Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70517	A. BUILDING: _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIERA HEALTHCARE AND REHABILITATION CENTER	8050 SPYGLASS HILL RD VIERA, FL 32940

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N 000	INITIAL COMMENTS Complaint Investigations #2025000902 and #2025001641 were conducted from to . The complaints were not substantiated but Viera Health and Rehabilitation Center had deficiencies found at the time of the visit.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to provide care and services to promote healing of a , (PU) as ordered by the physician for 1 of 1 residents reviewed for , , of a total sample of 10 residents, (#9). Findings: Review of the medical record revealed resident #9 was admitted to the facility on with diagnoses including aftercare following , replacement surgery, type 2 , and . Review of the Admission Summary Progress Notes dated revealed resident #9 required assistance with activities of daily living including bed mobility, transfers, ambulation, , bathing, and toileting. Review of resident #9's Admission Minimum Data Set (MDS) assessment with Assessment	N 054	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Information related to resident #9 was gathered through a historical document review and interview process. On , the nurse contacted the physician for resident #9 who gave orders for with , C and as recommended. On , the physician for resident #9 assessed the areas of skin , with continued healing noted.	

AHCA Form 3020-0001

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

Electronically Signed /25

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N 054	Continued From page 1 Reference Date of revealed she had a score of 12 out of 15 which indicated moderate cognition . The MDS assessment noted no rejection of care necessary to obtain goals for her health and well-being. The MDS assessment showed resident #9 was identified at risk of developing PU/injuries, she had a PU and a surgical . The National Pressure Injury Advisory Panel defines a pressure injury or as "localized damage to the skin and underlying soft tissue usually over a bony prominence. . .The injury can present as intact skin or an open and may be painful" (retrieved on from www.npiap.com). Review of resident #9's medical record revealed a PRN (as needed) Skin Check form dated . The form read, "New skin (s) that have not been previously noted - yes. Open area. Treatment in place. dr. (physician) to evaluate." Review of resident #9's medical record revealed a Change in Condition Evaluation dated read, "Resident stated her bottom was hurting. Assessed the area and noted an open between the cheeks of her ." The document indicated the physician was notified, and treatment orders and a consultation to the care physician were obtained. Review of resident #9's physician orders revealed an order dated to cleanse the with normal , apply , and cover with bordered gauze daily and as needed if the was soiled or dislodged.	N 054	(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed a 14 day look audit of active residents requiring care to identify other residents having the potential to be affected to ensure: 1. Treatments were performed and documented in the clinical record in accordance with physician orders. 2. Recommendations for care, including supplemental , were communicated with the physician and implemented in accordance with physician orders. Any concerns identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On , the Director of Nursing/designee completed re-education with the licensed nursing staff on the components of this regulation with emphasis on ensuring: 1. Treatments are performed and documented in the clinical record in accordance with physician orders. 2. Recommendations for care, including supplemental , are communicated with the physician and	

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N 054	Continued From page 2 Review of resident #9's Treatment Administration Record (TAR) and Progress Notes for revealed care was not performed on and . Review of resident #9's medical record revealed a care plan for skin , of a surgical to the right and PU to , initiated on . The goal was the resident would demonstrate healing without complications. The interventions included, "Perform treatments as ordered." Review of an Initial Evaluation & Management Summary form dated by the Care Physician revealed a , full thickness which measured 2.0 x 2.2 x 0.3 centimeters with moderate , 75% tissue, and 25% tissue. The treatment plan was to apply , a gauze island with border and skin prep on the peri daily. The physician's recommendations included a daily, C 500 milligrams (mg) twice daily and Sulphate 220 mg daily for 14 Days. Review of resident #9's physician orders did not include a daily, C 500 milligrams (mg) twice daily or Sulphate 220 mg daily for 14 Days. On at 11:55 AM, Licensed Practical Nurse (LPN) A stated he, along with another nurse, performed care to residents with in the facility 7 days a week. He indicated the other care nurse rounded most often with the	N 054	implemented in accordance with physician orders. Newly hired licensed nursing staff will be educated on these components during orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of at least 5 residents requiring care 3 times weekly X 4 weeks and then weekly X 2 months to ensure: 1. Treatments are performed and documented in the clinical record in accordance with physician orders. 2. Recommendations for care, including supplemental , are communicated with the physician and implemented in accordance with physician orders. Findings of these audits will be reviewed in the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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N 054	Continued From page 3 care physician but whenever he did it, he removed the ,, and cleaned the resident's , and redressed the after the care physician was done. He indicated he asked the care physician if there were any new orders when he finished with each resident. He explained after the care physician left the facility, they received their progress notes, usually within 3 to 4 hours, on the same day. He indicated if he felt he was lacking information, he referred to the progress note but not often. LPN A reviewed the Initial Evaluation & Management Summary form dated and validated the , C and the Sulphate were not added to resident #9's orders. He mentioned if the care physician did not mention any new orders, he did not check the notes, so "that is on me, but I will be doing it going on apparently." He explained he documented whenever he performed care. He stated he did not work on or and could not explain why care was not done those days. On at 12:57 PM, the Director of Nursing (DON) explained the facility had 2 nurses who performed care regularly, but they had a up if those nurses were out. She indicated her expectation for the care nurses was to perform care to any , or surgical and document it. She shared there was someone assigned to perform care 7 days a week. She expected the nurse performing care to either enter a progress note or sign off the TAR when care was done. She stated the physician should give new orders at time of rounding. She indicated the care nurse should review the note from the physician when received and update the	N 054		

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N 054	Continued From page 4 log each Friday. She stated she expected the nurse who updated the log to follow up on the physician's recommendations. She indicated if a recommendation was discovered during review of the note, the primary physician would be contacted. The DON explained if the primary physician agreed with the recommendations, the care nurse would enter the orders. The DON stated it did not appear the care nurse followed through with the care physician's recommendations for resident #9. When asked why care was not performed on and for resident #9, the DON response was she knew who the nurse was those days, and that nurse always documented. She validated she did not see a progress note and the TAR was blank on or . Review of the facility's policy and procedure titled Care dated read, " care procedures and treatments should be performed according to the physician orders." The policy included to document in the clinical record when treatment was performed. Class III	N 054		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or	N 101		

