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	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Viera Del Mar Health and Rehabilitation Center	2355 Vidina Drive Viera, FL 32940

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected prescribed medications for 1 of 2 residents reviewed for behaviors, of a total sample of 12 residents, (#2).Findings: Review of resident #2's medical record revealed she was readmitted to the facility from an acute care hospital on 8/20/25. Her diagnoses included multiple sclerosis, major depressive disorder, anxiety and seizures. Additional diagnoses of bipolar disorder, brief psychotic disorder, and psychosis were added after resident #2's readmission on [DATE]. Review of resident #2's significant change in status MDS assessment with an Assessment Reference Date (ARD) of 9/11/25 revealed she received high-risk medications classified as anticonvulsants and antibiotics during the 7-day look back period. Review of resident #2's medical record revealed physician's orders for Venlafaxine 150 milligrams (mg) daily for depression, Cephalexin 500 mg twice daily for urinary tract infection, Divalproex 250 mg every 12 hours for bipolar disorder, Haloperidol 5 mg twice daily for behavioral disorder, Lacosamide 200 mg twice daily for seizures, Lamotrigine 200 mg twice daily for seizures, Quetiapine 50 mg three times daily for psychosis, Seroquel 75 mg every eight hours for brief psychosis, and Oxycodone-Acetaminophen 5-325 mg every eight hours as needed (PRN) for non-acute pain. Review of the Medication Administration Report (MAR) for September 2025 revealed resident #2 received Venlafaxine, Cephalexin, Divalproex, and Lamotrigine from 9/07/25 to 9/11/25. She also received Haloperidol from 9/07/25 to 9/09/25, Lacosamide from 9/08/25 to 9/11/25, Quetiapine from 9/08/25 to 9/10/25, Seroquel on 9/10/25 and 9/11/25, and Oxycodone-Acetaminophen on 9/08/25. Review of Section N - Medications of the MDS assessment indicated the form required documentation of 11 drug classes by use and indication. The instructions directed staff to mark the box if the resident received medications within the pharmacological classification during the last seven days, or since admission or reentry if less than seven days. On 10/23/25 at 2:42 PM, the MDS Lead reviewed resident #2's significant change in status MDS assessment with an ARD of 9/11/25 alongside the September MAR. She confirmed section N should have included antipsychotic, antidepressant, and opioid medications. She explained MDS staff reviewed the MAR to determine which medications a residents received during the lookback period, using the Resident Assessment Instrument (RAI) as a guide. The MDS Lead stated the assessment was completed by a new MDS Coordinator and corporate audits were performed but only on a random basis. She acknowledged the expectation was for all MDS assessments to be accurate. Review of the facility's Comprehensive MDS Assessment and Care Plan policy, revised February 2024, revealed the facility would complete the comprehensive assessment using the RAI specified by the Centers for Medicare & Medicaid Services. The policy read, The facility will conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity initially and periodically.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. (continued on next page)

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F 0646 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 interview, and record review, the facility failed to ensure completion and accuracy of a Level I Preadmission Screening and Resident Review (PASARR) after a readmission for a resident diagnosed with a Serious Mental Illness (SMI), following a significant change in the resident's mental condition for 1 of 1 residents reviewed for PASARR from a total sample of 12 residents, (#2).Findings: Review of resident #2's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on 8/20/25. Her diagnoses included multiple sclerosis, major depressive disorder, anxiety and seizures. Additional diagnoses of bipolar disorder, brief psychotic disorder, and psychosis were added after resident #2's readmission on [DATE]. Review of resident #2's significant change in status Minimum Data Set (MDS) assessment with an Assessment Reference Date of 9/11/25 revealed a Brief Interview for Mental Status score of 15 out of 15 which, indicating intact cognition. The assessment documented a Mood Interview was conducted and no symptoms were identified. It also noted no rejection of care necessary to achieve health and well-being goals and no behavioral symptoms. The MDS assessment listed active diagnoses of anxiety, depression, bipolar, and psychotic disorder. Review of resident #2's Comprehensive Care Plan revealed a focus area initiated on 8/21/25 for a history of exhibiting behaviors. These included recent hallucinations/delusions, impulsivity, physical and verbal aggression, resisting care, crawling on the floor and in hallways, throwing objects when anxious or upset, chronic noncompliance with safety and medical interventions, refusal to wear clothing or briefs, socially inappropriate behaviors such as spitting and yelling. Another focus area showed mood instability, anxiety, bipolar disorder, depression, psychosis, and prior [NAME] Act (52-hour involuntary hold) with suicidal ideations. Review