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	09/09/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106123	A. Building B. Wing	09/09/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to provide a written discharge summary and list of medications for 1 of 2 residents reviewed for discharge status, of a total sample of 7 residents, (#2).Findings: Cross Reference F842 Review of resident #2's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including nontraumatic subacute subdural hemorrhage (brain bleed), chronic obstructive pulmonary disease, type 2 diabetes, repeated falls, speech and language deficits, abnormalities of gait and mobility, and difficulty walking. Review of resident #2's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 5/11/25 revealed a Brief Interview for Mental Status score of 15/15 indicating intact cognition. The MDS assessment showed the resident participated in the assessment, and there was an active discharge plan for return to the community. The assessment also reflected a referral to a Local Contact Agency had not been made because the discharge date was three or fewer months away. Review of the Discharge MDS assessment with ARD of 7/06/25 revealed a planned discharge home, return not anticipated. Review of resident #2's comprehensive care plan showed a focus for discharge to the community, initiated on 11/15/24 and resolved on 3/08/25. A new plan was initiated on 3/08/25 and read, The resident chooses to remain in this facility for long term care services. The care plan was closed on 7/15/25 after his discharge. Review of resident #2's medical record revealed a Discharge Summary form with an effective date of 7/06/25 at 11:06 (time of day was not specified). The Summary of Stay section indicated the resident was discharged home with his spouse and mother-in-law. The resident status was listed as long term care. Several sections of the discharge form were left blank or unanswered, including Skin Evaluation, Treatments, Cognitive/Psychosocial, ADLs (Activities of Daily Living)/Functional Status, Sensory, Dietary, Rehabilitation Services, and Education/Acknowledgement. The Instructions After Discharge section was only partially completed. The Medications and Treatments questions were unanswered. The form instructed staff to **ATTACH COPY OF MEDICATION LIST**, enter pharmacy details, and document whether scripts were provided. These were not addressed and were left unanswered. There was no evidence in the record that a copy of the Discharge Summary was given to resident #2, nor was it signed by the resident or staff. There was also no evidence of a medication reconciliation or confirmation that medications were provided upon discharge. Review of resident #2's physician orders revealed an order dated 7/07/25, which read, Discharge patient home with home health PT/OT (Physical Therapy/Occupational Therapy) and Nursing. Review of June 2025 and July 2025 Progress Notes did not reveal any entries regarding discharge planning. No documentation was found regarding education provided, disposition of medications, or scripts issued when the resident left. Review of the July 2025 Medication Administration Record (MAR) revealed medications scheduled for 9:00 PM were not given, with code 3 (out of pass) listed as the reason. Review of resident #2's Release of Responsibility for Leave of Absence Resident Sign Out Sheet revealed no entries in July 2025. Attempts to contact resident #2 by telephone on 9/08/25 and 9/09/25 by the survey team were unsuccessful. On 9/08/25 at 1:38 PM, in a telephone interview, resident #2's sister, listed in the medical record as the Health Care Surrogate, Power of Attorney (POA), and emergency contact for resident #1, confirmed her brother was discharged home on 7/06/25 but said she was not notified in advance. She shared she received a call from the facility afterward informing her the resident was no longer at the facility. On 9/08/25 at 8:15 PM, in a telephone interview, Certified Nursing Assistant (CNA) A shared she previously worked for the facility from March 2024 to August 2025. She recalled resident #2 was mostly independent. She acknowledged working some weekends and shared she did not see any visitors with resident #2 when she was assigned to his care. CNA A stated she did not assist, nor did she observe resident #2 packing his belongings or him leaving the facility during her 7 AM to 3 PM shift on Sunday, 7/06/25. On 9/09/25 at 1:48 PM, in a telephone interview, Licensed Practical Nurse (LPN) B stated she resigned mid-August 2025 and was assigned to resident #2's unit once or twice. She indicated she did not discharge anyone during her shift on Sunday 7/06/25. She explained she would have entered a progress note in the medical record if she discharged a resident. She did not recall any residents leaving for any reason that day. She stated no one from the facility had inquired about the care of resident #2 on Sunday 7/06/25 or afterwards. On 9/08/25 at 3:43 PM, 9/08/25 at 8:36 PM, and 9/09/25 at 10:39 AM, attempts were made to contact LPN C, who was assigned to resident #2 from 7 AM to 7 PM on Sunday 7/06/25, unsuccessfully. No reply from LPN C was received. On 9/09/25 at 12:26 PM, the Social Services Assistant indicated the Social Services Director (SSD)