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N 101	Continued From page 5 other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to accurately document the administration of medications in the Medication Administration Record (MAR) for 1 of 5 residents reviewed for medications, out of a total sample of 10 residents, (#3). Findings: Review of the medical record revealed resident #3 was admitted to the facility on . Her diagnoses included aneurysm of of upper extremity, ( ), and rapidly progressive nephritic with diffuse crescentic . According to the National Library of Medicine, "Rapidly progressive , (RPGN) is a clinical manifested by features of nephritic and rapid loss of the	N 101	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Information related to resident #3 was obtained during a historical document review and interview process. On , the physician for resident #3 was notified of the medication variation/inaccuracy of documentation of administration; new orders to administer	

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N 101	Continued From page 6 function over a period of a few weeks to months." (Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC4720204/ on). Review of resident #3's physician orders revealed an order dated for Sevelamer 800 milligrams (mg) 3 tables before meals for hypocalcemia related to . Sevelamer administration was scheduled for 6:30 AM, 11:30 AM, and 4:30 PM daily. Review of resident #3's MAR showed Sevelamer was administered on at 6:30 AM, at 6:30 AM and 4:30 PM, at 6:30 AM, and at 6:30 AM, 11:30 AM and 4:30 PM for a total of 7 doses. Review of the Progress Note revealed Sevelamer was not available to resident #3: * at 6:06 PM - on order, awaiting for pharmacy and the physician was aware. * at 12:17 PM - pending pharmacy delivery. * at 5:17 PM read, "Medication is not available, Medication has been reordered from pharmacy. Awaiting delivery from pharmacy. MD (physician) notified." * at 7:47 AM read, "Medication is not available. Contacted pharmacy. Awaiting approval." * at 10:40 AM read, "Pharmacy states they have to go through , to send pill, awaiting delivery." * at 6:29 AM read, "Medication is not available. Contacted pharmacy. Awaiting approval." * at 11:03 AM read, "Awaiting pharmacy delivery."	N 101	the Sevelamer once a day at 5pm while the resident was in the facility instead of administration at the , clinic. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed a 7 day look audit of active residents to ensure accuracy of the medical record and accurate documentation of medication administration to identify other residents having the potential to be affected. Any concerns identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On , the Director of Nursing/designee completed re-education with the licensed nursing staff on the components of this regulation with emphasis on ensuring accuracy of the clinical record and accurate documentation of medication administration. Newly hired licensed nurses will be educated on these components during orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not	

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N 101	Continued From page 7 * at 8:08 AM read, "Waiting arrival from pharmacy." * at 4:41 PM read, " to give." * at 6:39 AM read, " to give." * at 12:36 PM read, "Awaiting delivery. MD aware." * at 3:40 PM read, "Waiting on pharmacy." * at 12:53 PM read, "Medication to be administered at ." Review of resident #3's Baseline Care Plan initiated on read, "Resident needs ." Interventions included, "Administer any physician ordered medications for functioning. Monitor for side effects. . . . Communicate and collaborate with center regarding , medication, diet, and lab results." On at 1:35 PM, the Transitional Care Unit Manager (UM) stated she called their pharmacy yesterday because did not have Sevelamer. She shared she called every single day and informed the physician, but she did not document it in resident #3's medical record. She explained they recently received corporate approval for a 5-day supply of Sevelamer and it was received yesterday morning. Later at 2:18 PM, the UM stated she reviewed the documentation for resident #3 and could not find evidence that Sevelamer was in the facility before this morning. She stated she spoke with the nurses who documented the administration of Sevelamer when the medication was not available, and she said they did not have an answer. She mentioned one of the nurses confirmed he did not give the medication but documented he gave it and could not explain why he did that.	N 101	recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of at least 5 residents clinical records 3 times weekly X 4 weeks and then weekly X 2 months to ensure accuracy of the clinical record with emphasis on documentation of medication administration. Findings of these audits will be reviewed in the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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N 101	Continued From page 8 Review of the Pharmacy Packing Slip dated revealed resident #3's Sevelamer was included. The Signature, Date Signed, and Time Signed sections of the form were blank. On at 2:54 PM, the Director of Nursing (DON) stated she expected the nurses to document accurately in the medical record. She indicated if a medication was not given, the physician needed to be informed, and the communication documented in the medical record. She mentioned she was not sure of the steps the facility's UMs took to communicate with the centers regarding the unavailability of Sevelamer or if they documented their efforts. She said, "We do the best we can, do I document every single conversation I have with a physician or family? I cannot and I do not." She shared she had spoken to 3 physicians today and had not documented any of those conversations. Review of the policy titled Resident Identifiable Information / Medical Records dated revealed the intent to maintain a medical record for each resident in accordance with federal and state guidelines. The document read, "Medical records on each resident will be accurately documented; readily accessible; and systematically organized." Class III	N 101		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate	N 201		

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N 201	Continued From page 9 health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain effective communication between nursing staff and medical providers and failed to collaborate with a center to promote adequate treatment, monitoring, and continuity of care for 2 of 4 residents reviewed for care and services, out of a total sample of 10 residents, (#3 and #4). Findings: 1. Review of the medical record revealed resident #3 was admitted to the facility on . Her diagnoses included aneurysm of of upper extremity, ( ), and rapidly progressive nephritic with diffuse crescentic . According to the National Library of Medicine, "Rapidly progressive (RPGN) is a clinical manifested by features of nephritic and rapid loss of the function over a period of a few weeks to months." (Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC4720204/ on). Review of resident #3's physician orders revealed	N 201	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Information related to resident #3 was obtained during a historical document review and interview process. On , the physician for resident #3 was contacted with new orders to administer the Sevelamer once a day at 5pm while the resident was in the facility instead of administration at the clinic. Information related to resident #4 was obtained during a historical document review and interview process related to the incomplete communication forms on and when the	

