of breath with exertion or lying flat, did not have a history of falls within the previous 6 months of admission, nor since admission or during the assessment period. The resident received high-risk antidepressant, antibiotic, and diuretic (fluid removing) medications, and supplemental oxygen therapy. The assessment indicated a Care Area was triggered for an identified problem of Falls. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan documented undated Special Instructions that read, Staff to escort resident for safety to the courtyard A focus initiated on 7/15/24 read, The resident has impaired cognitive function/impaired thought processes r/t [related to] diagnosis of dementia. Interventions initiated on 7/15/24 noted nurses were expected to notify the physician of any changes in the resident's condition, and communicate concerns with family/caregivers about confusion, and the resident's capabilities or needs. Another focus initiated 9/19/24 described resident #1 as having impulsive behaviors. A Care Plan Focus initiated 7/17/24 and revised 9/16/24 described resident #1 was at risk for falls related to an unsteady gait, poor balance, use of antihypertensive medications, use of psychotropic medications, and history of falls. The care plan goal read, The resident potential for sustaining a fall-related injury will be minimized by utilizing fall precautions/interventions through next review date. On 9/06/24, an intervention to offer the resident assistance with toileting before and after meals was initiated. Interventions initiated on 9/16/24 included staff to offer and assist resident #1 to common areas while awake and as tolerated. On 10/07/24, after her fall, the facility implemented an intervention to encourage resident to only go out with staff/family supervision. The care plan did not contain an intervention for frequent checks or a fall program. Review of the facility's September and October 2024 Fall Logs showed before resident #1 fell on [DATE], she had four other falls: on 9/05/24, twice on 9/13/24, and on 9/15/24. In an interview on 10/14/24 at 3:26 PM, the Director of Nursing (DON) confirmed none of the falls before the fall on 10/05/24 were witnessed by staff. Review of a SBAR (Situation-Background-Assessment-Recommendation) Change In Condition note completed by Licensed Practical Nurse (LPN) A dated 10/05/24, revealed resident #1 fell and had a facial laceration with an altered level of consciousness which required emergency transport to the hospital. The Hospital Transfer Form noted the resident was combative and confused, and described her as a, high fall risk. On 10/14/24 at 11:17 AM, Certified Nursing Assistant (CNA) F recalled on 10/05/24 at approximately 1:00 PM, as he returned lunch trays to the dining room and looked outside, he saw resident #1 alone across the courtyard on the patio getting out of her wheelchair. He explained he ran outside and across the courtyard to help her, but by the time he reached her, she was already lying on the ground face first. He said resident #1 had blood on her face and swelling on her head. In a telephone interview with Licensed Practical Nurse (LPN) A on 10/13/24 at 3:53 PM, she explained she knew resident #1 well. She recalled on 10/05/24 at approximately 1:00 PM, she was alerted by CNAs resident #1 was on the patio outside face down on the ground. She said she assessed the resident and found her to be more disoriented than normal, and was bleeding from her nose and face with a large bump on her forehead. The LPN said she was very concerned the resident may have a serious head injury and she contacted Advanced Practice Registered Nurse (APRN) L for orders to send her out to the hospital. The LPN said the Emergency Contact consented to the transfer and resident #1 was emergently transported to the hospital. Review of APRN L's Nursing Home Visit Encounter dated 10/07/24 read, . weakness, had a fall out of her wheelchair over the WE (weekend). Sent to ER (emergency room), no sutures required and sent back to the facility . bruises to both eyes, forehead and abrasion to her nose and forehead. The note did not mention the possible nondisplaced nasal fracture from the hospital paperwork. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:54 AM, in a telephone interview, resident #1's Healthcare Surrogate recalled she was worried the resident would fall and get seriously hurt at the facility without one to one supervision, so she requested the Power of Attorney (POA) pay for the services on behalf of the resident. She explained she was especially worried and concerned when the resident started having multiple falls in September 2024, after the individual supervision stopped. She said after the resident fell on [DATE], the facility did not provide her with any updates, and she found out from the hospital later that the resident had a nasal fracture. She said the facility told her they didn't have the staff to provide one to one supervision and stated, she started falling when the one on one went away. In interviews on 10/16/24 at 1:00 and 2:00 PM, the DON explained when staff had concerns about any resident's behavior or safety, they reported it to the Unit Manager who communicated the information to the Interdisciplinary Team (IDT) in morning meetings. She said the team was aware resident #1 was a high fall risk so she was placed on the Falling Leaf Program with a magnet on her door after she started falling in September. On 10/16/24 at 2:15 PM, the Nursing Home Administrator conveyed the facility had not considered providing one to one supervision as a fall intervention for resident #1 and stated, she's on the Falling Leaf Program; it's to keep eyes on them; we review her and any resident in the clinical meetings. Review of resident #1's Comprehensive Care Plan, Kardex for CNAs, and Safety Interventions Records revealed no Falling Leaf Program nor were frequent checks added to the plan of care since the resident was admitted to the facility on [DATE], for three months. Review of the facility's form titled, Potential Adverse Report Incident Investigation Worksheet dated 10/08/24 noted a description of the event circumstances and read, This worksheet is designed to assist in determining if the incident/event is reportable on the AHCA 15 day report in compliance with Florida Statute 400.147 . resident had returned from the patio with [CNA G] less than 5 minutes prior, when the resident was observed by [CNA F] self propel thru patio door when she stood and lost her balance. The form noted three staff were involved, CNA F, CNA G, and LPN A. The facility's Conclusion/Analysis of Investigation read, Resident is independent with propulsion in the wheelchair. The resident had just left the patio less than 5 minutes prior with the assigned CNA (CNA G). (CNA F) witnessed the resident self propel from the doors on (unit name) to the patio (thru) door and stood and lose her balance falling forward. He immediately went to the resident and alerted the nurse. The form showed no State Agency reports were submitted. In a joint interview with the DON and Nursing Home Administrator on 10/14/24 at 11:45 AM, the DON said the facility did not report resident #1's incident on 10/05/24 because the resident was supervised, in an enclosed area, and staff didn't want to annoy her. The DON stated, it was just an accident; she stood from the wheelchair; it wasn't adverse. The Nursing Home Administrator acknowledged the resident required a higher level of care as a result of the incident and stated, neglect is considered to be someone who isn't taken care of. On 10/16/24 at 2:17 PM, the Nursing Home Administrator confirmed she was the Risk Manager and responsible for the facility's adverse incident reporting. She said the facility did not consider resident #1's incident to be reportable to the State Agency because her plan of care was followed and the facility was not aware at that time of resident #1's possible fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 12:36 PM, in a telephone interview the Medical Director said he was not