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	05/01/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor a resident's expressed wishes for Do Not Resuscitate (DNR) by not verifying those wishes were accurately documented to ensure a resident's wishes related to health care treatments and procedures at the end of life were followed for 1 of 1 resident reviewed for advance directives, out of a total sample of 57 residents, (#111). This failure contributed to resident #111 receiving cardiopulmonary resuscitation (CPR) and other invasive procedures in violation of an explicit wish for a natural and dignified death. There was likelihood resident #111 experienced severe pain, and could have suffered broken bones, organ damage, and a prolonged dying process. On [DATE], resident #111 was admitted to the facility with a physician order for DNR on the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008 Transfer Form). The facility's admitting nurse noted she verified the DNR wishes with the resident and family upon admission. The next day, on [DATE], a physician order was placed for full code status without family/resident consent. On [DATE] at 3:35 PM, the resident was found unresponsive, CPR was initiated and emergency medical services (EMS) were called. The staff initiated 3 rounds of CPR which was continued by EMS upon arrival at 3:41 PM. EMS continued CPR while transporting the resident to the hospital. While enroute to the hospital, resident #111 was intubated and EMS staff placed an intraosseous access to her right lower extremity. EMS reported they obtained a return of spontaneous circulation. Resuscitation efforts continued in the hospital where she expired. There were 48 residents in the facility with active DNR orders. An Intraosseous (IO) access is a rapid, lifesaving medical procedure that involves drilling a specialized needle into the bone marrow to deliver fluids and medication. The facility's failure to ensure accurate documentation of the resident's DNR wishes placed all residents with a do not resuscitate order at risk for serious psychosocial harm, physical trauma, and a prolonged, undignified death from unwanted resuscitative efforts. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE]. The census at the start of the survey was 116 with 48 residents identified as Do Not Resuscitate.Findings: Resident #111, an [AGE] year-old female, was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, acute myocardial infarction, Alzheimer's disease, acquired absence of left leg above knee and adult failure to thrive. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of [DATE] revealed resident #111 had a Brief Interview for Mental Status score of 03/15 which indicated she had severe cognitive impairment. The document indicated she was 65 inches tall and weighed 72 pounds and had medically complex conditions which included cancer, atrial fibrillation, coronary artery disease, Alzheimer's Disease, and adult failure to thrive. Review of resident #111's electronic medical record (EMR) revealed a Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form from the hospital which indicated her advanced care planning included DNR. The record also contained an Admission/readmission Nursing Evaluation dated [DATE] completed by Licensed Practical Nurse (LPN) C which indicated resident #111 was DNR which was current and verified by the resident and the resident's family. This assessment was locked by the (continued on next page)

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	200/400 LPN Unit Manager on [DATE]. Review of the physician orders showed an order for Full Code was entered into the EMR by the Director of Nursing (DON) on [DATE]. A care plan was initiated on [DATE] which read, Resident/Representative has requested DNR (Do Not Resuscitate) status indicating CPR measures ARE NOT performed. This care plan was cancelled on [DATE] and a new advance directive care plan was initiated. The new care plan read, Resident/Representative has requested FULL CODE STATUS indicating CPR measures ARE performed. The care plan remained in effect until it was cancelled after resident #111's death. In a phone interview on [DATE] at 4:28 PM, LPN B confirmed she worked the day of [DATE]. She explained she was the nurse on an adjacent unit when she heard the overhead page for an emergency. LPN B stated she went to resident #111's room and observed resident was unresponsive. She recalled the DON verified the resident's code status as full code and CPR was initiated. LPN B was unable to recall who initiated CPR but confirmed she assisted in resuscitative measures until emergency medical services staff arrived and took over. She stated resident #111 left facility with EMS personnel and she called the resident's son to inform him of the events and transfer to the hospital. LPN B acknowledged resident #111's son asked her why CPR was performed and she told him the record showed she was a full code. The facility's Code Blue Response Worksheet showed facility staff initiated 3 rounds of CPR which was continued by EMS upon arrival at 3:41 PM. EMS personnel left the facility with resident #111 at 3:48 PM. Review of emergency room records dated [DATE] showed EMS personnel continued CPR during transport to the hospital. The records documented that while enroute to the hospital, resident #111 was