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N 201	Continued From page 10 an order dated for Sevelamer 800 milligrams (mg) 3 tables before meals for hypocalcemia related to . Sevelamer administration was scheduled for 6:30 AM, 11:30 AM, and 4:30 PM daily. Review of resident #3's Medication Administration Record (MAR) showed Sevelamer was administered on at 6:30 AM, at 6:30 AM and 4:30 PM, at 6:30 AM, and at 6:30 AM, 11:30 AM and 4:30 PM for a total of 7 doses. Review of the Progress Note revealed Sevelamer was not available to resident #3 from to : * at 6:06 PM - on order, awaiting for pharmacy, physician aware * at 12:17 PM - pending pharmacy delivery * at 5:17 PM read, "Medication is not available, Medication has been reordered from pharmacy. Awaiting delivery from pharmacy. MD (physician) notified." * at 7:47 AM read, "Medication is not available. Contacted pharmacy. Awaiting approval." * at 10:40 AM read, "Pharmacy states they have to go through to send pill, awaiting delivery." * at 6:29 AM read, "Medication is not available. Contacted pharmacy. Awaiting approval." * at 11:03 AM read, "Awaiting pharmacy delivery." * at 8:08 AM read, "Waiting arrival from pharmacy." * at 4:41 PM read, " to give."	N 201	resident returned from . Resident #4 discharged from the facility on to the community. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed a 14 day look audit of active residents receiving treatments to identify other residents having the potential to be affected by: 1. Ensuring medications are administered in accordance with physician orders and documented in the clinical record with emphasis on , binders. 2. Ensuring communication sheets are completed prior to , completed by the center and then completed by the facility upon return from or appropriately documented in the clinical record. Any concerns identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On , the Director of Nursing/designee completed re-education with the licensed nursing staff on the	

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N 201	Continued From page 11 * at 6:39 AM read, " to give." * at 12:36 PM read, "Awaiting delivery. MD aware." * at 3:40 PM read, "Waiting on pharmacy." * at 12:53 PM read, "Medication to be administered at ." A Progress Provider Note entered by the Physician Assistant on revealed there were no concerns shared by the nursing staff. Review of resident #3's Baseline Care Plan initiated on read, "Resident needs ." Interventions included, "Administer any physician ordered medications for functioning. Monitor for side effects. . . . Communicate and collaborate with center regarding , medication, diet, and lab results." On at 1:30 PM, the Director of Nursing (DON) stated a new regulation from Centers for Medicare and Medicaid Services as of , specified centers were responsible for providing the binders which included Sevelamer. She explained they requested a 5-day supply of Sevelamer from their pharmacy for resident #3. The DON shared she expected to provide Sevelamer within 24 hours, but this was a brand-new rule, and everyone was "struggling with it." She stated the Transitional Care Unit Manager (UM) placed multiple phone calls yesterday with . On at 1:35 PM, the UM stated she called their pharmacy yesterday because did not have Sevelamer. She explained she had called every single day and informed the	N 201	components of this regulation with emphasis on: 1. Ensuring medications are administered in accordance with physician orders and documented in the clinical record with emphasis on binders. 2. Ensuring communication sheets are completed prior to , completed by the center and then completed by the facility upon return from or appropriately documented in the clinical record. Newly hired licensed nursing staff will be educated on these components during orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of at least 5 residents receiving services 3 times weekly X 4 weeks and then weekly X 2 months to ensure: 1. Medications are administered in accordance with physician orders and documented in the clinical record with emphasis on binders. 2. communication sheets are completed prior to , completed by the center and then completed by the facility upon return from or appropriately documented in the clinical record.	

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	70517	A. BUILDING: _____ B. WING _____	C 02/12/2025

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N 201	Continued From page 12 physician, but she did not document it in resident #3's medical record. She explained they recently received corporate approval for a 5-day supply of Sevelamer and it was received yesterday morning. She did not recall if she mentioned to that resident #3 had not had one dose of Sevelamer since admission. At 2:18 PM, the UM stated she reviewed the documentation for resident #3 and could not find evidence that Sevelamer was here before this morning. She stated she spoke with the nurses who documented administration of Sevelamer when the medication was not available and she said they did not have an answer. She mentioned one of the nurses confirmed he did not give the medication but documented he gave it and could not explain why he did that. Review of the Pharmacy Packing Slip dated revealed resident #3's Sevelamer was included. The Signature, Date Signed, and Time Signed sections of the form were blank. 2. Review of the medical record revealed resident #4 was admitted to the facility on . His diagnoses included with intoxication, , and . Review of a Provider Progress Note dated revealed a diagnosis of acute injury on . According to the National Foundation, " is a type of treatment that helps your body remove extra fluid and waste products from your when the are not able to." By performing some of the 's usual duties, helps to maintain safe levels of in	N 201	Findings of these audits will be reviewed in the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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N 201	Continued From page 13 your , such as , , , and . The organization's website indicated it was important to complete treatments according to the prescribed schedule and inform the provider about medications and supplements taken. (Retrieved on from https://www. .org/atoz/content/). Review of resident #4's Baseline Care Plan initiated on read, "Resident needs ." Interventions included, "Communicate and collaborate with center regarding , medication, diet, and lab results. . . . Resident goes out to . Check with nurse for the schedule and assist the resident to be ready to go on time. A bag of lunch may be needed, help ensure the resident has it with them." Review of resident #4's physician orders revealed an order dated which indicated center on Tuesday, Thursday and Saturday, with chair time at 7:30 AM and pick up at 6:15 AM. On at 10:31 AM, resident #4 explained he received 3 times per week. He indicated this was temporary and yesterday was his 4th time. A binder was noted at his bedside table and the cover had the name of the center where he received his treatments. Resident #4 said he brought the binder from his treatment yesterday and it was left in his room. Review of the binder revealed 2 Transfer Forms dated and . The top and middle sections were completed, but the bottom, Post-Treatment section, was blank on both forms. Resident #4 shared he did not get a snack nor	N 201		

