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
	AL11968483	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIERA	3325 BRESLAY DR MELBOURNE, FL 32940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A survey for Complaint # 2023014336 was conducted on [redacted] and [redacted] at [redacted] Viera Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision for 1 of 10 sampled residents who sustained . . Findings: On . . . . . at 1:35am resident #1 was found lying on his bedroom floor by nurse (E). He stated he hit his . . . hard. He was transferred to the hospital via 911.On documented at10:04am by staff (I). Notified by the resident's spouse that resident , , .	A 025		

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A 025	Continued From page 2 A review of resident #1's record revealed he moved into the facility on . He was discharged to the hospital on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included , , , and 's. He was independent with ambulation, toileting, and transfer. He required cueing for bathing, and and supervision for grooming and eating. Safety awareness was documented under special precautions on the1823. A review of the facility notes revealed 9 . 8 occurred in his apartment. (#9) On documented at 2:48am by nurse (E). without injury at 1:35am. Alert and responsive lying on his bedroom floor on his right side. Unable to give a clear answer how it happened. Stated he hit his hard. The right side of had a lump and a small . 911 to hospital. (#8) On documented by nurse (C) at 6:25pm resident found sitting on the floor near the bathroom. Bump on his right . His Spouse took him to urgent care. 8:50pm returned with wife. (#7) On documented by nurse (E). At 4:30am without injury. Resident lying on his on the floor. (#6) On 3:59am documented by nurse (F). Observed resident lying on apartment floor. He said he laid down on the floor. Encouraged to wear slipper socks.	A 025		

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A 025	Continued From page 3 (#5) On documented by nurse (G) at 1:33pm. Resident found lying on his . The resident did not have a pendant, but it was put in place before leaving the room. (#4) On documented by nurse (G) at 1:10pm. Resident found lying on the floor by the resident assistant. (#3) On documented by nurse (C) at 12:41pm. The resident was on the floor in the lunchroom. Transferred via 911 to the hospital. Returned with no findings the same day. (#2) On documented by nurse (H). Wife found resident on the floor at 5:30pm. (#1) On documented by nurse (H). At 8:10am found resident on the floor on his next to the bed. No injury. Encourage to use the call bell. Further review of resident #1's record found on a Mobility/ risk criteria form was completed on admission by staff (C). 5 risks were identified. New admission, ambulation issues, , sensory awareness, medications with side effects, diagnoses which predispose to . On Nurse (I) met with the resident's spouse and son in law for a 30-day review. A negotiated risk assessment was signed by the spouse, and she agreed to purchase a motion sensor for the resident's apartment due to . There was documentation of a Level of care change dated due to . His level of care was increased from a level 3 to a level 4 ($300). His record did not contain documentation	A 025		

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A 025	Continued From page 4 about what aspects of care increased. A review of the facility policy dated revised titled Management Protocol revised documented: "The resident Care Director and team members must be aware that any change of condition, environmental hazards, medical conditions, and process can increase the risk of ." "The resident Care Director will revise the Service Plan noting the individualized interventions." On a Mobility/ risk criteria form completed by nurse (I). 9 risks were identified. history (no comments documented), ambulation issues, uses assistive device, injuries from past (no comments documented), , , sensory awareness, Medications with side effects, diagnoses which predispose to , , and , safety awareness. On at 12:20pm the Administrator confirmed there was a significant change documented on the Mobility/ risk criteria form. She could not provide any service plans or forms mentioned in the policy in place at the time of the incident. On at 11:15am nurse (I) said in interview, the facility did order the motion sensor but the one that came was not compatible with their system. By the time the right part came, he was gone. She said she did not remember what other mitigating factors were put into place to decrease his likelihood of with injury. On at 11:20am. Staff (J) said there were a lot of changes in staff in and	A 025		

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A 025	Continued From page 5 2022. She was in the process of changing jobs. The regional director sat in until the new administrator started. She said she remembered resident #1's name but could not recall any specifics. She did not recall him enough to know if he was a faller or if anything specific was put into place. She again said there were a lot of changes. On .. .... at 1:45pm the Administrator confirmed no staff schedules could be provided for review for . . . . . , ... , or . . . . . . On .. .... at 2:06pm Nurse (E) said in interview, she worked the night shift. She did kind of remember resident #1. She said they checked on him often. As much as every 15 minutes. She could not recall staffing, but they may have been short due to COVID. She could not recall any special things that were put in place for him. On .. .... at 1:50pm The Administrator confirmed she could not provide any documentation of .. mitigating strategies put in place to decrease . with injury for resident #1 except the nurses documenting in the facility notes to remind resident (with) to use call pendant and non-skid socks. (Photo evidence obtained) Class II	A 025		