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	09/09/2025

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** Based on interview, and record review, the facility failed to accurately document the discharge plan and disposition in the medical record; and the Activities of Daily Living (ADLs) for 1 of 2 residents reviewed for discharge status and ADLs, of a total sample of 7 residents, (#2). Findings:Cross Reference F628 Review of resident #2's medical record revealed he was readmitted to the facility on [DATE] with diagnoses including nontraumatic subacute subdural hemorrhage (brain bleed), chronic obstructive pulmonary disease, type 2 diabetes, repeated falls, speech and language deficits, abnormalities of gait and mobility, and difficulty walking. Review of resident #2's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 5/11/25 revealed the resident participated in the assessment, and there was an active discharge plan for return to the community. Review of the Discharge MDS assessment with ARD of 7/06/25 revealed a planned discharge home, return not anticipated. Review of resident #2's medical record revealed a Discharge Summary form with an effective date of 7/06/25 at 11:06 (time of day was not specified). The Summary of Stay section indicated the resident was discharged home with his spouse and mother-in-law. The resident status was listed as long term care. Several sections of the discharge form were left blank or unanswered, including Skin Evaluation, Treatments, Cognitive/Psychosocial, ADLs (Activities of Daily Living)/Functional Status, Sensory, Dietary, Rehabilitation Services, and Education/Acknowledgement. The Instructions After Discharge section was only partially completed. The Medications and Treatments questions were unanswered. The form instructed staff to **ATTACH COPY OF MEDICATION LIST**, enter pharmacy details, and document whether scripts were provided. These were not addressed and not documented. There was no evidence in the record that a copy of the Discharge Summary was given to resident #2, nor was it signed by the resident or staff. There was also no evidence of a medication reconciliation or confirmation that medications were provided upon discharge. Review of resident #2's physician orders revealed an order dated 7/07/25 and read, Discharge patient home with home health PT/OT (Physical Therapy/Occupational Therapy) and Nursing. Review of June and July 2025 Progress Notes did not reveal any entries regarding discharge planning. No documentation was found regarding education provided, disposition of medications, or scripts issued when the resident left. Review of resident #2's Documentation Survey Report for June 2025 and July 2025, which showed ADL tasks such as dressing, personal hygiene, bladder and bowel, eating and fluids documented by the Certified Nursing Assistant (CNAs) were left blank on the following shifts: 7 AM to 3 PM - 6/5, 6/7, 6/8, 6/9, 6/11, 6/12, 6/13, 6/17, 6/21, 6/22, 6/23, 6/25, 6/27, 6/28, 6/29, 7/3, 7/4, 7/5, 7/6 3 PM - 11 PM - 6/7, 6/12, 6/14, 6/15, 6/19, 6/20. 6/21, 6/23, 6/25, 6/28, 6/29, 6/30, 7/2, 7/5, 7/6 11 PM - 7 AM - 6/5, 6/7, 6/9, 6/13, 6/14, 6/20, 6/21, 6/22, 6/26, 6/29, 6/30, 7/3, 7/4, 7/5, 7/6 On 9/09/25 at 12:44 PM, the Director of Nursing (DON) shared her expectation was that CNAs documented the care they provided to the residents prior to leaving the facility and as close as possible to the time the care was performed. She explained nurses were to document their assessments and progress notes before a resident left the facility. Later at 2:00 PM, the DON stated she was not working in the facility at the time but responded, I understand what you mean, in regard to the blanks in staff's documentation for resident #2. She acknowledged the Discharge Summary was incomplete and unsigned. Review of the facility's Medical Records policy and procedure revised in January 2024 read, Medical Records will be maintained within the facility per federal requirements.

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	09/09/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure implementation of policies to the extent of including thorough monitoring of previously identified areas of concern and adequately tracking performance to ensure prior improvement measures were realized and sustained. Findings: Review of the facility's Quality Assurance and Performance Improvement (QAPI) Program policy, undated revealed objectives which included to Establish systems through which to monitor and evaluate corrective actions. The Implementation section described the process in which the QAPI plan identified and corrected deficiencies. The key components included developing and implementing corrective action or performance improvement activities and monitoring or evaluating the effectiveness of the corrective action, revising when necessary. The facility had deficiencies at F842 in complaint surveys conducted on 12/14/23 and 10/16/24 for non-compliance with the medical record and accuracy of documentation. Review of the Statement of Deficiencies and Plan of Correction form for the survey conducted on 12/14/23 revealed a Plan of Correction was completed on 1/19/24. The facility documented education to the nursing staff on the components of F842, resident records, and accuracy of documentation was performed. Review of the Statement of Deficiencies and Plan of Correction form for the survey conducted on 10/16/24 revealed a Plan of Correction was completed on 11/22/24. The facility again documented education was provided to the current nursing staff and newly hired nurses on the components of F842. The Plan of Correction indicated audits were to be performed until compliance was reached. During this survey, deficiencies were again identified at F842, for resident records and accuracy of documentation. As a result of the repeated citation, it was identified there was insufficient auditing and oversight by the QAPI team to prevent repeated deficiencies. On 9/09/24 at 5:15 PM, the Administrator (NHA) stated she had attended two QAPI meetings since starting to work in the facility in mid-July 2025. She explained during the QAPI meeting, they reviewed processes relevant to each department to ensure no deficiencies or concerns with deviations from their policy were identified. She indicated when issues were identified, they worked with their corporate team to develop and implement a Performance Improvement Plan. The NHA stated she was not aware of the previous deficiencies regarding medical records documentation.