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 _____	11/30/2023

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
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print ... notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print ... notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person ... . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	CZ816		

AHCA Form 3020-0001

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

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CZ816	Continued From page 1 professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Service	CZ816		

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CZ816	Continued From page 2 s/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 1 of 4 sampled staff (C) sign and date the AHCA Attestation of Compliance with Background Screening Requirement form 3100-0008 to meet	CZ816		

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CZ816	Continued From page 3 qualifications for employment by the employer as required. Findings: Staff C's personnel record review revealed a hire date of . A review of her Level 2 Background Screening (BGS) eligibility dated and she was added on the facility's BGS employee roster on . On at 5 PM, an interview with the Administrator confirmed the finding. He did not find the signed and dated BGS attestation form in the personnel file. Unclassified	CZ816		
A 000	Initial Comments A re-licensure survey and a generator monitoring was conducted at East at Viera Memory Care Assisted Living Facility with Limited Nursing Services (LNS) on . The provider had deficiencies found at the time of the survey 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 , 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	A 025		

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A 025	Continued From page 4 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 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	A 025		

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A 025	Continued From page 5 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 for 4 of 6 residents sampled who sustained with injury (#1, 5, 6 & 7). Findings: 1. On at 10pm a resident was found sitting on the floor with on her and . There was on the floor. The resident did not recall what happened. She was sent to the hospital for an evaluation. She returned at 2:23am. The resident sustained a black , . A review of resident #5 record revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included , , , , and hospice care. She required precautions. She needed supervision with eating and assistance with all other activities of daily living. A review of a facility note dated 11/27/23 at 6:20am revealed resident #5 was found on the floor next to her bed. She had a knot on the of her . A review of resident #5 individualized service plan dated revealed a risk intervention section. Documented under intervention "Staff to implement risk	A 025		

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A 025	Continued From page 6 interventions to assist resident in preventing ." There were no dated personalized interventions documented. 2. A review of resident #6 record revealed she was admitted on . Her record contained an 1823 dated . Her diagnoses included , of , and history of . She walked with a walker. She required assistance with bathing, , grooming, toileting, and transfer and supervision with ambulation. A review of the facility notes revealed the following: On at 9:39am the resident was found in the hallway on the floor with her against the door. No documentation of implementation of interventions to help decrease the likelihood of and injury was found. On at approximately 11:30am the resident was in the common area. She stood from her wheelchair, lost her balance, and . She was transferred to the hospital for evaluation. A review of a fax correspondence with resident #6 health care provider dated with no time indicated, documented resident had second "this evening". She slid from her chair. Hourly checks were started. After the incident the hospice provided a high wheelchair. On at 4:28am the resident was found on the floor in her apartment. There was surrounding her . She sustained an injury to her left temple. 911 to hospital. The note documented resident #6 required stand by assistance to use her walker and to transfer. No	A 025		

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A 025	Continued From page 7 documentation of implementation of interventions to help decrease the likelihood of and injury was found. A review of resident #6 individualized service plan dated revealed a risk intervention section. Documented under intervention "Staff to implement risk interventions to assist resident in preventing ." The last intervention was dated which included - medication for treatment of . Lab work was ordered which included a . Hospice was contacted to evaluate and provide services. It was also documented hospice provided a high/low bed. A review of the facility Management Protocol policy dated as revised on documented "A mobility assessment will be completed at move in, 30 days post move in, every 6 months, with change in condition, and after every ." 3. Resident #1's record review revealed an admission date . The last 1823 Health Assessment dated listed medical history of , left , replacement, and . Resident #1 is a precaution and was admitted on Hospice care on for of the . He needs assistance with all activities of daily living (ADLs) with bathing, grooming, ambulating, transferring and toileting and independent with eating. He needs assistance with self-administration of medications. An order for rail hospital bed dated and wheelchair order dated provided by the Hospice physician. There was no documentation of a risk assessment completed for resident #1 as indicated as a risk resident on the 1823	A 025		

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A 025	Continued From page 8 Health Assessment. A change of condition assessment was completed on but did not address resident #1 being a risk. A negotiated risk assessment was signed on , about two weeks after admission into the facility. During the duration time of - , resident #1 has had nine (9) total with and without injuries as follows below: 1 on at 8 AM by a facility staff documented resident #1 had a this morning, slid out of his wheelchair. No injuries noted. Notified the family and physician. Will continue to monitor. 2 on at 10:30 AM by a facility staff documented resident #1 was observed on the floor. No apparent injuries. No complaint of , . Notified the family and physician. Will continue to monitor. 3 on at 11 AM by a facility staff documented resident #1 had a observed a knot of his . The family and physician were notified. 911 was called and resident #1 sent to the hospital. Resident #1 returned to the facility the same day and a hospice referral was made. 4 on at 1:15 PM by a facility staff documented resident #1 leaped out of his wheelchair onto the floor, a lump to the left side of forehead. No other apparent injuries. No complaint of , . Resident #1's family declined to send to hospital. Notified the physician and will continue to monitor. 5 on at 12:13 PM by nurse F	A 025		