intubated and EMS staff placed an intraosseous access. EMS reported they obtained a return of spontaneous circulation. The document showed that resuscitation efforts continued in the hospital until she expired. In a phone interview on [DATE] at 12:12 PM, resident #111's son reported his mother was in the hospital previously where she had her leg amputated and started going downhill. He stated she was admitted to the facility from her most recent hospital stay. The son confirmed he was notified by the facility of the events on [DATE]. He explained a nurse called him and informed him that his mother was found unresponsive, CPR was performed and she had been transferred to the hospital. He recalled asking her why CPR was done and she told him she was a full code and there was no information in the chart for DNR. He expressed to the surveyor that his mother was a DNR in the hospital and was supposed to be at the facility as well. He recalled she was admitted in the evening on [DATE]. He explained he visited her the next day and saw she still had the DNR bracelet from the hospital on her right wrist. He did not understand why they would do CPR on his mother. He explained she was very frail and doing chest compressions would have cracked her ribs. He recalled the facility did CPR, then EMS did CPR and to his understanding, the hospital did CPR as well. He stated he could not fathom that taking place. Resident #111's son reported he was told by hospital staff that she had come back for a few moments but then passed away. He again stated he did not understand why she would be put through that. He explained his mother had expressed she wanted to be a DNR. He stated she had already suffered enough and was diagnosed with failure to thrive. Resident #111's son stated he never gave anyone permission to change his mother's DNR status. On [DATE] at 4:34 PM, the 200/400 LPN Unit Manager stated she spoke to resident #111's son the night she was admitted to obtain verbal consents to treat but did not discuss advanced directives with him. She verified she locked the Admission/readmission Nursing Evaluation completed by LPN C. The 200/400 LPN Unit Manager stated she was not aware LPN C had documented resident #111's code status as DNR. She acknowledged she only verified the form was filled out, not that the information was accurate. She confirmed she was part of the interdisciplinary/clinical team. She stated they reviewed admission information for all new admissions each morning. She explained the 3008 Transfer Form from the hospital did identify the resident as a DNR, but the hospital did not send a goldenrod Do Not Resuscitate Order (DNRO) form with the resident, so they considered resident #111 to be a full code. On [DATE] at 2:17 PM, the Social Services Director (SSD) stated she was responsible for Advanced Directives along with the clinical team. She explained they reviewed new (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admissions daily and reviewed the hospital records as well as the 3008 Transfer Form from the hospital. She recalled resident #111's admission paperwork did not contain a goldenrod DNRO so she was considered a full code until that form could be completed. The SSD stated the admitting nurse usually completed an Advance Directive Discussion form with resident or resident representative upon admission but was unable to locate one. She stated she attempted to contact the resident's son but was unable to reach him. The SSD stated the physician, or his nurse practitioner, may have spoken to the family. She reviewed the chart and could not identify any documentation from her, the physician, his nurse practitioner, or any other facility person regarding a discussion with resident #111 or her son regarding advanced directives. The SSD was not aware that the goldenrod DNRO form was not required for a resident to have an expressed wish to be a DNR status. She was also unaware resident #111's son was in the facility the day after her admission. On [DATE] at 2:41 PM, the Registered Nurse (RN) MDS Coordinator verified she signed the baseline care plan but did not complete it. She stated she signed it as the RN but was unable to explain why both DNR and Full Code were checked. The RN MDS Coordinator reviewed the care plans and confirmed a DNR care plan was initiated and cancelled on [DATE] and a Full Code care plan was created in its place. She explained the DNR care plan was developed initially by the SSD who replaced it with the Full Code care plan when they realized a goldenrod DNRO form had not been included in the admission packet from the hospital. The RN MDS Coordinator stated as far she knew, whether a resident was considered a DNR was based on the presence of a goldenrod DNRO form. In a meeting with the nursing home administrator (NHA), DON, Assistant Director of Nursing (ADON) and Compliance Officer on [DATE] at 10:40 AM, the Compliance Officer stated when resident #111's admission paperwork was reviewed on [DATE], there were inconsistencies noted. He explained that staff realized there was whiteout on the transfer form as well as different [NAME] and no goldenrod DNRO form was included in the packet. He stated the admission packet did not contain a goldenrod DNRO form or any paperwork regarding the son's ability to make healthcare decisions for resident #111. He reported staff