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
	AL11969855	A. BUILDING: _____ B. WING _____	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERTUS VRO OPCO LLC	5380 US HWY 1 VERO BEACH, FL 32967

(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 An unannounced Complaint survey (#2024006823 & #2024011319) and a Generator Monitoring survey were conducted on at Certus VRO OPCO LLC. The facility had deficiencies related to the complaint survey (#2024011319) identified at the time of the visit.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to investigate and implement interventions for and injuries of unknown origin that could be attributed to inadequate supervision and/or assistance with activities of daily living (ADLs), for 3 out of 3 sampled residents (Residents #1-#3). The findings included: The facility's policy and procedure for " " was reviewed on . . . . . and revealed the following: a. "Should a resident experience a . , associates will provide or arrange for necessary care, and will follow up with service plan updates, if necessary". b. "...newly implemented interventions will be noted in the resident chart". c. "The following best practices outline guidelines for...implementing appropriate	A 028		

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A 028	Continued From page 1 interventions...These practices aim to minimize risks...and promote effective prevention measures". 1. "Ensure that the assessment findings, including the resident's risk status and any recommended interventions, are clearly recorded for easy reference and communication among the care team". 2. "Conduct regular ongoing risk assessments at a minimum of once a month for each resident identified if considered a high-risk faller". 3. "Residents that endure a should be considered at high risk for . A list of these residents will be communicated to the care staff and interventions/observations explained". 4. "Thoroughly document all risk assessments, interventions, and incidents in the resident's file". 5. "Assess the need for -based solutions such as sensors, or other technological ...". The following residents were reviewed for and injuries of unknown origin related to ADL assistance: A. Resident #1 was observed laying in bed at 10:15 AM on . The resident was not able to be interviewed due to . There was a used brief observed on the floor next to the bed. Caregiver Staff A stated during interview at this time that the night staff must have left it on the floor because the resident had not gotten out of bed for breakfast yet, and showed this writer that the resident had a clean brief on her. The resident's room was observed again at 12:15 PM with three used briefs in the room, one on the floor and one in each garbage pail in	A 028		

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A 028	Continued From page 2 the room and bathroom. There were soiled towels piled on the floor that appeared to have feces smeared on them. The Licensed Practical Nurse (LPN) who had accompanied this writer during this tour stated at this time that the resident was going to be showered today, so the room would be picked up and cleaned after the resident was showered. She also stated that if the resident's shower cannot be completed for any reason, the staff notify her and she communicates this to the next shift. There was no documentation available for review to show when the ADL assistance was not completed as scheduled. During observation of the resident at 10:15 AM, she was noted to have a 3" by 3" round covered by an undated bandage on her left lower extremity. When the resident was observed at lunch at 12:00 PM, the was not covered. During interview with the LPN at this time, she stated that when the bandage comes off, she cleans the area and places a new one on instead of contacting the home health agency that is to care for it. She was not aware of the cause of the . During review of the resident's electronic ADL documentation that is required by the facility to be completed by the caregivers, it was realized that the staff were not documenting daily in that they were assisting the resident with toileting and showering prior to this afternoon's documentation ( ). During interview with the Administrator at 2:00 PM on , she confirmed that they were expected to check on the residents for toileting every 1 to 2 hours, and document this. It is unknown if the staff were placing this resident on the toilet to , or if they were only changing the resident's	A 028		

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A 028	Continued From page 3 brief. During interview with the resident's representative on at 4:18 PM, she acknowledged that the facility did not always shower the resident twice a week or perform oral hygiene as they were expected to. She also stated that the possible cause of the left lower had not been identified, and that she was notified of the by the home health agency nurse that found it while treating the other for a . Review of the resident's file revealed no incident report for the injury of unknown origin on the resident's lower left extremity. A Third Party Visit Note dated from the home health agency nurse notes the resident had a "re-opened area to right lower extremity...may be from itching/picking?". On , the home health agency nurse notes, "lower left extremity-bandaid-appears to have new . Will need daily changes. Recommend drainage". The potential cause of the could not be determined. The resident received assistance from staff with ambulation (propelled in wheelchair), toileting and transfers. There was no documentation of the injury of unknown origin's identification by facility staff. B. Resident #2 was observed seated in a wheelchair on at 10:25 AM. The resident was not able to be interviewed due to . Review of the resident's health assessment (AHCA Form 1823) dated notes the resident is to receive "total care" with all ADLs. An incident report dated documents at 10:00 PM, Caregiver Staff B "went into (Resident #2's) room to go do rounds and I found her on the floor and eyewatch never	A 028		

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A 028	Continued From page 4 said anything about her falling. I called eyewatch and they told me that she slid down her recliner chair and she did not hit her . . . . She had a really deep on her right and was . . . . . I cleaned her up, changed her and took her into the living room because she said she wasn't tired anymore". There was no potential cause of the noted, why the resident was trying to get out of the recliner, or any interventions to attempt to prevent reoccurrence documented. During interview with Staff B on at 2:30 PM, she stated that it was possible that the previous shift had not toileted the resident timely as this was occurring at times. Review of the resident's electronic documentation of assistance with ADLs that was required by the facility to be completed by staff revealed that the documentation was not done daily for the month of . . . . . It could not be determined if the resident's on could have been prevented or if any interventions were put in place to reduce the risk for reoccurrence. C. Resident #3 was observed on at 9:50 AM with . . . . on the left side of her . . . . The resident was not able to be interviewed due to . . . . . Review of the resident's health assessment (AHCA Form 1823) dated revealed the resident's diagnoses included , with decreased safety awareness and mobility, declining memory and at high risk for . The assessment indicates the resident requires assistance with ambulation, toileting and transfers. The incident reports documented for this resident include the following: 1. 8:10 PM "Resident was getting up out of her wheelchair and it wasn't locked and on her bottom".	A 028		

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A 028	Continued From page 5 2. . . . . 4:45 PM "Resident was placed in common area in wheelchair. Med Tech at med cart looking down into cart and hear a thud when looked up resident was on ground . . above her left . . . called Wellness Director to examine patient . cleaned and steri strips place to pen area to help stop . . . .". 3. . 4:34 PM "Resident observed lying on floor in hallway near her room. . . . to forehead along with a forming hematoma...resident sent to (hospital) via ambulance for evaluation and treatment". There was no potential reason documented from a resident statement or other assessment of resident needs to indicate if the resident was trying to get out of the wheelchair to toilet herself or reposition. There were no interventions documented to possibly prevent reoccurrence of the . Review of the resident's electronic documentation of assistance with ADLs by staff revealed sporadic documentation a few days a month in . . . . . to show assistance was provided with toileting, grooming, showers and/or ambulation. There were no interventions documented that were measurable to see if they would alleviate the resident's attempts to get out of her wheelchair such as scheduled toileting with placement of the resident on the toilet to . , repositioning the resident or a seatbelt to allow staff additional time to respond to the attempts. These findings were discussed with the Administrator and Director Of Wellness on . . . . . at 3:00 PM. The facility provided no additional information for review at the time of the survey. Class III	A 028		