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N 201	Continued From page 14 breakfast yesterday when he left for , but he ate lunch upon his return to the facility. Review of the Transfer Form, given to residents who went to on each visit, revealed the document included 3 sections. The top and bottom sections were to be completed by the facility's nurses and the middle section by the nurse. Resident #4's form dated included a message from that read, "Please place hoyer under patient for transfer." The nurse also wrote resident #4 was late for treatment and received an abbreviated treatment. There was no evidence in resident #4's medical record the note was clarified or addressed by the facility. On at 10:50 AM, Licensed Practical Nurse (LPN) B stated resident #4's treatment was in the early morning. She explained they gave him a binder with the transfer form and lunch to take with him. She recalled resident #4 left for yesterday at approximately 7:30 AM and he was by the nurses station when she started her shift at 7:00 AM. She mentioned when he returned from before the end of her shift, she took his vital signs, and he ate lunch. She stated she reviewed the binder from and completed the section at the bottom. She indicated she documented the vital signs on the form also, as she did not enter a note in the Electronic Medical Record (EMR). She stated they kept the binder by the nurses station, not in the resident's room. At 10:56 AM, the nurse walked into resident #4's room and the UM was in the room holding the binder in her . On at 11:00 AM, the UM explained any	N 201		

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N 201	Continued From page 15 information they would like to communicate to ¸ was included in the ¸ binder. She stated when a resident returned from ¸ , transportation staff took the resident to his room, and they were expected to the binder to the nurse. She indicated the binder was not left in the resident's room. She shared she expected the nurse to take the vital signs, observe the ¸ port site, and document it on the transfer form. She indicated she was not sure if the assessment was also documented in the EMR or not. The UM looked in resident #4's EMR and stated there was documentation of the vital signs for Saturday at 2:23 PM but not for yesterday. She indicated she did not see a progress note entered for or after the resident returned from ¸ . She validated the forms dated and in resident #4's binder were not completed after he returned to the facility from ¸ . She mentioned at times binders were left at the ¸ center and she was looking for resident #4's binder this morning but could not locate it. She said she was not aware resident #4 did not get breakfast or snacks before going to ¸ but she was aware of an issue with transportation yesterday. She indicated she had not seen the note added by the ¸ nurse on . She noted the expectation was for the nurses to review the transfer form and address any questions or concerns by the ¸ team. On at 12:31 PM, the Director of Nursing (DON) stated their practice was to "chart when there is something to chart about." She indicated an assessment was done by the nurse upon the resident's return from ¸ based on the documentation on the Treatment Administration Record (TAR). She explained the TAR showed a	N 201		

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N 201	Continued From page 16 check mark when the nurses assessed the resident's every shift. She stated the Transfer Form was a tool to communicate with the center and nurses were expected to review it when residents returned from . Review of the agreement between the center for resident #3 and the facility dated read, "Emergency and non-emergency changes in a resident's medical condition will be immediately communicated by the party having primary knowledge of the change to the other party. Center will communicate with Nursing Facility via Communication Form, including when a resident refuses scheduled medical management or non-compliance with medical management relating to treatment (i.e. diet, fluid restriction and medications). Center will also provide Nursing Facility with a Patient Plan and Progress Report for each resident served." Class III	N 201		

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F 000	INITIAL COMMENTS Complaint Investigations #2025000902 and #2025001641 were conducted from to . The complaints were not substantiated but Viera Health and Rehabilitation Center was not in compliance with 42 CFR 483 and 488, requirements for Long Term Care Facilities.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent , and does not develop , unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with , receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent and prevent new from developing. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to provide care and services to promote healing of a , (PU) as ordered by the physician for 1 of 1 residents reviewed for , , of a total sample of 10 residents, (#9). Findings: Review of the medical record revealed resident #9 was admitted to the facility on with	F 686	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:	

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

Electronically Signed /2025

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.

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F 686	Continued From page 1 diagnoses including aftercare following , replacement surgery, type 2 , and . Review of the Admission Summary Progress Notes dated revealed resident #9 required assistance with activities of daily living including bed mobility, transfers, ambulation, , bathing, and toileting. Review of resident #9's Admission Minimum Data Set (MDS) assessment with Assessment Reference Date of revealed she had a score of 12 out of 15 which indicated moderate cognition , . The MDS assessment noted no rejection of care necessary to obtain goals for her health and well-being. The MDS assessment showed resident #9 was identified at risk of developing PU/injuries, she had a PU and a surgical . The National Pressure Injury Advisory Panel defines a pressure injury or as "localized damage to the skin and underlying soft tissue usually over a bony prominence. . .The injury can present as intact skin or an open and may be painful" (retrieved on from www.npiap.com). Review of resident #9's medical record revealed a PRN (as needed) Skin Check form dated . The form read, "New skin , (s) that have not been previously noted - yes. Open area. Treatment in place. dr. (physician) to evaluate." Review of resident #9's medical record revealed a	F 686	Information related to resident #9 was gathered through a historical document review and interview process. On , the nurse contacted the physician for resident #9 who gave orders for with , C and as recommended. On , the physician for resident #9 assessed the areas of skin , with continued healing noted. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed a 14 day look audit of active residents requiring care to identify other residents having the potential to be affected to ensure: 1. Treatments were performed and documented in the clinical record in accordance with physician orders. 2. Recommendations for care, including supplemental , were communicated with the physician and implemented in accordance with physician orders. Any concerns identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make	

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F 686	Continued From page 2 Change in Condition Evaluation dated read, "Resident stated her bottom was hurting. Assessed the area and noted an open between the cheeks of her ." The document indicated the physician was notified, and treatment orders and a consultation to the care physician were obtained. Review of resident #9's physician orders revealed an order dated to cleanse the with normal , apply , and cover with bordered gauze daily and as needed if the was soiled or dislodged. Review of resident #9's Treatment Administration Record (TAR) and Progress Notes for revealed care was not performed on and . Review of resident #9's medical record revealed a care plan for skin , of a surgical to the right and PU to initiated on . The goal was the resident would demonstrate healing without complications. The interventions included, "Perform treatments as ordered." Review of an Initial Evaluation & Management Summary form dated by the Care Physician revealed a , full thickness which measured 2.0 x 2.2 x 0.3 centimeters with moderate , 75% tissue, and 25% tissue. The treatment plan was to apply , a gauze island with border and skin prep on the peri daily. The physician's recommendations	F 686	to ensure that the practice does not recur: On , the Director of Nursing/designee completed re-education with the licensed nursing staff on the components of this regulation with emphasis on ensuring: 1. Treatments are performed and documented in the clinical record in accordance with physician orders. 2. Recommendations for care, including supplemental , are communicated with the physician and implemented in accordance with physician orders. Newly hired licensed nursing staff will be educated on these components during orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of at least 5 residents requiring care 3 times weekly X 4 weeks and then weekly X 2 months to ensure: 1. Treatments are performed and documented in the clinical record in accordance with physician orders. 2. Recommendations for care, including supplemental , are communicated with the physician and implemented in accordance with physician	

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F 686	Continued From page 3 included a daily, C 500 milligrams (mg) twice daily and Sulphate 220 mg daily for 14 Days. Review of resident #9's physician orders did not include a daily, C 500 milligrams (mg) twice daily or Sulphate 220 mg daily for 14 Days. On at 11:55 AM, Licensed Practical Nurse (LPN) A stated he, along with another nurse, performed care to residents with in the facility 7 days a week. He indicated the other care nurse rounded most often with the care physician but whenever he did it, he removed the ,, and cleaned the resident's , and redressed the after the care physician was done. He indicated he asked the care physician if there were any new orders when he finished with each resident. He explained after the care physician left the facility, they received their progress notes, usually within 3 to 4 hours, on the same day. He indicated if he felt he was lacking information, he referred to the progress note but not often. LPN A reviewed the Initial Evaluation & Management Summary form dated and validated the , C and the Sulphate were not added to resident #9's orders. He mentioned if the care physician did not mention any new orders, he did not check the notes, so "that is on me, but I will be doing it going on apparently." He explained he documented whenever he performed care. He stated he did not work on or and could not explain why care was not done those days.	F 686	orders. Findings of these audits will be reviewed in the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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F 686	Continued From page 4	F 686		

On at 12:57 PM, the Director of Nursing (DON) explained the facility had 2 nurses who performed care regularly, but they had a up if those nurses were out. She indicated her expectation for the care nurses was to perform care to any , or surgical and document it. She shared there was someone assigned to perform care 7 days a week. She expected the nurse performing care to either enter a progress note or sign off the TAR when care was done. She stated the physician should give new orders at time of rounding. She indicated the care nurse should review the note from the physician when received and update the log each Friday. She stated she expected the nurse who updated the log to follow up on the physician's recommendations. She indicated if a recommendation was discovered during review of the note, the primary physician would be contacted. The DON explained if the primary physician agreed with the recommendations, the care nurse would enter the orders. The DON stated it did not appear the care nurse followed through with the care physician's recommendations for resident #9. When asked why care was not performed on and for resident #9, the DON response was she knew who the nurse was those days, and that nurse always documented. She validated she did not see a progress note and the TAR was blank on or .

Review of the facility's policy and procedure titled Care dated read, " care procedures and treatments should be performed according to the physician orders." The policy

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F 686	Continued From page 5 included to document in the clinical record when treatment was performed.	F 686		
F 698 SS=D	CFR(s): 483.25(l) §483.25(l) The facility must ensure that residents who require receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain effective communication between nursing staff and medical providers and failed to collaborate with a center to promote adequate treatment, monitoring, and continuity of care for 2 of 4 residents reviewed for care and services, out of a total sample of 10 residents, (#3 and #4). Findings: Cross Reference F842 1. Review of the medical record revealed resident #3 was admitted to the facility on . Her diagnoses included aneurysm of of upper extremity, ( ), and rapidly progressive nephritic with diffuse crescentic . According to the National Library of Medicine, "Rapidly progressive , (RPGN) is a clinical manifested by features of nephritic and rapid loss of the function over a period of a few weeks to months."	F 698	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Information related to resident #3 was obtained during a historical document review and interview process. On , the physician for resident #3 was contacted with new orders to administer the Sevelamer once a day at 5pm while the resident was in the facility instead of administration at the clinic. Information related to resident #4 was obtained during a historical document	

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F 698	Continued From page 6 (Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC4720204 / on). Review of resident #3's physician orders revealed an order dated for Sevelamer 800 milligrams (mg) 3 tables before meals for hypocalcemia related to . Sevelamer administration was scheduled for 6:30 AM, 11:30 AM, and 4:30 PM daily. Review of resident #3's Medication Administration Record (MAR) showed Sevelamer was administered on at 6:30 AM, at 6:30 AM and 4:30 PM, at 6:30 AM, and at 6:30 AM, 11:30 AM and 4:30 PM for a total of 7 doses. Review of the Progress Note revealed Sevelamer was not available to resident #3 from to : * at 6:06 PM - on order, awaiting for pharmacy, physician aware * at 12:17 PM - pending pharmacy delivery * at 5:17 PM read, "Medication is not available, Medication has been reordered from pharmacy. Awaiting delivery from pharmacy. MD (physician) notified." * at 7:47 AM read, "Medication is not available. Contacted pharmacy. Awaiting approval." * at 10:40 AM read, "Pharmacy states they have to go through to send pill, awaiting delivery." * at 6:29 AM read, "Medication is not available. Contacted pharmacy. Awaiting	F 698	review and interview process related to the incomplete communication forms on and when the resident returned from . Resident #4 discharged from the facility on to the community. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed a 14 day look audit of active residents receiving treatments to identify other residents having the potential to be affected by: 1. Ensuring medications are administered in accordance with physician orders and documented in the clinical record with emphasis on binders. 2. Ensuring communication sheets are completed prior to completed by the center and then completed by the facility upon return from or appropriately documented in the clinical record. Any concerns identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:	

