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
	AL11969906	A. BUILDING: _____ B. WING _____	08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST AT VIERA	4206 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 complaint investigation #2023006857 was conducted on [redacted] at [redacted] East at Viera Assisted Living Facility. There were deficiencies identified at the time of the visit.	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 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 or . 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 , , 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		

AHCA Form 3020-0001

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

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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 record reviews, and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to for 3 of 3 residents sampled who sustained multiple with injury. (#1, 2, and 3) Findings: On . . . . . A review of resident #1 record revealed she was admitted on and discharged on . . . . . . Her record contained a Resident Health Assessment form (1823) dated . . . . . Her diagnoses included right	A 025		

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A 025	Continued From page 2 , and a history of . Her record also contained an 1823 dated which documented her diagnoses as acute post and severe . She required assistance for all activities of daily living. A review of facility notes revealed: On at 8:30am resident #1 was found lying on her in the hallway. At 12:31pm A Hospice nurse evaluated resident and ordered a STAT of her left . At 5:03pm the results were received and were positive for a left . Resident was transferred to the hospital for further evaluation and treatment. Resident #1 returned to the facility after rehabilitation on . Resident #1 was noted to have a history of . On at 7:30pm resident in the dining room and hit her . She was from her and was transferred to the hospital. 2. On A review of resident #2 record revealed she was admitted on . Her record contained an 1823 dated . Her diagnoses included and a history of . She required supervise with ambulation, bathing, and . The 1823 documented under Special precautions. A review of the facility notes revealed: On at 2:45PM Resident #2 was walking between the chair and table in the dining room and hitting her . On at 3:05pm resident was sent via 911	A 025		

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A 025	Continued From page 3 to the hospital after a . She was observed on her right side crying in , , holding the right side of her . Her had a hematoma. On at 10:43 am resident was heard yelling for help. She was found on the floor in the hallway. 3. On A review of resident #3 record revealed she was admitted on . Her record contained an 1823 dated . Her diagnoses included , , and . She required assistance with all activities of daily living except eating for which she required supervision. The 1823 documented under Special precautions. A review of the facility notes revealed: On at 6:50pm resident #3 stood from her wheelchair and in the hallway. She hit her and sustained a to her left temple. She was transferred to the hospital via 911. On at 6:02pm the nurse heard a noise and observed resident #3 on the dining room floor with her wheelchair next to her. There was a lump on the of her . She was transferred to the hospital via 911 for evaluation. Review of a policy titled " Prevention" dated , revealed a history of prior to or during the residents stay will be documented on the resident's assessment and service plan. The facility would document interventions, on the service plan, for residents with a history of .	A 025		

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A 025	Continued From page 4 Photographic Evidence Obtained On at 3pm in an interview with the administrator, he confirmed residents #2 and #3 did not have interventions on their service plans. Residents #1, 2, and 3 did not have all documented on their service plans. Class II	A 025		