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A 025	Continued From page 9 documented resident #1 observed on the floor beside his bed laying on his . Resident #1 stated he rolled out of his bed and denied , at the time. No injuries observed. Notified the family and physician. Followed up with Hospice referral due to the number of , concern about safety. On at 10:54 AM nurse G documented that a hospice company was out today to complete an assessment for resident #1. No decision was made to admit resident #1 on Hospice care from family. Will continue to monitor for anymore . 6 on by nurse H documented resident #1 found on floor in his apartment stating he was trying to transfer to his chair from his bed. It was encouraged to resident #1 to ask for assistance when needing help. Resident #1 denied , and denies hitting his . His skin was intact. Contacted Power of Attorney, no answer and left voicemail message. Notified the physician. Will continue to monitor. On at 12:45 PM by nurse I documented resident #1 was finally admitted on Hospice Care. 7 on by nurse I documented resident #1 slid out of his wheelchair and landed on floor. No injuries noted. Resident #1 denied , . Vitals checked and notified Hospice and family. 8 on at 4:31 PM by nurse G documented resident #1 was found on the floor on his right side His wheelchair was behind him. Resident #1 stated that he scooted to the edge of the wheelchair and did not know what happened after that. No apparent injuries observed, and he	A 025		

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A 025	Continued From page 10 denies hitting his . . . . Vitals checked. Notified Hospice and family. Will continue to monitor. 9 on at 3 PM by nurse I documented that resident #1 . . out of his wheelchair into the flower bushes. Resident #1 stated that his wheelchair tipped over. A . . . was observed to right upper arm, left and two areas on the left upper arm. The nurse cleaned and vitals taken. Assisted resident #1 . . . to his room. Notified the family, Hospice, and physician. (Photographic Evidence Obtained) On at 3:30 PM, an interview with the Administrator confirmed the findings. He could not explain why no risk assessment was completed. 4. Resident #7's record review revealed an admission date of . The 1823 Health Assessment dated . . . . . listed medical history of , , , , , and . . . . and unfortunately , ... , ( ) on . She was admitted to Hospice care on . . . . . She needed assistance with activities of daily living (ADLs) with bathing, ... , and toileting. Supervision with ambulation, grooming and transferring and independent with eating. She needed assistance with self-administration of medications. She was solely wheelchair bound. An incident was reported on . . . . . at 11:45 AM by the Director of Nursing documented resident #7 in the hallway, on the way to going to lunch in the dining room. A caregiver staff	A 025		

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A 025	Continued From page 11 observed resident #7 was leaning forward as she was propelling herself in the wheelchair very fast. The caregiver staff could not get to resident #7 fast enough and resident #7 forward out of the wheelchair onto the floor hitting her & . Her was . 911 was called and resident #7 was transported to the hospital. The family and physician were notified. Resident #7 returned to facility at 4:15 PM and was completed on resident , , , , and , was done on left ankle. No and no hematoma injury to the . An individual service plan was completed on for the recent but did not indicate any interventions put in place. An incident was reported on at 5:55 AM by nurse J documented a with injury for resident #7. Resident #7 was observed on the floor when going to her room to give her medications. She was next to her bed and a pool of on the floor. Resident #7 stated that she and couldn't explain what happened. Assessed resident #7 and noticed a small open area to the right side of the . Resident# 7 had hit her on the corner bedside table. 911 was called, resident #7 was taken to the hospital. The family and physician notified. The son stated he will meet the first responders at the hospital. A facility note dated at 6:47 AM by nurse H documented resident #7 returned from hospital. No hematoma, just to her , , arms, and , . A small to right . A small stitches to the right side of . A referral for Hospice care and for a private sitter every day 7p-7am to assist and help resident #7 with any overnight bathroom trips and	A 025		

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A 025	Continued From page 12 A facility note dated 11/1/2023 at 4:27 PM by nurse G documented resident #7 was admitted to Hospice care today. A new order to crush medications. A facility note dated 11/2/2023 at 11:15 AM by nurse H documented resident #7 was observed at breakfast very shaken and unsteady with , closed. The nurse asked resident #7 if she was in , she answered yes that her left , and right hurt. Vitals checked, normal and called Hospice. The family was present and visiting, also informed him that the Hospice nurse will be out to the facility shortly to check on resident #7. The hospice nurse came at 1:16 PM and gave , medication. Resident resting well now. Will continue to monitor. A facility note dated 11/3/2023 at 12:45 PM by nurse I documented that the hospice nurse reported that resident #7 was very agitated, and in , during visit today. Stabilized resident #7 with , medications and resting comfortably. The private sitter will monitor overnight and will contact the family, facility staff, and Hospice if any changes. A facility note dated 11/4/2023 at 5:49 PM by nurse G documented that resident #7 , , ( ) this evening and reported by Hospice nurse. The family was notified. (Photographic Evidence Obtained) On at 4:30 PM, an interview with the Administrator confirmed the findings. Class II	A 025		

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A 093	Continued From page 13	A 093		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of	A 093		

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	AL11969906	A. BUILDING: _____ B. WING _____	11/30/2023

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 093	Continued From page 14 the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal.	A 093		

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EAST AT VIERA	4206 BRESLAY DR MELBOURNE, FL 32940

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A 093	Continued From page 15 Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to provide menu substitutions of comparable nutritional value. Findings: On at 12:30pm residents were observed sitting in the dining room for lunch. The lunch being served was a Patty Melt sandwich, fries, and cheese soup. No fruit or comparable alternative was served.	A 093		

Agency for Health Care Administration

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A 093	Continued From page 16 A menu was posted on the dining room wall which indicated the lunch menu was ziti, beets, garlic bread, and fruit salad. A review of the dietician approved menu, provided by the administrator, indicated the lunch meal should have been chicken, Au gratin potatoes, baby carrots, soup of the day, dinner roll, and brown betty desert. On [redacted] at 3:45pm in an interview with the food service manager, he confirmed the substitution provided was not ziti as posted in the dining room. He said they were going to substitute the chicken, as noted on the dietician approved menu, with ziti. The sausage was not available, so they served patty melts instead. He confirmed there was no comparable alternative served for the fruit salad because the kitchen staff forgot to deliver it with the meal. Class III	A 093		