resident #1's attending physician, and the facility had not notified him of the fall or a possible adverse incident. Review of the facility's standards and guidelines dated January 2024 and titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin indicated neglect was defined as the failure to the facility, or it's employees to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress to a resident. The document described neglect included cases where the facility's indifference or disregard for resident care, comfort or safety resulted in or could have resulted in physical harm, pain, mental anguish or emotional distress. Further, the document indicated the facility must ensure all alleged violations were reported immediately and in accordance with laws through established procedures. The facility's Risk Manager job description, dated and signed by the Nursing Home Administrator and DON on 3/22/24 described the Risk Manager would investigate allegations of abuse or neglect in coordination with the Abuse Coordinator, would ensure an event reporting system was implemented in the facility to ensure staff reported adverse events to the Risk Manager timely to develop appropriate measure to minimize the risk of adverse events to residents. The document included direction that the Risk Manager would ensure the mandatory immediate and completed 5-day reports were submitted per regulation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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** 46665 Based on interview and record review, the facility failed to thoroughly investigate and identify possible neglect for 1 of 3 residents reviewed for neglect, of a total sample of 4 residents, (#1). Findings: Review of the medical record revealed resident #1, an [AGE] year old female was admitted to the facility from an acute care hospital on 7/12/24 with diagnoses including acute respiratory failure, sepsis (blood infection), primary thrombocytopenia (slow blood clotting), urinary tract infection (UTI), muscle weakness, dementia with behavioral disturbance, need for assistance with personal care, and difficulty in walking. Hospital records dated 10/05/24, revealed resident #1 sustained a fall with a head injury that required emergency transport to the hospital. While at the hospital, the resident received emergency physician assessments, monitoring, treatment, diagnostic laboratory blood work, prescription medication orders, and imaging. Review of the most recent Minimum Data Set Admission 5-day assessment with reference date 7/16/24 revealed during the look-back period, resident #1 scored 4 out of 15 on the Brief Interview for Mental Status exam which indicated she was severely cognitively impaired. No behavioral symptoms or rejection of care necessary to achieve goals for health and well-being were noted. The Preferences for Customary Routine and Activities interview completed with the resident noted it was somewhat important for her to go outside for fresh air. The Functional Abilities and Goals assessment showed the resident required a wheelchair and walker, substantial/maximum staff assistance to complete Activities of Daily Living (ADL), mobility functions, and to wheel a wheelchair. Walking was not assessed due to her medical condition/safety concerns. The resident did not have a history of falls within the previous 6 months of admission, nor since admission or during the assessment period. The assessment indicated a Care Area was triggered for an identified problem of Falls, to include a positive Care Plan Decision. Review of the Comprehensive Care Plan documented undated Special Instructions that read, Staff to escort resident for safety to the courtyard A focus initiated on 7/15/24 read, The resident has impaired cognitive function/impaired thought processes r/t [related to] diagnosis of dementia. Interventions initiated on 7/15/24 noted nurses were expected to notify the physician of any changes in the resident's condition, and communicate concerns with family/caregivers about confusion, and the resident's capabilities or needs. A focus initiated 9/19/24 indicated resident #1 had a history of impulsivity. Review of a Change In Condition progress note completed by Licensed Practical Nurse (LPN) A and dated 10/05/24, revealed resident #1 fell and had a facial laceration with an altered level of consciousness that required emergency transport to the hospital. The Hospital Transfer Form noted the resident was totally dependent on human assistance for mobility and ADLs, was combative and confused, and indicated she was a high fall risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 10/14/24 at 11:17 AM, Certified Nursing Assistant (CNA) F recalled that on 10/05/24 at approximately 1:00 PM, while he was returning lunch trays to the dining room he looked outside, and saw resident #1 outside, alone across the courtyard on the patio getting out of her wheelchair. He explained he ran out the door and across the courtyard to help her, but by the time he reached her, she was lying on the ground, face first. He stated resident #1 had blood on her face and swelling on her head. On 10/14/24 at 10:44 AM, CNA G recalled on 10/05/24 at approximately 1:00 PM, resident #1 fell from her wheelchair outside on the nursing unit courtyard. The CNA explained staff were expected to conduct 15 minute checks on the resident because she had severe dementia and was a fall risk. She said the resident frequently wanted to go outside to sit in the courtyard but could not go out alone safely. The CNA recalled she assisted the resident for lunch on the nursing unit near the courtyard and then she had to assist other dependent residents with their meals. She said at approximately 1:15 PM, she was informed resident #1 was outside alone and fell . She said she provided a handwritten statement about the event on 10/05/24 and placed it in the Unit Manager's box. The CNA explained she actually provided two handwritten statements to facility management; one on 10/05/24, the day of the incident, and another earlier that morning, 10/14/24, with the Nursing Home Administrator. On 10/15/24 at 3:16 PM, LPN A said she struggled to keep a close eye on resident #1 because she had poor safety awareness and was impulsive. The LPN explained she tried to be creative and redirect the resident while she passed medications to other residents. She said she would try to keep her busy and distracted at the medication cart. She recalled on 10/05/24, CNA G took the resident outside until lunch time when the CNA was busy assisting other residents in their rooms with their meals. The LPN recalled at about 1:00 PM, other CNAs alerted her the resident was outside on the ground. She said the resident was at the hospital for the remainder of her shift that ended at 7:00 PM. She said she returned the next day on the day shift and she received report from LPN I who told her resident #1 had a UTI with prescriptions. The LPN said all the nurses thought the resident should be on one to one supervision and stated, even if you take your eyes off her for 5 minutes it can be a disaster; she is confused and can get up again. A Progress Note entered by the Assistant Director of Nursing (ADON) on 10/07/24 read, IDT [Interdisciplinary Team]- On 10/05/24 at approximately 1645 [4:45 PM] the resident was observed lying on the ground. Laceration to the facial area and swelling on the forehead. First aid performed, MD [Medical Doctor] and family was notified, resident transferred to ER[emergency room] for evaluation and returned with negative FX [fracture] results and [NAME] [antibiotics] for UTI, MD and family notified, treatment to skin alterations in place, neurological checks and CP [care plan] reviewed and updated. Staff to encourage resident to go outside with staff supervision. On 10/14/24 at 12:09 PM, the DON said the ADON was not available for interview, as she was out of the country on leave. On 10/14/24 at 1:04 PM, Patient Care Assistant (PCA) B recalled on the day of resident #1's fall, 10/05/24, she was assigned to resident #1. The