tried to contact the son to validate DNR but were unable to reach him. The DON acknowledged the ADON and 200/400 LPN Unit Manager signed consent forms indicating they spoke with the son on the evening of [DATE] and obtained consents to treat but did not complete an Advance Directive Discussion form. She could not explain why the son was able to make these healthcare decisions without paperwork but could not validate an advance directive. The DON stated the son only came once and was in and out so fast no one was aware he was there. The facility team was unable to provide any documentation of attempts to contact resident #111's son. The NHA reviewed the visitor log and verified resident #111's son had visited on [DATE] and [DATE]. On [DATE] at 9:34 AM, resident #111's attending physician at the facility confirmed he was also her attending physician in the hospital just prior to her admission to the facility. He stated the son initially wanted his mother to be sent to in-patent hospice, but she did not qualify. He recalled the son agreed to send her to the facility for therapy. The attending physician acknowledged he had spoken with resident #111 and her son regarding code status and was aware her wishes were DNR. He also acknowledged he signed the 3008 Transfer Form which indicated she was DNR. The attending physician explained that a goldenrod DNRO form was not included in the admission packet when resident #111 arrived so he gave order for Full Code until they could talk to the son. He confirmed the goldenrod DNRO form was only for EMS personnel. The attending physician acknowledged he had personal knowledge of the resident's and son's wishes to be DNR and that neither the son nor the resident ever told him to change from DNR to Full Code status. He could not explain why resident #111's wishes were not honored. Review of admission hospital records showed the attending physician documented resident #111's status as DNR/Do Not Intubate on [DATE], [DATE] and [DATE]. Review of the facility's policy and procedure for Advanced Directives Code Status revised 9/2025 revealed it was the policy of the facility to honor Advanced Directives, Code Status and Do Not Resuscitate Orders in accordance with State and Federal regulations. The document provided guidelines that the admitting nurse would verify a resident's code (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	status upon admission with the resident/representative and would confirm the decision with the attending physician. Under the DNR rescinded section, the document instructed social services and nursing to document in a progress note that the code status was changed as per resident/representative request. Review of the immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team: *On [DATE], the NHA and DON reviewed the Code Status binders for accuracy. *On [DATE], the NHA and DON confirmed the physician order for code status of all residents *On [DATE], the NHA and DON confirmed each resident's care plan matched the resident's physician order for code status. *On [DATE], the NHA and DON confirmed that residents who were unable to make their own decisions had a designated legally authorized decision maker with supporting documentation. *On [DATE], the NHA and DON ensured each resident with DNR order had a goldenrod Do Not Resuscitate Order form uploaded into the EMR. *On [DATE], the DON and Clinical Team confirmed each resident's desired code status with resident/responsible party and documented their decision in the resident's EMR. Any requested changes were communicated to the resident's physician. *On [DATE], education was initiated for all staff present in facility including contracted staff on preventing, reporting, and stopping resident abuse; Advanced Directives Code Status Policy; updated CPR policy & Competency; and required documentation specific to code status and responsible party. Staff competencies were completed at time of education. *From [DATE] through [DATE], 111 of 184 staff members were educated (60%). Remaining staff will complete education prior to working next shift. *All new hires will be educated on the revised CPR policy during orientation. *On [DATE], Ad-HOC Quality Assurance and Performance Improvement (QAPI) meeting was held, and the committee reviewed the event, discussed the details of the event including lack of hospital documentation and no document supporting the family member as the legally authorized decision maker. The committee determined the root cause was the facility was unable to confirm the resident's legally responsible party which led to the facility being unable to validate her code status. Education was initiated and immediate interventions were implemented to ensure residents' wishes are honored. The facility's Advanced Directives Code Status policy was updated to address actions to take when staff were unable to verify a legally authorized decision maker and approved education and immediate corrective actions, policy change, and review of Facility Assessment through Ad-Hoc. Adopted facility Quality Review plan. *On [DATE], Ad-HOC QAPI meeting was held, and the committee reviewed the plan and the Immediate Jeopardy citation as it related to the event. Facility Assessment reviewed. Facility audits were continued for all immediate corrective actions. Policy changes were added to