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	105885	A. BUILDING _____ B. WING _____	C 02/12/2025

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F 698	Continued From page 7 approval." * at 11:03 AM read, "Awaiting pharmacy delivery." * at 8:08 AM read, "Waiting arrival from pharmacy." * at 4:41 PM read, " to give." * at 6:39 AM read, " to give." * at 12:36 PM read, "Awaiting delivery. MD aware." * at 3:40 PM read, "Waiting on pharmacy." * at 12:53 PM read, "Medication to be administered at ." A Progress Provider Note entered by the Physician Assistant on revealed there were no concerns shared by the nursing staff. Review of resident #3's Baseline Care Plan initiated on read, "Resident needs ." Interventions included, "Administer any physician ordered medications for functioning. Monitor for side effects. . . . Communicate and collaborate with center regarding , medication, diet, and lab results." On at 1:30 PM, the Director of Nursing (DON) stated a new regulation from Centers for Medicare and Medicaid Services as of , specified centers were responsible for providing the binders which included Sevelamer. She explained they requested a 5-day supply of Sevelamer from their pharmacy for resident #3. The DON shared she expected to provide Sevelamer within 24 hours, but this was a brand-new rule, and everyone was "struggling with it." She stated the	F 698	On , the Director of Nursing/designee completed re-education with the licensed nursing staff on the components of this regulation with emphasis on: 1. Ensuring medications are administered in accordance with physician orders and documented in the clinical record with emphasis on binders. 2. Ensuring communication sheets are completed prior to completed by the center and then completed by the facility upon return from or appropriately documented in the clinical record. Newly hired licensed nursing staff will be educated on these components during orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of at least 5 residents receiving services 3 times weekly X 4 weeks and then weekly X 2 months to ensure: 1. Medications are administered in accordance with physician orders and documented in the clinical record with emphasis on binders. 2. communication sheets are completed prior to , completed by	

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F 698	Continued From page 8 Transitional Care Unit Manager (UM) placed multiple phone calls yesterday with ˛ . On at 1:35 PM, the UM stated she called their pharmacy yesterday because ˛ did not have Sevelamer. She explained she had called ˛ every single day and informed the physician, but she did not document it in resident #3's medical record. She explained they recently received corporate approval for a 5-day supply of Sevelamer and it was received yesterday morning. She did not recall if she mentioned to ˛ that resident #3 had not had one dose of Sevelamer since admission. At 2:18 PM, the UM stated she reviewed the documentation for resident #3 and could not find evidence that Sevelamer was here before this morning. She stated she spoke with the nurses who documented administration of Sevelamer when the medication was not available and she said they did not have an answer. She mentioned one of the nurses confirmed he did not give the medication but documented he gave it and could not explain why he did that. Review of the Pharmacy Packing Slip dated revealed resident #3's Sevelamer was included. The Signature, Date Signed, and Time Signed sections of the form were blank. 2. Review of the medical record revealed resident #4 was admitted to the facility on . His diagnoses included with intoxication, ˛ , and ˛ ˛ . Review of a Provider Progress Note dated revealed a diagnosis of acute ˛ injury on	F 698	the ˛ center and then completed by the facility upon return from ˛ or appropriately documented in the clinical record. Findings of these audits will be reviewed in the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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F 698	Continued From page 9	F 698		

According to the National Foundation, " is a type of treatment that helps your body remove extra fluid and waste products from your when the are not able to." By performing some of the 's usual duties, helps to maintain safe levels of in your , such as , , , , and . The organization's website indicated it was important to complete treatments according to the prescribed schedule and inform the provider about medications and supplements taken. (Retrieved on from https://www. .org/atoz/content/).

Review of resident #4's Baseline Care Plan initiated on read, "Resident needs ." Interventions included, "Communicate and collaborate with center regarding , medication, diet, and lab results. . . . Resident goes out to . Check with nurse for the schedule and assist the resident to be ready to go on time. A bag of lunch may be needed, help ensure the resident has it with them."

Review of resident #4's physician orders revealed an order dated which indicated center on Tuesday, Thursday and Saturday, with chair time at 7:30 AM and pick up at 6:15 AM.

On at 10:31 AM, resident #4 explained he received 3 times per week. He indicated this was temporary and yesterday was his 4th time. A binder was noted at his bedside table and

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F 698	Continued From page 10	F 698		

the cover had the name of the , center where he received his treatments. Resident #4 said he brought the binder from his treatment yesterday and it was left in his room. Review of the binder revealed 2 , Transfer Forms dated and . The top and middle sections were completed, but the bottom, Post- , Treatment section, was blank on both forms. Resident #4 shared he did not get a snack nor breakfast yesterday when he left for , , but he ate lunch upon his return to the facility.

Review of the , Transfer Form, given to residents who went to , on each visit, revealed the document included 3 sections. The top and bottom sections were to be completed by the facility's nurses and the middle section by the , nurse. Resident #4's form dated included a message from , that read, "Please place hoyer , under patient for transfer." The , nurse also wrote resident #4 was late for treatment and received an abbreviated treatment. There was no evidence in resident #4's medical record the note was clarified or addressed by the facility.

On at 10:50 AM, Licensed Practical Nurse (LPN) B stated resident #4's , treatment was in the early morning. She explained they gave him a binder with the transfer form and lunch to take with him. She recalled resident #4 left for , yesterday at approximately 7:30 AM and he was by the nurses station when she started her shift at 7:00 AM. She mentioned when he returned from , before the end of her shift, she took his vital signs, and he ate lunch. She stated she reviewed the binder from , and completed

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F 698	Continued From page 11	F 698		

the section at the bottom. She indicated she documented the vital signs on the form also, as she did not enter a note in the Electronic Medical Record (EMR). She stated they kept the binder by the nurses station, not in the resident's room. At 10:56 AM, the nurse walked into resident #4's room and the UM was in the room holding the binder in her .

On at 11:00 AM, the UM explained any information they would like to communicate to was included in the binder. She stated when a resident returned from , transportation staff took the resident to his room, and they were expected to the binder to the nurse. She indicated the binder was not left in the resident's room. She shared she expected the nurse to take the vital signs, observe the port site, and document it on the transfer form. She indicated she was not sure if the assessment was also documented in the EMR or not. The UM looked in resident #4's EMR and stated there was documentation of the vital signs for Saturday at 2:23 PM but not for yesterday. She indicated she did not see a progress note entered for or after the resident returned from . She validated the forms dated and in resident #4's binder were not completed after he returned to the facility from . She mentioned at times binders were left at the center and she was looking for resident #4's binder this morning but could not locate it. She said she was not aware resident #4 did not get breakfast or snacks before going to but she was aware of an issue with transportation yesterday. She indicated she had not seen the note added by the nurse on

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F 698	Continued From page 12 . She noted the expectation was for the nurses to review the transfer form and address any questions or concerns by the team. On at 12:31 PM, the Director of Nursing (DON) stated their practice was to "chart when there is something to chart about." She indicated an assessment was done by the nurse upon the resident's return from based on the documentation on the Treatment Administration Record (TAR). She explained the TAR showed a check mark when the nurses assessed the resident's every shift. She stated the Transfer Form was a tool to communicate with the center and nurses were expected to review it when residents returned from . Review of the agreement between the center for resident #3 and the facility dated read, "Emergency and non-emergency changes in a resident's medical condition will be immediately communicated by the party having primary knowledge of the change to the other party. Center will communicate with Nursing Facility via Communication Form, including when a resident refuses scheduled medical management or non-compliance with medical management relating to treatment (i.e. diet, fluid restriction and medications). Center will also provide Nursing Facility with a Patient Plan and Progress Report for each resident served."	F 698		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		

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F 842	Continued From page 13	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
( ) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical

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F 842	Continued From page 14 record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; ( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, , and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately document the administration of medications in the Medication Administration Record (MAR) for 1 of 5 residents reviewed for medications, out of a total sample of 10 residents, (#3). Findings: Cross Reference F698 Review of the medical record revealed resident #3 was admitted to the facility on . Her	F 842	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Information related to resident #3 was	

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F 842	Continued From page 15 diagnoses included aneurysm of , of upper extremity, ( ), and rapidly progressive nephritic , with diffuse crescentic , According to the National Library of Medicine, "Rapidly progressive , (RPGN) is a clinical , manifested by features of nephritic , and rapid loss of the , function over a period of a few weeks to months." (Retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC4720204 / on). Review of resident #3's physician orders revealed an order dated for Sevelamer 800 milligrams (mg) 3 tables before meals for hypocalcemia related to . Sevelamer administration was scheduled for 6:30 AM, 11:30 AM, and 4:30 PM daily. Review of resident #3's MAR showed Sevelamer was administered on at 6:30 AM, at 6:30 AM and 4:30 PM, at 6:30 AM, and at 6:30 AM, 11:30 AM and 4:30 PM for a total of 7 doses. Review of the Progress Note revealed Sevelamer was not available to resident #3: * at 6:06 PM - on order, awaiting for pharmacy and the physician was aware. * at 12:17 PM - pending pharmacy delivery. * at 5:17 PM read, "Medication is not available, Medication has been reordered from pharmacy. Awaiting delivery from pharmacy. MD (physician) notified." * at 7:47 AM read, "Medication is not	F 842	obtained during a historical document review and interview process. On , the physician for resident #3 was notified of the medication variation/inaccuracy of documentation of administration; new orders to administer the Sevelamer once a day at 5pm while the resident was in the facility instead of administration at the , clinic. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed a 7 day look audit of active residents to ensure accuracy of the medical record and accurate documentation of medication administration to identify other residents having the potential to be affected. Any concerns identified were immediately addressed. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: On , the Director of Nursing/designee completed re-education with the licensed nursing staff on the components of this regulation with emphasis on ensuring accuracy of the clinical record and accurate documentation	

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F 842	Continued From page 16 available. Contacted pharmacy. Awaiting approval." * at 10:40 AM read, "Pharmacy states they have to go through ˛ to send pill, awaiting delivery." * at 6:29 AM read, "Medication is not available. Contacted pharmacy. Awaiting approval," * at 11:03 AM read, "Awaiting pharmacy delivery." * at 8:08 AM read, "Waiting arrival from pharmacy." * at 4:41 PM read, " ˛ to give." * at 6:39 AM read, " ˛ to give." * at 12:36 PM read, "Awaiting delivery. MD aware." * at 3:40 PM read, "Waiting on pharmacy." * at 12:53 PM read, "Medication to be administered at ˛ ." Review of resident #3's Baseline Care Plan initiated on read, "Resident needs ˛ ." Interventions included, "Administer any physician ordered medications for functioning. Monitor for side effects. . . . Communicate and collaborate with ˛ center regarding ˛ , medication, diet, and lab results." On at 1:35 PM, the Transitional Care Unit Manager (UM) stated she called their pharmacy yesterday because ˛ did not have Sevelamer. She shared she called ˛ every single day and informed the physician, but she did not document it in resident #3's medical record. She explained they recently received corporate approval for a 5-day supply of Sevelamer and it	F 842	of medication administration. Newly hired licensed nurses will be educated on these components during orientation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing/designee will conduct an audit of at least 5 residents clinical records 3 times weekly X 4 weeks and then weekly X 2 months to ensure accuracy of the clinical record with emphasis on documentation of medication administration. Findings of these audits will be reviewed in the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	

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F 842	Continued From page 17	F 842		

was received yesterday morning. Later at 2:18 PM, the UM stated she reviewed the documentation for resident #3 and could not find evidence that Sevelamer was in the facility before this morning. She stated she spoke with the nurses who documented the administration of Sevelamer when the medication was not available, and she said they did not have an answer. She mentioned one of the nurses confirmed he did not give the medication but documented he gave it and could not explain why he did that.