of the progress notes in the medical record revealed the following entries:*8/24/25 - Nurse documented resident #2 called 911 reporting seizures. Upon evaluation, no seizure activity was observed. Emergency Medical Services (EMS) responded, and despite the absence of seizure activity, the resident insisted on being transferred to the hospital and was transferred to the Emergency Room. *9/01/25 - Nurse documented the resident refused medications, food and drink. The Psychiatric Advanced Practice Registered Nurse (APRN) was notified and ordered Lorazepam and Haldol, along with one-on-one observation for safety. The resident continued exhibiting behaviors throughout the night, including removing clothes, and urinating and defecating in the room. The Psychiatric APRN was notified the medications were ineffective and issued an order for a [NAME] Act resident. The nurse notified the Director of Nursing (DON), the resident's husband, and called 911. The [NAME] Act is a Florida law that enables families and loved ones to provide emergency mental health services and temporary detention for people who are impaired because of their mental illness, and who are unable to determine their needs for treatment. (Retrieved from www.ufhealth.org on 11/01/25). Review of resident #2's Certificate of Professional Initiating Involuntary Examination dated 9/01/25 and signed by Psychiatric APRN K listed diagnoses of psychosis, refusal of care, and suicidal ideation. It stated due to her mental illness, the resident was unable to determine whether an examination was necessary, and there was a substantial likelihood she would cause serious bodily harm to herself without treatment. The supportive evidence read, Pt (patient) with history of psychosis and refusing care. Pt has been experiencing the exacerbation. No specific triggers. The patient has been naked, throwing herself on the floor with death wishes. The patient is refusing all kind of care. The patient is not redirectable and refusing to eat or drink. Giving IM medicine has been ineffective. [NAME] Act is the least restrictive alternative to ensure the safety of the other frail residents and staff. If not [NAME] Acted and received appropriate treatment in a psychiatric hospital, the patient will likely continue to escalate and hurt others. As the behaviors occur periodically and not consistently, [NAME] Act should not be rescinded based on a lack of behavior for a few consecutive hours. Review of the hospital's Attending admission Note dated 9/01/25 revealed an Assessment and Plan including complicated Urinary Tract Infection (UTI), aggression, violent behavior requiring restraints, suicidal ideation, history of psychosis, acute metabolic encephalopathy and one-on-one sitter under continued [NAME] Act status. Review of hospital's psychiatrist note dated 9/01/25 indicated the patient was admitted under a [NAME] Act after being violent and confused. The patient's husband described the situation as going out of whack, correlating with her refusal to eat and discontinuation of prescribed medications. Her symptoms included confusion and behavioral disturbances. The psychiatrist noted a possible exacerbation of bipolar disorder and anxiety, worsened by the UTI. Review of additional progress notes in resident #2's

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain sufficient nursing staff to provide the necessary care and services and ensure resident needs and preferences were addressed timely for 4 of 9 residents reviewed for call light response, of a total sample of 12 residents, (#7, #10, #11 and #12).Findings: On 10/22/25 at 1:17 PM, observation of the Montecito South's nurses station computer screen showed three rooms with active call lights and the following wait times: room [ROOM NUMBER] - 25 minutes, room [ROOM NUMBER] - 20 minutes, and room [ROOM NUMBER] -8 minutes. On 10/22/25 at 1:22 PM, call lights were illuminated outside rooms #301, #302 and #303. Resident #12, in room [ROOM NUMBER], was heard calling out, Hello, I need assistance, please. 1.On 10/22/25 at 1:24 PM, resident #12 was lying in bed, holding his left thigh approximately 45 degrees upward. Staples were present on his left stump, with redness noted around the incision site. Resident #12 stated he had returned from the hospital the previous evening for wound care and therapy. He reported pressing his call light to request pain medication, as his last dose was received at 9:00 AM and he was now due for more. He rated his pain as 9 out of 10 on his left stump. The surveyor exited the room at 1:28 PM; no staff were seen in the hallway, and the call lights for rooms #301 and #303 remained on. Review of resident #12's medical record revealed he was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE] with diagnoses including orthopedic aftercare following a surgical amputation, infection of the amputation stump, type 2 diabetes, and repeated falls. Review of the 5-day Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/08/25 showed resident #12 Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Review of resident #12's Medication Administration Record (MAR) revealed resident #12 last received Oxycodone 10 milligrams (mg) on 10/22/25 at 11:46 AM, with the effect noted as effective. The physician's order specified Oxycodone 10 mg every 8 hours as needed (PRN) for moderate pain. Prior to his readmission, the resident had received 2 tablets of Oxycodone 10 mg every 4 hours PRN for non-acute pain from 10/03/24 to 10/10/25. Review of resident #12's comprehensive care plan dated 10/22/25 revealed a focus on pain related to neuropathy, postoperative discomfort, wound, and disease process. Interventions directed nurses to evaluate the effectiveness of pain interventions and to notify the physician if interventions were unsuccessful. 