facility New Hire Orientation. Facility audits of Resident Code Status were reviewed and verified completion of audits for accuracy.Interviews conducted on [DATE] with 20 facility staff (1 RN, 3 LPNs, 10 CNAs, 1 housekeeper, 1 therapy staff, 2 MDS staff, 1 ADON, 1 social services staff) across all shifts indicated they were knowledgeable of advanced directives and facility procedures to verify the resident's code status.The survey team validated the education through interviews for staff knowledge; reviewed code binders for accuracy; and sampled new admissions for accuracy of code status and documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain separation between contaminated and clean laundry processes with potential cross-contamination of clean linen and soiled linen. Findings: On 4/29/26 at 12:42 PM, a tour of the laundry room was done with the Housekeeping Manager, Infection Preventionist and Regional Housekeeping Director. It was observed that in the dirty area where linen were sorted, there were three washing machines. The bins containing the soiled linen were very close to the washers and there was no defined separation of the area thereby creating the risk of cross contamination. The housekeeping Manager and the Regional Director of Housekeeping stated they were not aware that clean and soiled linen needed to be separated. They acknowledged that after completing the wash cycle the linen were clean and therefore having the bins with dirty linen so close to the washers, when emptied could cause possible cross contamination of linen. The facility's Infection Prevention and Control Plan 2026 stated the program is designed to prevent, identify, report, investigate and control the spread of infections and communicable disease in the facility.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management for 2 of 3 residents reviewed for pain management of a total sample of 57 residents, (#26, #133).Findings1.Resident #26 was admitted to the facility on [DATE] with diagnoses that included unspecified fracture of the right patella, fracture of the nasal bones, rheumatoid arthritis, unspecified injury of the head and muscle weakness.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident #26 had a a brief interview for mental status score (BIMS) of 11 out of 15 which indicated she had moderate cognitive impairment. The MDS assessment also revealed the resident had pain occasionally.Review of the physician orders dated 4/23/36, read resident #26 was to receive 5-325 milligrams (mg) Hydrocodone -Acetaminophen tablet every 6 hours as needed for non-acute pain.Resident #26's plan of care revealed interventions which instructed nurses to administer analgesia medication per orders because of the resident had pain, and /or is at risk for pain because of arthritis, fracture, impaired mobility, multiple co-morbidities and Postoperative discomfort.On 4/27/26 at 9:34 AM, resident #26 was observed in bed and stated she had her call light on because she requested pain medication. She explained she could not go to physical therapy because she was in pain. Resident #26 said that she had been requesting pain medication since 4 AM and had not received any yet. Resident #26 continued to explain the pain medication was recently changed from being scheduled to as needed and stated it might not be a good thing because now she has to ask for it and usually had to wait before they brought it to her. The facility Administrator answered the call light and told the resident the nurse would be in with her medication.Review of the Medication Administration Record (MAR) revealed resident #26 received hydrocodone-acetaminophen 5-325 mg 25 minutes later, at 9:59 AM, and the last time she received it was on 4/26/26 at 1AM.Further review of the MAR revealed that resident #26's order for Hydrocodone-Acetaminophen 5-325 mg was scheduled for every 6 hours from 4/9/26 to 4/23/26. The medication administration audit report revealed the scheduled times of administration were 6 AM, 12 PM, 6 PM and midnight. The report revealed for three days the 12 PM doses were administered almost two and a half hours later than the scheduled time.On 4/20/26 12 PM dose was administered at 2:42 PMOn 4/22/26 12 PM dose was administered at 2:50 PMOn 4/23/25 12 PM dose was administered at 2:40 PMThere were no corresponding progress notes indicating the reason for the late medication administration.On 4/29/26 at 1:54 PM the Director of Nursing (DON) and a Regional Nurse consultant could not provide an explanation nor progress notes to explain why the medication was given almost two and a half hours late. They acknowledged this not was not their process.On 4/29/26 at 2:58 PM, Registered Nurse (RN) H stated that if a medication was given late, she would document the reason and would also call the doctor and the family and document in the medical record. RN H said that she could give the medication one hour before or one hour after the scheduled administration time.On 4/29/26 at 3:05 PM, RN I said that if a medication was scheduled, she had one hour before or one hour after to administer the medication. RN I explained that she rarely gave medications late but sometimes on the Marvista Unit it takes longer to administer medications when there are 37 residents. RN I said if she gave medication later than the scheduled time she would write a