PCA explained, she was assigned dining room duty from 11:00 AM to 1:00 PM and the resident remained on the nursing unit. She said when she returned to the unit, she saw the nurse going outside, and resident #1 was face down on the concrete. The PCA stated, nobody saw her fall. The person that found her was walking from that side to our side going to the courtyard and saw her on the ground; They didn't ask me to write a statement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 10/14/24 at 1:15 PM, the Long Term Care Unit Manager recalled on 10/07/24, two days after resident #1's fall incident, she collected some written staff statements from her box, and some of them were placed under the DON's door. She explained on 10/07/24, she assisted in the facility's investigation and called some staff later for additional statements that she transcribed to a form. Review of CNA G's Interview Record form provided by the facility dated 10/07/24, indicated the Nursing Home Administrator was the interviewer. No other statements from CNA G for the day of the incident (10/05/24), or for that day (10/14/24) were provided to the surveyor. On 10/14/24 at 11:32 AM, in an joint interview with the DON, the Nursing Home Administrator reviewed the facility's investigation and staff statements collected from resident #1's incident and said the facility had one statement from CNA G dated 10/07/24. The Nursing Home Administrator explained she met with CNA G that morning to review the timeline. The Nursing Home Administrator and the DON were informed surveyor interviews with staff conflicted with the facility's investigation evidence provided. On 10/14/24 at 12:09 PM, the DON and Nursing Home Administrator said they were concerned information attained in staff interviews conflicted with their investigation of the incident. The DON stated, all the statements are in the folder. Review of the facility's investigation documents revealed no statement from assigned PCA B. On 10/16/24 at 9:20 AM, the Long Term Care Unit Manager explained all resident falls and interventions/revisions of care were discussed in the morning clinical meetings in which she participated. She said on 10/07/24, a Monday, she discussed what happened with APRN L who assessed her. She said CNAs were expected to check on residents with frequent checks in between patient care and stated, we know she's a fall risk so everybody on the unit that works frequently check on her. Review of the hospital ER treatment and discharge notes on 10/05/24 revealed resident #1's Computed Tomography (CT) scan findings showed a possible nondisplaced nasal fracture and the ER physician summary noted the need for antibiotics per resident #1's nondisplaced nasal fracture. Review of APRN L's Nursing Home Visit Encounter dated 10/07/24 read, . weakness, had a fall out of her wheelchair over the WE (weekend). Sent to ER, no sutures required and sent back to the facility . bruises to both eyes, forehead and abrasion to her nose and forehead. The note did not mention resident #1 sustained a nondisplaced nasal fracture. On 10/16/24, two unsuccessful attempts were made to contact APRN L by telephone. On 10/16/24 at 12:51 PM, the DON explained the facility reviewed all resident emergency visits for orders and test results every weekday morning during clinical meetings. She recalled the resident's fall and ER visit was discussed on 10/07/24, and the Unit Manager reported the resident had a UTI and was prescribed antibiotic medications. She said she checked the hospital ER discharge records and was not aware resident #1 had sustained a nasal fracture. The DON stated, I didn't know we had this; I would say that the hospital didn't send it; she should be monitored for the fracture. On 10/14/24 at 2:29 PM, the Regional Nurse Consultant stated, she (resident #1) doesn't need supervision; she goes outside; she goes out there, they take her outside and they don't watch her because she gets mad when they go out there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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	In a telephone interview on 10/16/24 at 9:53 AM, attending physician M said he was aware resident #1 fell on [DATE], he previously reviewed the hospital records, and recalled she had a UTI. The physician explained he expected APRN L to review the hospital ER records and test results as part of the assessment. The physician acknowledged he reviewed and signed APRN L's note on 10/15/24 and recalled the resident complained of a headache. At 1:42 PM, physician M said he was unaware resident #1 had sustained a nasal fracture. The physician explained he expected nurses to monitor residents for complications of fractures and stated, any head injury we always want to keep an eye on it after they come back from the ER and if they complain of pain we jump on it. A written statement from physician M dated 10/15/24 provided by the facility indicated he had completed a review of resident #1's chart related to her fall on 10/05/24 including hospital records, care plan, prior falls, etc. Review of the facility's form titled, Potential Adverse Report Incident Investigation Worksheet dated 10/08/24 noted a description of the event circumstances and read, This worksheet is designed to assist in determining if the incident/event is reportable on the AHCA 15 day report in compliance with Florida Statute 400.147 . resident had returned from the patio with [CNA G] less than 5 minutes prior, when the resident was observed by [CNA F] self propel thru patio door when she stood and lost her balance. The form noted three staff were involved, CNA F, CNA G, and LPN A. The facility's Conclusion/Analysis of Investigation read, Resident is independent with propulsion in the wheelchair. The resident had just left the patio less than 5 minutes prior with the assigned CNA (CNA G). (CNA F) witnessed the resident self propel from the doors on (unit name) to the patio (thru) door and stood and lose her balance falling forward. He immediately went to the resident and alerted the nurse. The form showed no State Agency reports were submitted. Review of the facility's standards and guidelines dated January 2024 and titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin indicated neglect was defined as the failure to the facility, or it's employees to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress to a resident. The document described the facility should take action as soon as practicable once notified to initiate an investigation and any corrective actions depended on the result of the investigation. It detailed that a coordinated effort would allow the Quality Assessment and Assurance Committee to determine a thorough investigation was conducted, the resident was protected and analysis was conducted as to why the situation occurred. Review of the Facility assessment dated [DATE] revealed the facility would provide person-centered/directed care, record and discuss treatment and care preferences and would identify hazards and risks for residents. The facility's Risk Manager job description dated and signed by the Nursing Home Administrator and DON on 3/22/24 indicated the Risk Manager/Designee would investigate allegations of abuse, neglect, and exploitation of a resident in coordination with the Abuse Coordinator and develop appropriate measure to minimize the risk of adverse events to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm 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** 46665 Based on observation, interview, and record review, the facility failed to develop and implement appropriate interventions to include provision of adequate supervision to prevent fall with major injury for 1 of 3 residents reviewed for falls, of a total sample of 4 residents, (#1). The facility's failure to increase supervision for a resident with a history of repeated falls resulted in actual harm for resident #1. Findings: Review of the medical record revealed resident #1, an [AGE] year old female was admitted to the facility from an acute care hospital on 7/12/24 with diagnoses including acute respiratory failure, sepsis (blood infection), primary thrombocytopenia (slow blood clotting), dementia with behavioral disturbance, need for assistance with personal care, and difficulty walking. Review of the most recent Minimum Data Set (MDS) Admission 5-day assessment with assessment reference date of 7/16/24 revealed during the look-back period, resident #1 scored 4 out of 15 on the Brief Interview for Mental Status which indicated she was severely cognitively impaired. No behavioral symptoms or rejection of care necessary to achieve goals for health and well-being were noted. The Preferences for Customary Routine and Activities interview completed with the resident noted it was somewhat important for her to go outside for fresh air. The Functional Abilities and Goals assessment showed the resident required a wheelchair and walker, substantial/maximum staff assistance to complete Activities of Daily Living (ADL), mobility functions, and to wheel a wheelchair. Walking was not assessed due to her medical condition/safety concerns. The resident was incontinent of bladder and bowel functions, short of breath with exertion or lying flat, did not have a history of falls within the previous 6 months of admission, nor since admission or during the assessment period. The assessment indicated a Care Area was triggered for an identified problem of Falls. Review of the Lifestyle & Activity Preferences Evaluation dated 7/24/24 noted resident #1 had impaired hearing, required glasses, needed reminders for activity participation, and needed assistance to/from activity settings with wheelchair mobility. On 10/13/24 at 12:10 AM, resident #1 was observed sitting in a wheelchair at the end of the nursing unit hallway looking out the windows into the parking lot. Licensed Practical Nurse (LPN) U was nearby and explained the resident had poor cognition; was confused and enjoyed the sun. Review of Unscored Fall Risk Evaluations completed on 9/05/24 and 9/14/24 noted nurses assessed resident #1's Safety Awareness/Behavior with a lack of understanding of cognitive functions and altered awareness of physical environment. The evaluation completed 9/15/24 noted additional risks had developed related to Safety Awareness/Behaviors with lack of understanding of physical limitations, including anxiety and restlessness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	On 10/15/24 at 11:05 AM, resident #1 was observed lying awake in bed in her room. The resident's right lower leg was hanging off the side of the bed. Faded, healing bruises were observed under her eyes and a half inch partially healed laceration was visible near the bridge of her nose. Resident #1 was not able to answer basic questions appropriately. Review of the facility's September and October 2024 Fall Logs revealed before resident #1 fell on [DATE], she had 4 previous falls on 9/05/24, twice on 9/13/24, and again on 9/15/24. In an interview on 10/14/24 at 3:26 PM, the Director of Nursing (DON) confirmed none of the falls before the fall incident on 10/05/24 were witnessed by staff. A nurse's Progress Note completed by the Unit Manager (UM) showed that on 9/05/24, a Certified Nursing Assistant (CNA) observed resident #1 on the floor of her room, bleeding from the back of her head. A Physical Medicine And Rehabilitation Progress Note dated 9/05/24 read, . (resident #1) reports falling but does not remember how. She states she does have some pain to her head. Nurse reports patient attempted to transfer herself this morning and subsequently fell in the process. Nurse reports patient is at baseline with confusion and neurochecks and vital signs had been normal. Patient had a head laceration that was bleeding. I asked patient if she would like Tylenol, she initially stated no that she has a high pain tolerance but when asked again she said yes. Psych: Alert oriented to person only.Falls: Risk of complication: HIGH . PT (Physical Therapy)/OT (Occupational Therapy) to assess balance/gait and recommended to improve balance/coordination, and strength. Fall precautions optimized per facility. On 10/15/24 at 10:50 AM, CNA J explained she knew resident #1 well and sometimes had her on assignment. The CNA said resident #1 often attempted to get out the wheelchair to stand up on her own, she enjoyed being near the windows with sunlight, and CNAs monitored the resident in common areas or the television viewing area. She described frequent checks as, whenever I'm done and making sure they're okay. The CNA said she was not ever directed to check on resident #1 within specific timeframes. She described the resident as impulsive and could get up from her wheelchair very quickly and it was difficult to monitor her all the time. She explained they could be attending to another resident for more than 20 minutes at one time and staff needed to watch the resident closely to make sure she was not trying to go outside alone. Review of a SBAR (Situation-Background-Assessment-Recommendation) form completed by LPN A documented resident #1 fell on [DATE] and had a facial laceration with altered level of consciousness that required emergency 911 transport to the hospital. The Hospital Transfer Form noted the resident was combative and confused, and was high fall risk. On 10/14/24 at 11:17 AM, CNA F recalled on 10/05/24 at approximately 1:00 PM, he returned lunch trays to the dining room and as he looked outside, he saw resident #1 alone across the courtyard on the patio getting out of her wheelchair. He explained he ran outside and across the courtyard to help, but by the time he reached her, she was lying on the ground face first. He said resident #1 had blood on her face and swelling on her head. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	On 10/14/24 at 10:44 AM, CNA G said she frequently had resident #1 on her assignment. The CNA recalled she was working on 10/05/24, the day the resident fell outside. She said staff knew the resident was a high fall risk and they had to keep a very close eye on her because she liked to go outside for sunshine and frequently tried to go out the door unsupervised. She said she intercepted the resident multiple times over the past few months and prevented her from going out alone. The CNA explained resident #1 was not safe to be outside on her own. She described resident #1 used her feet to scoot in the wheelchair and could not go very far but she could open the door. She said on 10/05/24 after lunch, the resident was sitting in her wheelchair in the common area near the courtyard exit door when she told the CNA she wanted to go outside. The CNA said she told the resident she would return to go out with her as soon as she could, after she assisted other residents. The CNA explained, she assisted another resident in a room with lunch and was later alerted by another CNA that resident #1 was outside on the ground. She said CNAs were unable to monitor the resident closely while they assisted other residents with meals and incontinence care because she was very quick. The CNA explained frequent checks were supposed to be every 15 minutes or as often as possible. She said CNAs did not have written documentation for residents who were at high risk for falls and that it was communicated to each other verbally, we all just know. In a telephone interview with LPN A on 10/13/24 at 3:53 PM, she explained resident #1 was frequently included in her assignments and knew her well. She recalled on 10/05/24 at approximately 1:00 PM, she was alerted by CNAs the resident had fallen outside on the patio, face down on the ground. She said she assessed the resident and found her to be more disoriented than normal. She was bleeding from her nose and face with a large bump on her forehead. The LPN said she was very concerned the resident may have a serious head injury and she contacted Advanced Practice Registered Nurse (APRN) L for orders to send her out to the hospital. She said the APRN was hesitant to send the resident out because she wasn't on blood thinner medication and the Health Care Surrogate (HCS) didn't want her to go out to the hospital. The LPN said she was unable to reach the HCS and then successfully reached another Emergency Contact who consented to the transfer. She said the resident was transported to the hospital by emergency personnel. On 10/14/24 at 1:04 PM, Personal Care Assistant (PCA) B said she knew resident #1 well. The PCA said the resident enjoyed being outside and often wandered. The PCA explained the resident previously had someone with her at all times doing one to one supervision but that had stopped a few weeks ago. She said after the one to one supervision stopped, resident #1 had many falls. She recalled on 10/05/24, the day the resident fell , she was assigned to resident #1 during the day shift. She explained that from 11:30 AM to 1:00 PM, she was assigned to be in the dining room to assist with lunch and was unable to monitor the resident. The PCA explained staff were often occupied in a room for extended periods with other residents for meal assistance, incontinence care, and showers and could not always monitor resident #1 closely. She recalled when she returned to the unit after dining room duties, the resident was outside on the concrete, flat on her face. The PCA stated, I don't know what we can do for her if she doesn't have that one on one supervision. On 10/14/24 at 1:15 PM, the long term care UM stated nurses delegated to CNAs and let them know verbally when residents were on frequent checks. She explained, frequent checks normally meant about every 15 minutes. The Unit Manager stated, she (resident #1) likes to sit outside, she is very confused, and she will try to open the door and go out when she's on the unit; she doesn't remember she can't walk; no, she is not safe to sit outside by herself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	Review of the Comprehensive Care Plan documented undated Special Instructions that read, Staff to escort resident for safety to the courtyard. A focus initiated on 7/15/24 read, The resident has impaired cognitive function/impaired thought processes r/t [related to] diagnosis of dementia. Interventions initiated on 7/15/24 noted nurses were expected to notify the physician of any changes in the resident's condition, and communicate concerns with family/caregivers about confusion, and the resident's capabilities or needs. A focus initiated 9/19/24 read, The resident has a history of exhibiting the following behaviors: Chronic/frequent refusals of care and/or services, Impulsivity, Resists care, Verbal aggression. In an interview on 10/14/24 at 2:23 PM, the Regional Nurse Consultant checked resident #1's records and acknowledged the care plan Special Instructions for staff to escort the resident to the courtyard were undated. She confirmed the entry was added to the care plan after the resident fell on [DATE], but she could not locate any date/time stamp entry history for it in the Electronic Health Record (EHR). Review of a Care Plan focus initiated 7/17/24 and revised 9/16/24 read, The resident is at risk for falls R/T Unsteady Gait/Poor Balance, Use of antihypertensive medications, Use of psychotropic medications, Hx [history] of falls. The care plan goal was for the resident's potential for sustaining a fall-related injury would be minimized by utilizing fall precautions/interventions through next review date. On 9/06/24, an intervention was initiated to offer the resident assistance with toileting before and after meals. On 9/16/24 interventions initiated included a non-slip mat applied to the wheelchair, floor mats, offer and assist to common areas while awake and as tolerated, and a scoop mattress. There were no interventions in place before resident #1's fall on 10/05/24 that specified increased supervision or the frequency of any supervision by staff. A Progress Note entered by LPN I on 10/05/24 at 10:04 PM, documented after resident #1 was treated at the hospital emergency room (ER), she returned to the facility on a stretcher with two attendants. The nurse noted facial bruising and swelling, and orders for antibiotic medications for a urinary tract infection (UTI). A Progress Note entered by LPN I on 10/06/24 at 8:14 AM, noted the physician was notified the resident had returned from the hospital the previous day with findings of a UTI with antibiotic medication orders. A Progress Note entered by the Assistant DON on 10/07/24 indicated the interdisciplinary Team reviewed resident #1's fall incident that occurred at approximately 4:45 PM the resident was observed lying on the ground with a laceration to the facial area an swelling of the forehead. The note revealed first aid was performed, and the family and physician were notified. Treatment to the skin alterations were in place, neurological checks and the care plan was reviewed and updated. Review of the Electronic Health Record (EHR) revealed no neurological evaluations/assessments were completed by nurses after the resident returned from the hospital on 10/05/24. On 10/16/24 at 12:51 PM, the DON checked resident #1's medical record and acknowledged nurses did not complete neurological (neuro) checks after the fall on 10/05/24. The DON stated, there wouldn't be a reason for them not to do neuro checks after the fall; they should do them. Review of the hospital's Emergency physician's discharge note dated 10/05/24 revealed the resident sustained a closed nondisplaced nasal fracture. The CT scan showed possible nasal fracture. On 10/14/24 at 12:09 PM, the DON said the Assistant DON was not available for interview. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	Review of the Safety Interventions Record reports from July through October 2024 revealed no record of any entries for instructions or interventions for fall prevention. The CNA Kardex with print date 10/14/24 indicated resident #1 required two staff for transfers with a mechanical lift as she was dependent and unable to assist. Under the section for Behavior/Mood it was noted if the resident had behavior issues, CNAs were expected to remove her from the situation and take her to an alternate location. The form read, Special Instructions: Staff to escort resident for safety to the courtyard . SAFETY . Encourage and remind resident to use CALL BELL and to wait for staff assistance with transfers, ambulation, toileting, etc. Encourage resident to only go out with staff family supervision. Offer and assist to common areas while awake as tolerated. The Physical Therapy (PT) Evaluation & Plan of Treatment report dated 7/14/24 indicated the reason for referral was due to new onset of decrease in functional mobility, decrease in strength, reduced dynamic balance and increased need for assistance from others. The Evaluation indicated resident #1 had precautions due to falls and Confusion. The document revealed patient behaviors required consistent supervision, and had worsening of cognitive impairment and changes. On 9/18/24 at 8:49 AM, additional precautions section was changed from one to one supervision required for falls and confusion to only falls and confusion, modified by the Therapy Director. The Occupational Therapy Progress Report dated 9/21/24 read, . Remaining impairments: Patient continues with deficits in standing balance/tolerance, general strength and cognition . The PT Treatment Encounter Note dated 10/04/24 was similar and read, . Precautions: (falls) and Confusion . with no mention of the previous required supervision from 7/14/24. On 10/15/24 at 10:43 AM, the Therapy Director said he participated in daily clinical meetings where fall management and interventions were discussed. He said resident #1 received ongoing PT and OT services since she was admitted [DATE]. He recalled the resident had multiple falls and therapy implemented wheelchair interventions and continued services for fall risk prevention to improve ADL self-care functions, balance, strength, and gait (walking). He did not recall clinical discussions to increase supervision for the resident. He stated therapy services included treatments and adaptive equipment, and did not include or provide increased supervision interventions outside of therapy sessions. On 10/15/24 at 10:39 AM, LPN H said when the resident was admitted to the facility, her family paid for one on one supervision, and she did well. She explained the private aide took her outside as resident #1 enjoyed it and it seemed to make her calmer. She said after the private supervision stopped, facility nurses and CNAs were expected to do frequent checks on resident #1 which meant every 15 minutes. The LPN said nurses were concerned the resident had multiple falls, after the one to one supervision was removed. She said several nurses informed management who responded that nurses' concerns were discussed in clinical meetings, but resident #1's supervision was never increased. The LPN recalled the resident was never safe to go outside to the courtyard patio alone before or after she fell outside. She said it was difficult for nurses to monitor up to 33 residents at a time and also constantly watch resident #1. She said in the past, the facility placed other residents on one to one when needed, but not resident #1. She stated, after she came off the private one to one, we could see why she needed it; she was restless; I would take her outside when I could, but I couldn't even chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	On 10/16/24 at 2:25 PM, LPN E said frequent checks meant every 15 to 30 minutes. She said residents who were not safe to be outside alone needed staff present to make sure they didn't fall. She explained nurses voiced their opinions about residents' needs for increased supervision and/or fall risks to the Unit Managers, and they relayed the concerns to management. She conveyed it was unrealistic for nurses to frequently check and watch residents with dementia, poor safety awareness, and impulsivity who tried to walk or get up on their own as well as being responsible for other multiple residents at the same time. The LPN stated, it's difficult for us to keep them safe and it's hard to get them management) to put them on one to one. On 10/15/24 at 2:36 PM, LPN I explained, resident #1 was a super high fall risk and when the resident was admitted , she needed to be watched constantly and had a 24-hour sitter that helped to keep her calmer. The LPN said she tried to check on resident #1 every 15 minutes, but she was really fast and didn't understand even when staff tried to reorient her. The LPN stated, she tried to self-transfer, get up and walk. The LPN conveyed, that many nurses inquired with management about the resident's high fall risk because they struggled to keep her redirected and busy to avoid falling. The LPN stated, when the sitter went away, we saw why she needed one to one; the CNAs cannot constantly watch her. On 10/15/24 at 2:08 PM, CNA F explained resident #1 was very impulsive, sometimes combative, and tried to move around all the time. The CNA expressed staff often were not able to closely observe resident #1 and take care of other residents at the same time. The CNA stated, it was known not to put her outside by herself; she's pretty quick. On 10/15/24 at 3:16 PM, LPN A said she struggled to keep a close eye on resident #1 because she had poor safety awareness and was impulsive. The LPN explained she tried to be creative and redirect the resident while she passed medications to other residents by keeping her busy and distracted at the medication cart. She recalled on 10/05/24, CNA G took the resident outside before lunch time until the CNA was occupied and assigned to assist other residents in their rooms with meals. The LPN recalled at about 1:00 PM, CNAs alerted her the resident was outside on the ground. She said the resident was at the hospital for the remainder of her shift that ended at 7:00 PM. She said she returned the next day for the day shift and received report from LPN I who said resident #1 had a UTI with prescriptions. The LPN said all the nurses thought the resident should go back on 1:1 and stated, even if you take your eyes off her for 5 minutes it can be a disaster; she is confused and can get up again. Review of Progress Notes documented by the Psychiatric Nurse Practitioner on 9/11/24 read, . Mood is labile. She is agitated. Nursing staff report she's had increased behaviors since her private duty nurse was discontinued by the patient's POA (power of attorney). She had a recent fall due to impulsive behaviors and trying to self-transfer. She is confused and reports not knowing what is going on. She enjoys sitting outside in the sun and eating in the dining room. Appearance/Behaviors: Sitting in the common area restless . Thought process: Somewhat disorganized . Thought association: Somewhat loose . Insight and Judgement: Impaired . Recall/Short-term memory: Impaired . Attention span/Concentration: Impaired . Fund of knowledge: Impaired . The Psychiatry Subsequent Note dated 9/20/24 read, . Mood is, trapped. Nursing staff report the patient remains anxious and restless. She is impulsive and gets up without asking for help . She reports feeling trapped in the facility . As per collected information and interview, it appears that patient is unstable. I feel the symptoms are occurring due to exacerbation of underlying anxiety disorder. They symptoms are occurring almost daily and causing severe distress . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	In a telephone interview on 10/13/24 at 4:05 PM, resident #1's POA explained she was responsible for the resident's financial affairs. The POA recalled when resident #1 was admitted to the facility in July 2024, she had 24-hour 1:1 supervision paid for by the resident because the Healthcare Surrogate (HCS) was concerned she would fall and be seriously injured, she was very impulsive and had very bad dementia. She stated the resident paid 1:1 service was discontinued after a couple of months because it was very expensive, and the resident could no longer afford it. On 10/16/24 at 10:05 AM in a telephone interview, resident #1's Emergency Contact Representative explained the resident was never safe to be outside in the courtyard alone. She said the resident was placed on private duty supervision at her own expense because the HCS feared she would fall and be seriously hurt. She said the resident was very impulsive and she stood up on her own while in the wheelchair. She said the private supervision stopped for financial reasons and she worried after that because the resident started to have falls and stated, they (facility) don't provide 1:1 service. On 10/16/24 at 10:54 AM in a telephone interview, resident #1's HCS recalled she was worried the resident would fall and get seriously hurt at the facility without 1:1 supervision, so she requested the POA pay for the services on behalf of the resident. She explained she was especially worried and concerned when the resident started having multiple falls in September 2024, after the individual supervision stopped. She said after the resident fell on [DATE], the facility did not provide her with any updates and she found out from the hospital later that the resident had a nasal fracture. She said the facility told her they didn't have staff to provide 1:1 supervision and stated, she started falling when the one on one went away. Review of APRN L's Nursing Home Visit Encounter dated 10/07/24 read, . weakness, had a fall out of her wheelchair over the WE (weekend). Sent to ER, no sutures required and sent back to the facility . bruises to both eyes, forehead and abrasion to her nose and forehead. The note did not mention resident #1 sustained a nondisplaced nasal fracture. On 10/16/24, two unsuccessful attempts were made to contact APRN L by telephone. On 10/15/24 at 2:36 PM in a telephone interview, LPN I said she frequently had resident #1 on her assignment. She recalled on 10/05/24 during the 7:00 PM to 7:00 AM shift, the resident returned to the facility by stretcher from the hospital. She recalled 2 transportation attendants accompanied the resident with the hospital discharge packet. She said the discharge packet included new