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 _____	03/10/2025

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 #2025002085 and a generator monitoring were conducted on and at East at 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 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	A 025		

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A 025	Continued From page 1 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 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 resident #1 who sustained an injury of unknown origin and for resident #4 who sustained a resulting in a significant injury. Findings: On at 10 am a tour of the facility was conducted. The facility is a memory care unit with a census of 30 residents at the time of the investigation. There was one (1) licensed	A 025		

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A 025	Continued From page 2 practical nurse (LPN), 3 Caregivers, and one (1) activity staff were observed in the unit. Twenty two (22) residents were observed in the dining room and common area. On documented at 9:12 am nurse to nurse report documented resident #1 ate ½ bar of white soap. The Resident was in the common area very and unable to stand. The resident started yelling when attempting to assist the resident to the table. A review of resident #1's closed record revealed she was admitted on . The resident's record contained a Resident Health Assessment for 1823 dated . Her diagnoses were listed as of , paranoia, , and agitation. The resident was under the care of Hospice. The resident was assessed to need precautions and assistance with all activities of daily living (ADL's). The resident required assistance with self-administration of medications. A review of the facility notes found: On documented at 3pm - Resident was observed on the floor in the TV room. Unable to say how she . No injury On documented at 6:38am - Resident up most of the night. Staff placed her in bed a couple of times. The morning staff was getting resident up and found a bar of soap that had been eaten. Residents had soap residue and smelled like soap. Nurse practitioner (NP) and hospice notified. On documented at 9:12am nurse to nurse report resident ate ½ bar of white soap. Resident in common area very and unable to stand. The resident started yelling when	A 025		

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A 025	Continued From page 3 attempting to assist the resident to the table. On Hospice Crisis Care started at 8PM. On , documented at 11:32 am resident showing signs of left , , . Fax sent to NP for , . Hospice nurse was present. On documented at 12:41 pm , results received: left . Hospice and family informed of findings. A review of resident #1 service plan found it was reviewed and it contained the following documentation: Resident to receive intervention to prevent . reduction strategies: observe changes in balance and safety awareness and report changes to nurses. Nursing will evaluate and report changes to PCP and responsible party. On at 10:40am spoke with the Director of Nursing (DON). She said resident #1 probably could have gotten herself up off the floor if she had . Not sure if she could get up if she had a . She did not know how the incident happened. She confirmed it was an incident of unknown origin. On at 10:15am interview with nurse E. She said resident #1 ambulated independently. She could have gotten herself up if she . She could not recall if the resident had any other on her shift. She said there sometimes is 2 caregivers and sometimes 3. A lot of residents need 2-person assistance when receiving personal care. She said sometimes we need more staff to properly watch all the residents. 2. A review of resident #4 closed record revealed she was admitted . The resident's record contained a Resident Health Assessment for 1823 dated1/15/25. Her diagnoses included	A 025		

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A 025	Continued From page 4 ˇ of the , agitation, fatigue, ambulation limitations, , and . The resident was dependent on the wheelchair for ambulation. The resident was under the care of Hospice. The resident was assessed to need assistance with all her ADLs and assistance with self-administration of medications. A review of the facility notes found: On documented at 12:53 - ˛ positive for displaced angulated and , . (LEFT) On documented at 2:23pm - Resident showing signs of , and screaming when staff toilet her. Hospice called. On documented at 7:48am - It was reported resident scooted out of her wheelchair while being escorted to breakfast. When the nurse arrived, the resident had already been assisted to her wheelchair. No signs of , . Son notified. On documented at 6:28pm - Large discoloration across left ˛ with large lump underneath. Origin unknown. Will continue to observe. On documented at 3:17pm - Resident in hallway in front of apartment on the floor. at 11:48am in an interview with the DON, she said she reviewed the camera footage of resident #4 . She said the resident put her down which caused the wheelchair to stop abruptly causing the resident to slide out of the chair. She said it was a housekeeper who was pushing the wheelchair to help the resident to the common area. On at 12:45pm interview with housekeeper H. She said on she was	A 025		

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A 025	Continued From page 5 pushing resident #4 in wheelchair because the handle of her wheelchair was stuck under the flowerbox decoration on the wall. Caregiver I helped to get resident unstuck and then left to assist another resident. Resident #4 started screaming so housekeeper H assisted the resident by pushing her in her to the dining room. Resident #4 leaned out of her wheelchair onto her right side. She did not hit her . Housekeeper H and the caregiver I assisted the resident to her wheelchair and caregiver I took her to the nurse's station. Housekeeper H confirmed she should not have helped to pick up the resident, but the caregiver said she was unable to do it alone. A review of the facility policy dated found - if a resident is at high risk for an action plan that includes specific interventions will be developed. There was no specific documentation about non caregiviers assisting residents. On at 1pm in an interview with the DON. She said, "caregiver I is no longer employed by the facility." She confirmed that the housekeeper should not have assisted the resident to the wheelchair with the caregiver and the nurse should have been notified to evaluate the resident prior to being transferred to her chair. Class II	A 025		