2. On 10/22/25 at 1:29 PM, resident #10 was sitting in a wheelchair in her room, #301. She stated she wanted to be transferred back to bed because she had been sitting for over two hours. She explained she required assistance from a Certified Nursing Assistant (CNA) to stand and could not do so without help. She reported her call light had been on for approximately 30 minutes, adding, We are having a big staffing issue around here. She mentioned another resident down the hall had been yelling for help and said, I normally wait 30 minutes for the call light to be answered. On 10/22/25 at 1:32 PM, CNA B entered resident #10's room, stating she was not the resident's assigned CNA but was responding to the call light. On 10/22/25 at 1:33 PM, while exiting room [ROOM NUMBER], the surveyor heard resident #12 moaning and cursing, with his call light still illuminated. Review of resident #10's medical record revealed she was admitted to the facility on [DATE] with diagnoses including heart failure, migraine, difficulty in walking, and osteoarthritis. Review of the MDS quarterly assessment with an ARD of 7/22/25 showed resident #10's BIMS score was 15 out of 15, indicating intact cognition. Review of resident #10's comprehensive care plan with a focus on Activities of Daily Living (ADL) selfcare deficit related to chronic medical conditions, fatigue, and impaired balance was revised on 4/22/25. Interventions indicated resident #10 may require dependent assistance from one or two staff for ADL care, with needs fluctuating based on weakness, fatigue, and weight bearing status. On 10/23/25 at 12:40 PM, resident #10 stated she had waited over an hour for assistance the previous day due to staffing shortages. She expressed frustration, saying, Why do I have to wait until they are done with everybody else? She added she felt sidelined. She described CNAs as overworked, managing dressing, toileting, meal services, and transfers, and concluded, The wait times tell me they are understaffed and overworked. 3. On 10/22/25 at 1:33 PM, resident #11 was sitting in her wheelchair in her room and stated she activated her call light over 15 minutes ago. She reported suffering from breathing problem and needed her inhaler before physical therapy, scheduled for 1:15 PM. She added, her main concern was waiting at times for call lights to be answered. Resident #11, who had been in the facility less than a week, noted long call light wait times regardless of shift or day. She said, The fellow across in room [ROOM NUMBER] kept hollering hello, hello multiple times

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow appropriate hand hygiene and personal protective equipment (PPE) practices in accordance with infection control standards when assisting a resident with an intravenous (IV) infusion for 1 of 1 residents observed during the facility tour, from a total sample of 12 residents, (#5).Findings: Review of resident #5's medical record revealed she was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction), type 2 diabetes, stroke, anemia, and weakness. Review of resident #5's comprehensive care plan identified a focus area related to a midline catheter in the right upper extremity for treatment of anemia. The goal of the care plan was for the resident to experience no complications associated with the IV access or its use through the next review date. On 10/23/25 at 12:09 PM, Licensed Practical Nurse (LPN) G exited resident #5's room wearing gloves on both hands. While outside the resident's room, LPN G used scissors from the medication cart to open an IV-line package, then reentered the room. Inside the room, LPN G connected the IV line to a medication pouch on the IV pole, pulled a garbage can closer to her and the IV pole and continued setting up the IV tubing to begin an iron infusion. After several minutes working with the IV machine, LPN G informed resident #5 she needed to step out to obtain assistance. On 10/23/25 at 12:15 PM, LPN G confirmed she had exited resident #5's room without removing her gloves or performing hand hygiene and then returned to the room wearing the same gloves. She validated she moved the trash can wearing the same gloves and resumed working with the IV line. LPN G stated she was in a rush because the resident was waiting on her to finish setting up the infusion to eat her lunch. She acknowledged her actions violated infection control protocol and placed resident #5 at risk for infection. On 10/24/25 at approximately 2:20 PM, the Director of Nursing (DON) stated staff were expected to remove gloves before exiting a resident's room and perform hand hygiene immediately afterward. The DON added, Obviously, the nurse knew it was incorrect. Review of the Facility Assessment, updated on 10/06/25, revealed all staff received infection control and hand hygiene education upon hire and annually thereafter.