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 _____	12/03/2024

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 survey for complaint #2024015678 was conducted on at East at Viera Assisted Living Facility. There was a ere deficiency 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 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 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		

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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 3 sampled residents who sustained multiple resulting in significant injuries (#1). Findings: On at 10:30am during a tour of the locked memory care facility 18 residents were observed in the common area participating in activities. One resident was finishing her breakfast in the dining room. There was one activity staff in the	A 025		

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A 025	Continued From page 2 common area. One nurse was observed in the medication room. There was no caregiver staff observed in the common areas. The census was 33. Review of the schedule revealed two unlicensed caregivers were scheduled. A review of resident #1 record revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included of the and . She was alert, , and under Hospice care. She required precautions and assistance with all activities of daily living. A review of the facility notes found: On at 1:07am Nurse D documented - Resident observed on the floor inside a fellow resident's room. Appeared to have an injured right . Transfer to the hospital. Incident day/time 4:30pm. On Nurse E documented at 1:06am - Resident is a high risk frequent monitoring in place. On Nurse F documented at 5:23am. Resident was found on the floor by staff making rounds in front of her door sitting on her bottom. was unwitnessed. Incident day/time 1:15am. On resident #1 returned from rehabilitation in a wheelchair. On Nurse A documented at 3:59am. Found resident on the floor in apartment around 3:45am. Resident laying in front of the door. Transfer to hospital. Diagnosed with a right . A review of the policy provided by the Administrator found it was dated as revised on . It documented if a resident is at risk for	A 025		

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A 025	Continued From page 3 an action plan that includes specific interventions will be developed. On at 2:40pm The Administrator confirmed there was no action plan developed with resident specific interventions for mitigation for resident #1. He said the policy he provided was the new owners policy and they are in the process of merging the old policy with the new. Class II	A 025		