Review of the Pharmacy Packing Slip dated revealed resident #3's Sevelamer was included. The Signature, Date Signed, and Time Signed sections of the form were blank.

On at 2:54 PM, the Director of Nursing (DON) stated she expected the nurses to document accurately in the medical record. She indicated if a medication was not given, the physician needed to be informed, and the communication documented in the medical record. She mentioned she was not sure of the steps the facility's UMs took to communicate with the centers regarding the unavailability of Sevelamer or if they documented their efforts. She said, "We do the best we can, do I document every single conversation I have with a physician or family? I cannot and I do not." She shared she had spoken to 3 physicians today and had not documented any of those conversations.

Review of the policy titled Resident Identifiable Information / Medical Records dated revealed the intent to maintain a medical record for each resident in accordance with federal and state

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F 842	Continued From page 18 guidelines. The document read, "Medical records on each resident will be accurately documented; readily accessible; and systematically organized."	F 842		
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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	105885	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIERA HEALTHCARE AND REHABILITATION CENTER	8050 SPYGLASS HILL RD VIERA, FL 32940

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F 880	Continued From page 19 communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to adhere to proper hygiene and use of personal protective equipment (PPE) practices per control standards	F 880	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth	

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F 880	Continued From page 20 when handling soiled linens in 1 of 2 units. Findings: On at 10:43 AM, Certified Nursing Assistant (CNA) C was observed leaving with a bag of dirty linens in a plastic bag and wearing a glove on her right . While holding the bag and wearing the glove, CNA C entered , asked the resident if everything was okay, removed the glove in her right and kept it in her , then grabbed a couple of hospital gowns that were lying on a chair in with her other . CNA C left and re-entered , placed the bag on the floor, touched the bed sheet and left the room without performing hygiene. On at 1:45 PM, CNA C acknowledged she left with soiled linens in a plastic bag while wearing a glove on her right when she entered . She stated she was taking trash, gowns and things patients no longer needed to the soiled utility room. She indicated she was assigned 12 residents who had to be ready for , , and , , and she was "only one" and did not always have time to go around for all the tasks she was assigned to do. She said, "The correct way, politically, I was supposed to dispose the bag in the soiled utility room." She stated she was "just trying to do so many things at one time. I do the best I can." She validated bringing a bag of soiled linens from one room to another was "an issue." She indicated she "was not supposed to have gloves on in the hallway because of control." She added when she removed gloves, she was supposed to wash her and	F 880	on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: On , the Unit Manager re-educated CNA (C) on control techniques including ensuring soiled linens are not brought from resident room to resident room, gloves are not worn in the hallway and proper hygiene is to be completed prior to donning gloves and after doffing gloves. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: On , the Director of Nursing/designee completed an observational audit of nursing staff to identify other residents having the potential to be affected by ensuring: 1. Soiled linens are not brought from resident to resident rooms. 2. Gloves are not worn in the hallway. 3. Proper hygiene is conducted prior to donning of gloves and after doffing of gloves. Any concerns identified were immediately addressed.	

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F 880	Continued From page 21	F 880		

confirmed she did not perform hygiene. She confirmed she grabbed the hospital gowns on the chair and removed them from the room without placing them in a plastic bag. She stated she left them in the soiled utility room. She asked, "What do I do if I am carrying soiled items and a call light is on or a resident , what am I supposed to do?" She then stated she was supposed to take it to the soiled utility room when done with patient care. She indicated she received Control training during her orientation in , .

Review of a Certificate of Completion for Control: Comprehensive Review dated revealed satisfactory completion by CNA C. Review of Certificates of Completion for Donning and Doffing PPE and Principles of Control and , revealed satisfactory completion by CNA C on .

On at 3:11 PM, the Direct of Nursing (DON) stated staff could not bring soiled linens into another resident's room or wear gloves in the hall. She stated CNA C was not following their policy.

Review of the facility's policy titled Standard Precautions for Control dated read, "It will be the policy of this facility to assume that every person is potentially or colonized with an organism that could be transmitted in the healthcare setting and apply the following control practices during the delivery of health care." The document revealed hygiene was considered the primary means of preventing the transmission of . The policy instructed staff to remove and discard PPE

(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:

On , the Director of Nursing/designee re-educated the nursing staff on the components of this regulation and completed an observational audit of nursing staff with emphasis on ensuring:
1. Soiled linens are not brought from resident to resident rooms.
2. Gloves are not worn in the hallway.
3. Proper hygiene is conducted prior to donning of gloves and after doffing of gloves.

Newy hired nursing staff will be educated on these components during orientation.

(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:

The Director of Nursing/designee will conduct an observational audit of at least 10 nursing staff members 3 times weekly X 4 weeks and then weekly X 2 months to ensure:
1. Soiled linens are not brought from resident to resident rooms.
2. Gloves are not worn in the hallway.
3. Proper hygiene is conducted prior to donning of gloves and after doffing of gloves.

Findings of these audits will be reviewed in

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F 880	Continued From page 22 before leaving the resident's room.	F 880	the QA/Risk Management meeting monthly until such time as the committee determines substantial compliance has been achieved.	