note and call the doctor.2. Resident #133 was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery, unilateral primary osteoarthritis right knee and pain in unspecified joint. Review of the admission MDS assessment dated [DATE] revealed resident #133 was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. The MDS also revealed the resident had frequent pain.Review of the medical record revealed physician's orders for the resident to receive 5-325 mg of Oxycodone -Acetaminophen tablet every 6 hours for non-acute pain.The plan of care initiated on 4/20/26 read that resident #133 had (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain and/or is at risk for pain because of chronic physical disability, impaired mobility, migraine, multiple co-morbidities, postoperative discomfort, chronic back pain and neuropathy. The interventions instructed nurses to administer analgesia medication per physician orders.On 4/27/26 at 9:03 AM, resident #133 was sitting up in bed and explained that she was planning to leave the facility because they were not giving her pain medications on time. She said that on Saturday she did not receive her pain medication until 12:30 PM and the nurse told her the next dose would be at 5 PM, but at 6:15 PM, the resident said she was told that she received the last pill at 12:30 PM. The resident stated I got mad because if the nurse knew that was the last one, they should have called the pharmacy. I did not receive anything until 11 PM from the night nurse who got an emergency order. I want to leave this place today, I am leaving at 11 AM. The resident said she was vocal about all her concerns and staff were aware.Review of the MAR read on Saturday 4/25/26, the scheduled times for oxycodone were 12 AM, 6 AM, 12 PM and 6 PM. At midnight the resident received her medication and at 6 AM, she did not receive it because it was marked with the number 12. The corresponding chart code for 12 was Medication on order from Pharmacy, MD aware. At 12 PM the medication was administered and the audit report showed it was documented as given at 2:04 PM. The 6 PM dose was not administered as evidenced by the number 9, chart code read Other, See nurses notes. There were no notes seen. The medication audit report also revealed the next time the medication was administered was on 4/25/26 at 11:09 PM. A progress note written on 4/27/26 at 11:54 AM revealed resident #133 was discharged home.On 4/29/26 at 2:38 PM the UM for the Montecito Unit said that she was aware of resident #133's concerns and that the resident wanted to leave because she did not get her medication on time. She explained that the nurse could have obtained the medication on 4/25/26 on their emergency medication dispensing system. On 4/29/26 at 2:15 PM, the DON was made aware of the findings and said that she did not know this had happened. She said that it was not acceptable for residents to wait for pain medications and that this resident had a script on 4/18/26. The DON explained that Pain Management group came to the facility on Tuesdays and Thursdays and would ask if anyone needed new scripts. She noted the order was changed on 4/23/26 from every 4 hours as needed to every six hours and acknowledged the medication was in their emergency dispensing system. The DON said it should not have been difficult for nurses to get the script from the doctors and reorder the medication if it was not available.The facility's Standards and Guidelines for Medication Administration revised January 2024 stated, Medications are ordered and administered safely and as prescribed and that Medications are administered within 1 hour before or after the prescribed time, unless otherwise specified. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall document the rational in the resident's medical record and notify the physician and responsible party if indicated.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to prevent medication errors greater than 5 per cent for 1 of 5 residents sampled for medication administration, (#101). There were 2 errors in 32 opportunities on 1 of 5 units by 1 of 5 nurses observed, for a medication error rate of 6.25%.Findings:On 04/27/2026 at 9:00 AM, during a medication administration observation, Licensed Practical Nurse (LPN) B removed the following medications for resident # 101 and placed them in a cup, Folic Acid 1 milligram (mg), Apixaban 5 mg, Midodrine 5 mg, Midodrine 10 mg, Sodium Chloride 1 mg, Miralax 1 capful, and Advair inhaler.During the reconciliation process it was noted on the Medication Administration Record (MAR) that Potassium Chloride 20 milliequivalent (meq) was marked as given and Sertraline 50 mg was also marked as given. These medications were not given during the medication administration observation.On 4/28/26 at 11:48 AM, Unit Manager (UM) for 200 and 400 Halls was informed of the medication error. The UM stated her expectation during medication administration is for the nurses to administer the medications to the residents according to physician orders to include administration of medications at the frequency and the time ordered. Review of the Standards and Guidelines: Medication Administration issued 10/2020 and revised 01/2024, read: Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meals, and at bedtime).As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered.