

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Viera Del Mar Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878</p> <p>Based on observation, interview and record review, the facility failed to implement the recommended restorative care to provide a splint application to prevent the potential for worsening of contractures for 1 of 2 residents reviewed for mobility/range of motion, of a total sample of 43 residents, (#85).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #85 was admitted to the facility on [DATE] from the hospital. His diagnoses included spinal stenosis, muscle weakness, and rheumatoid arthritis.</p> <p>Resident # 85's Annual Minimum Data Set (MDS) with an assessment reference date of 6/15/24 revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status which indicated the resident did not have any cognitive impairment. The MDS assessment noted the resident had upper extremity impairment on both sides and required substantial/maximal assistance with upper body dressing. The MDS assessment also noted the resident did not exhibit behavior symptoms or rejection of care that was necessary to achieve the resident's goals for health and well-being.</p> <p>Review of resident #85's medical record revealed a care plan was initiated on 7/09/24 and revised on 7/18/24 which indicated the resident had restorative nursing for his left resting hand splint to decrease the risk for further contraction.</p> <p>Resident #85's Order Summary Report showed an active physician's order for restorative nursing program for active and passive range of motion and splint application.</p> <p>Review of resident #85's restorative nursing program referral, signed and dated by the Occupational Therapist (OT) on 7/18/24 indicated passive range of motion (PROM) and splint/brace assistance for the resident's left hand 4-5 days a week for 4-6 hours.</p> <p>On 7/29/24 at 12:17 PM, and on 7/30/24 at 10:10 AM, resident #85 was observed with a left-hand contracture with no splint in place. He stated the splint was supposed to be applied daily, but it had not been applied several times last week, over the weekend, the day before (7/29), or today (7/30). He stated he needed the splint and wanted it to be applied but was unsure why staff were not applying it.</p> <p>(continued on next page)</p>

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
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/31/24 at 11:30 AM, the Director of Rehabilitation stated resident #85 was admitted with a contracture in his left elbow, wrist, and fingers, along with mild impairment in his right hand. He conveyed the resident was discharged from Occupational Therapy on 2/27/24 to restorative nursing care for left hand splinting and was reassessed by the OT on 7/18/24. He acknowledged the resident was to have a splint applied to his left upper extremity 4-5 days a week 4-6 hours each time to prevent further contracture. He confirmed the resident liked to wear the splint and was compliant with its use. He also noted it was the restorative nurse's responsibility to ensure the splint was applied as ordered.</p> <p>On 7/31/24 at 12:30 PM, the Director of Rehabilitation stated resident #85 informed him today, 7/31/24, that his splint had not been applied for some time.</p> <p>On 7/31/24 at 12:45 PM, the Restorative Nurse stated she was responsible for updating the electronic medical record task list for splinting and ensure it was recorded on the Kardex. She explained the restorative nurses applied the splints according to the physician orders and noted resident #85 was currently on the restorative caseload for left-hand splint application. She acknowledged the resident was to have the left-hand splint applied 4-5 days a week for 4-6 hours as prescribed, and the splint application was documented in the task section of the electronic medical record. She reviewed the task report and confirmed the splint had not been applied on 7/18/24, 7/22/24, 7/25/24, 7/27/24, 7/28/24, 7/29/24, or 7/30/24. She also confirmed that although staff documented the application as not applicable, the resident had not refused it on those days. She stated the splint should have been applied and was unsure why it had not been applied as required.</p> <p>On 7/31/24 at 12:50 PM, the Director of Nursing acknowledged resident #85 was not cognitively impaired and stated she would take the resident's word when he said the splint was not applied. She confirmed the resident should have had the left-hand splint applied 4-5 days a week for 4-6 hours each time.</p> <p>The facility's Restorative Nursing Services Standards and Guidelines read, To promote the resident's optimum function, a restorative nursing program may be developed .Restorative nursing program refers to interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878</p> <p>Based on observation, interview and record review, the facility failed to maintain oxygen flow rates as ordered by the physician for 1 of 2 residents reviewed for respiratory care, of a total sample of 43 residents, (#75).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #75 was admitted to the facility on [DATE] from the hospital. His diagnosis included rhabdomyolysis, chronic respiratory failure with hypoxia, heart failure, muscle weakness, and chronic obstructive pulmonary disease (COPD).</p> <p>Resident # 75's Admission Minimum Data Set (MDS) with an assessment reference date of 5/06/24 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status which indicated the resident did not have any cognitive impairment. The MDS assessment noted the resident required partial/moderate assistance with sit to stand transfer and upper body dressing and received oxygen therapy. The MDS assessment also noted the resident did not exhibit behavior symptoms or rejection of care that was necessary to achieve the resident's goals for health and well-being.</p> <p>Review of resident #75's medical record revealed a care plan was initiated on 5/03/24 that indicated the resident to be administered oxygen as ordered.</p> <p>Resident #75's Order Summary Report showed an active physician's order for continuous oxygen at 2 liters per minute, via nasal cannula every shift for COPD.</p> <p>Oxygen can be given to COPD patients but only in controlled amounts .Hypercapnia respiratory failure is when there is too much carbon dioxide in your blood, and near normal or not enough oxygen in your blood, and it can be fatal. It commonly occurs in people with COPD who are given too much or uncontrolled amounts of oxygen, (retrieved on 8/02/24 from www.drugs.com).</p> <p>On 7/29/24 at 3:42 PM, resident #75 was observed lying in bed with oxygen administered through a nasal cannula. The oxygen concentrator's flow rate was set at 4 liters per minute. Resident #75 stated he had not adjusted the oxygen concentrator flow rate. His family member by his bedside stated she had not adjusted the oxygen concentrator and had noticed the flow rate was sometimes set at 4 liters but was supposed to be set at 2 liters instead.</p> <p>On 7/29/24 at 3:52 PM, Licensed Practical Nurse (LPN) A reviewed resident #75's oxygen order and confirmed the current order specified the resident was to receive 2 liters per minute of oxygen continuously via nasal cannula for COPD. She observed resident #75's oxygen concentrator flow rate and acknowledged it was incorrectly set to 4 liters per minute instead of 2 as prescribed. The LPN stated it was the nurse's responsibility to set the resident's oxygen flow rate as prescribed by the physician and to routinely monitor the oxygen settings to ensure the flow rates aligned with the physician's order. She reiterated it was important to have the oxygen set at the correct flow rate to prevent respiratory distress or oxygen toxicity.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/31/24 at 9:30 AM, the Director of Nursing reviewed resident #75's oxygen order and confirmed it specified the resident was to receive 2 liters per minute of oxygen continuously for COPD. She acknowledged it was the nurse's responsibility to check the oxygen concentrator every shift to ensure the oxygen flow rate matched the physician order. She stated resident #75 had COPD, making it important for him to receive the prescribed amount of oxygen. She emphasized that too much oxygen could diminish his natural drive to breathe and suppress his breathing.</p> <p>The facility's Oxygen Standards and Guidelines read, Review physician's order .Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or other device per physicians' orders .</p>