prescriptions for UTI, and she contacted the on call APRN for orders. The LPN explained the records contained lab results, a chest X-ray, and CT of the head and stated, she had a lot of stuff; I didn't read the scans in-depth; when they dropped her off, they said she had no fractures. On 10/16/24 at 9:20 AM, the Long Term Care Unit Manager explained all resident falls and interventions/revisions of care were discussed in morning clinical meetings where she participated. She said resident #1 was on frequent checks and the 1:1 status was removed by the family for financial reasons. She said on 10/07/24, a Monday, she discussed what happened with APRN L who saw and assessed her. She said CNAs were expected to check on residents with frequent checks in between patient care and stated, we know she's a fall risk so everybody on the unit that works frequently check on her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	On 10/16/24 at 2:17 PM, the DON explained the facility had a Falling Leaf Program to alert staff of residents who were high fall risk. She said the program consisted of a green magnet placed on the residents door to alert staff and it was intended to bring increased awareness. The DON said the facility did not have written standards and guidelines for the program and stated, we didn't consider putting her on the 1:1; she's (resident #1) on the Falling Leaf Program; it's to keep eyes on them; we review her in the clinical meetings. On 10/16/24 at 12:51 PM, the DON explained the facility reviewed all resident emergency visits for orders and test results every weekday morning during clinical meetings. She recalled the resident's fall and ER visit was discussed, on 10/07/24, and the Unit Manager reported the resident had a UTI and was prescribed antibiotic medications. She checked the hospital ER discharge records and said she was not aware resident #1 had sustained a nasal fracture. The DON stated, I didn't know we had this; I would say that the hospital didn't send it; she should be monitored for the fracture. On 10/16/24 at 1:00 PM, the DON explained when staff had concerns about any resident's behavior or safety, they reported it to the Unit Manager who communicated the information to the Interdisciplinary Team (IDT) in morning meetings. She said the team was aware resident #1 was a high fall risk and she was placed on the Falling Leaf Program with a magnet on her door after she started falling in September. Review of resident #1's Comprehensive Care Plan, Kardex for CNAs, and Safety Interventions Records revealed no Falling Leaf Program nor Frequent Checks were added to the plan of care since the resident was admitted to the facility on [DATE], for three months. On 10/16/24 at 2:17 PM, the NHA conveyed resident #1 was not considered for facility provided 1:1 supervision and stated, she's on the Falling Leaf Program; it's to keep eyes on them; we review her and any resident in the clinical meetings. On 10/16/24 at 2:30 PM, LPN E referred to the Falling Leaf Program and stated, it's something about guardian angel or something like that. The LPN could not accurately explain what the facility's high risk fall program was. On 10/16/24 at 2:34 PM, CNA P explained the magnet on the door to designate a leaf was to check the room when it's cleared for a fire. PCA Q stated, I think you're right; I've seen them. We check the room then we put it there. The CNA nor the PCA had knowledge of the facility's Falling Leaf Program for residents with high fall risk. In a telephone interview on 10/16/24 at 9:53 AM, MD M said he was aware resident #1 fell on [DATE], he previously reviewed the hospital records, and recalled she had a UTI. The MD explained he expected APRN L to review hospital ER records and test results as part of the assessment. At 1:42 PM, MD M said he was unaware resident #1 had sustained a nasal fracture. He explained he expected nurses to monitor residents for complications of fractures and stated, any head injury we always want to keep an eye on it after they come back from the ER and if they complain of pain we jump on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 - Actual harm Residents Affected - Few	A written statement provided by MD M dated 10/15/24 read, . I completed a case study on resident (#1) related to her fall on 10/05/24. After review of chart including but not limited to: hospital records, BIMS assessment, care plan, activity preferences, psych notes, prior falls, etc. The facility followed residents plan of care and resident preferences and resident was adequately supervised based on the investigation review including statements. On 10/16/24 at 12:36 PM in a telephone interview the Medical Director said he expected nurses to notify the physician of ER findings and test results. He said he expected nurses to monitor residents with fractures and stated, they must do neuro checks if it's a head injury. Review of the Facility assessment dated [DATE] read, . Mobility and fall/fall risk with injury prevention Transfers, ambulation, restorative nursing, falling leaf program for high fall risk residents, supporting resident independence in doing as much of these activities by himself/herself. With consistent assignments in person-centered care, staff and management place value on a stable team of individuals committed to knowing the resident and building care on a foundation of relationships. Staff, as well as residents and families benefit, as they get to know and depend on one another to work fluidly and flexibly support the unique strengths of each elder: .Routine tasks are assigned by the appropriate manager based upon demonstrated knowledge, skills and abilities per shift and needs of the facility/resident. When requirements are identified that overlap departments, the manager that identifies a shortfall will address the concern with the interdisciplinary team toward establishing a process. Managers are expected to closely monitor any changes in processes or procedures to maintain a positive culture for our staff and residents. A nasal fracture is a break in the bone or cartilage over the bridge, or in the sidewall or septum (structure that divides the nostrils) of the nose. Serious nose injuries cause problems that need a health care provider's attention right away. For example, damage to the cartilage can cause a collection of blood to form inside the nose. If this blood is not drained right away, it can cause an abscess or a permanent deformity that blocks the nose. It may lead to tissue death and cause the nose to collapse. Sometimes, surgery may be needed to correct a nose or septum that has been bent out of shape by an injury. A doctor may be able to return nasal bones that have moved out of place back to their normal position within the first 2 weeks after the break. (retrieved on 10/17/24 from www.medlineplus.gov). Review of the facility's standards and guidelines dated February 2024 and titled Falls-Managing, Preventing, and Documentation read. Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling. <[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for administration had a complete and readily accessible medical record, of a total sample of 4 residents, (#1). Findings: Review of the medical record revealed resident #1, an [AGE] year old female was admitted to the facility from an acute care hospital on 7/12/24 with diagnoses including acute respiratory failure, sepsis (blood infection), primary thrombocytopenia (slow blood clotting), urinary tract infection (UTI), muscle weakness, dementia with behavioral disturbance, need for assistance with personal care, and difficulty in walking. On 10/15/24 at 10:39 AM, Licensed Practical Nurse (LPN) H said nurses reviewed residents' (emergency room) ER and hospital records to implement follow up needs, alert physicians, and obtain orders. The LPN explained hospital records were placed in an upload bin at the nurse's station for Medical Records personnel to scan to the electronic health record (EHR). On 10/15/24 at 2:36 PM, in a telephone interview, LPN I recalled on 10/05/24 during the 7:00 PM to 7:00 AM shift, resident #1 returned to the facility by stretcher from the hospital. She said two transportation attendants accompanied the resident with the hospital discharge packet/documents. The LPN explained, she placed the packet in a drawer at the nurse's station. LPN I said the hospital ER discharge packet included two prescriptions for UTI, laboratory blood results, chest X-ray results, and CT of the head results. The LPN stated, she had a lot of stuff and a plethora of labs; I didn't read the scans in-depth; when they dropped her off, they said she had no fractures. On 10/16/24 at 9:20 AM, the Long Term Care Unit Manager explained all resident ER findings were discussed in morning meetings so care needs/revisions could be implemented. The Unit Manager said she could not recall if she brought the resident's hospital discharge packet to the meeting however she did remember the resident had a UTI with prescriptions. The Unit Manager did not mention any hospital results for a nasal fracture. On 10/16/24 at 10:54 AM, in a telephone interview, resident #1's Health Care Surrogate (HCS) recalled after resident #1 fell on [DATE], the facility did not provide her with any updates and after the resident returned to the facility, she found out from the hospital physician the resident had a nasal fracture. She said she worked at the hospital and the ER discharge records were always faxed to the facility's Admissions office. On 10/14/24 at 10:30 AM, the Medical Records Clerk said she was responsible for retrieving ER and hospital records from the nursing units to scan to the EHR. She said there were no unscanned records in her office and confirmed resident #1's ER/hospital records from 10/05/24 were not scanned into the EHR and said she would try and locate it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 1:15 PM, the Long Term Care Unit Manager explained, nurses needed ER records to review resident follow up needs and provide physician notifications. She said after processing, nurses placed the documents in a bin at the nurse's station for Medical Records, who picked them up daily to scan to EHRs. By the end of the day on 10/14/24 (the second day of the survey), the facility had still not provided the requested hospital records from resident #1's visit on 10/05/24. On 10/15/24 at 12:13 PM, the Director of Nursing (DON) confirmed the facility was unable to locate resident #1's hospital ER discharge records from 10/05/24. She presented some of the records was unable to provide the complete discharge record. She could not explain why the original records were missing. Review of resident #1's hospital ER treatment and discharge notes revealed on 10/05/24, resident #1 sustained a fall with a head injury and required emergency transport to the hospital. While at the hospital, the resident received emergency physician assessments, monitoring, treatment, diagnostic laboratory blood work, prescription medication orders, and Computed Tomography (CT) imaging. The paperwork revealed the CT scan found a possible nondisplaced nasal fracture, and the ER physician noted the closed nasal fracture. Review of Advanced Practice Registered Nurse (APRN) L's Nursing Home Visit Encounter dated 10/07/24 revealed resident #1 had a fall out of her wheelchair, was sent to the ER, and sent back to the facility. Her documentation described the resident had bruises to both eyes, and her forehead, and an abrasion to her nose and forehead. The note contained no mention resident #1 sustained a possible nondisplaced nasal fracture. On 10/16/24, two attempts were made to contact APRN L by telephone. On 10/16/24 at 8:36 AM, the DON explained residents' hospital discharge records and instructions were reviewed every morning in clinical meetings. The DON referred to resident #1's 10/05/24 records and stated, now the records are missing. On 10/16/24 at 9:20 AM, the Long Term Unit Manager explained the Interdisciplinary Team (IDT) discussed resident ER visits and new admissions in morning clinical meetings. She acknowledged hospital records were reviewed to ensure follow up and coordinate any changes to plans of care. She recalled she returned to work on Monday, 10/07/24 and attended the morning meeting where resident #1's fall and ER visit was discussed. She recalled the resident had a UTI with prescriptions and the weekend nurse had entered the medication orders. She confirmed the hospital discharge notes couldn't be located and stated, we didn't have the packet; I believe MDS [Minimum Data Set Coordinator] requested the records. On 10/16/24 at 9:39 AM, the MDS Coordinator explained she completed MDS assessments which required a complete medical record including hospital/ER notes and reports in order ensure accuracy. She stated, if any additional or missing information was needed, I do have e-fax or I can fax a request. The MDS Coordinator said no one had asked her to request resident #1's 10/05/24 ER notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 11:15 AM, the Director of Marketing said the hospital normally sent resident ER hospital records to the Admissions Department. She confirmed no one from the facility requested resident #1's 10/05/24 ER records from her. On 10/16/24 at 10:00 AM, the Medical Records Clerk said she cleared the nursing unit baskets every day and collected records to scan to the EHR. She said she knew the clinical providers needed all the records to accurately assess the resident. A short time later at 10:30 AM, the Medical Records Clerk said resident #1's medical record was incomplete and confirmed no one asked her to follow up and locate the missing records before the surveyor requested them on 10/14/24. On 10/16/24 at 12:51 PM, the DON said Unit Managers brought ER records and results to morning meetings and the records were reviewed by the clinical team. She recalled resident #1's ER visit was discussed and there were two prescriptions for UTI. The DON said it was important to have all the ER records in a timely manner for clinical review. The DON reviewed the hospital documents provided by the facility on 10/15/24 and acknowledged the CT showed a possible nasal fracture. She confirmed she had not been aware of the fracture and stated, she (resident #1) should be monitored for the fracture; I don't know that we had this; I would say the hospital didn't send it. A written statement provided by attending physician M dated 10/15/24 revealed he had completed a case study on resident #1 related to her fall on 10/05/24. He indicated he reviewed her chart including but not limited to the hospital records, care plan, activity preferences, prior falls, etc. In a telephone interview on 10/16/24 at 9:53 AM, attending physician M confirmed he was aware resident #1 fell on [DATE], and recalled she had a UTI. The physician explained he expected providers to review hospital ER records and test results as part of the assessment. The physician said he thought the resident had a headache and acknowledged he reviewed and signed APRN L's progress note on 10/15/24. In a second interview later that day at 1:42 PM, attending physician M said he had been unaware resident #1 had sustained a nasal fracture. The physician explained he expected nurses to monitor residents for complications of fractures and stated, any head injury we always want to keep an eye on it after they come back from the ER and if they complain of pain we jump on it. On 10/16/24 at 12:36 PM, in a telephone interview, the Medical Director said he expected nurses to notify the physician of ER findings and test results. He said he had hospital record electronic access but MD M did not have direct access to the hospital's EHR system as he did not see patients in the hospital. The Medical Director conveyed all clinical records were needed to properly assess a resident and he expected nurses to notify the doctor and monitor residents with fractures. Review of the undated Facility Assessment revealed the Medical Records Clerk was responsible for the organization and completeness of patient medical records.