

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Melbo		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 S Hickory St Melbourne, FL 32901	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131</p> <p>Based on interview, and record review, the facility failed to ensure an allegation of neglect was reported to the relevant State Agencies within the regulatory timeframe for 1 of 2 resident reviewed for Abuse and Neglect, (#1).</p> <p>Findings:</p> <p>Resident #1, a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included cerebrovascular disease, hypertension, dysphagia (difficulty swallowing), anxiety disorder, and dementia.</p> <p>Review of the resident's quarterly Minimum Data Set assessment dated [DATE], revealed the resident was rarely/never understood, and was dependent on staff assistance for her activities of daily living (ADLs).</p> <p>Review of the facility's incident log reflected the resident had a fall on 11/01/24, and review of the reportable log revealed an entry for resident #1 dated 11/01/24, classified as neglect.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Melbo		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 S Hickory St Melbourne, FL 32901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/02/24 at 1:40 PM, the entries for the resident on the facility's incident and reportable logs were discussed with the Director of Nursing (DON). She recalled that on 11/01/24 the Evening Supervisor called her and reported that the resident fell . The DON explained that on 11/01/24 at 10:45 PM, Certified Nursing Assistant (CNA) A called for help, and when the resident's assigned nurse responded, she found resident #1 lying on the floor on her right side, blood was coming from the resident's right temple. The DON recalled she asked the resident's assigned nurse Registered Nurse (RN) B how the fall happened, since the resident was bedbound. She said the RN explained that while CNA A was providing incontinence care for the resident, the CNA pulled the resident towards her using the bed linen, she then turned the resident away from her, and the resident rolled to the opposite side of the bed, fell to the floor, sustained a laceration/injury to her right temple, and was sent out to the hospital. The DON stated the incident happened because CNA A rolled the resident away from her, instead of towards her. She explained that after each fall, the Interdisciplinary (IDT) team would meet to discuss the fall, evaluate, and implement interventions to prevent a fall from happening again, and during the IDT meeting on 11/04/24, the facility decided that the incident was possible neglect, and an immediate [State Survey Agency] report should be submitted. When asked why an Immediate Report was not submitted as per regulatory guidelines of two hours after an allegation was made, or within 24 hours if no serious bodily injury occurred, the DON stated that when a fall occurred on a Friday, the IDT would meet on the following Monday to discuss the fall. She stated that while watching the re-enactment of the event by CNA A on 11/04/24 she saw where the error was, and the management team decided then that it was a reportable incident. However, the CNA's action of turning the resident away from her, instead of towards her was discussed and reported to the DON on 11/02/24 by RN B.</p> <p>On 12/02/24 at 3:37 PM, in an interview conducted with CNA A, who was accompanied by the Assistant Director of Nursing, the CNA confirmed that on 11/01/24 she was resident #1's assigned CNA. She stated the resident required total care with her ADLs, and verbalized that prior to the resident's fall on 11/01/24, the resident required one person assist for ADLs, and mechanical lift with two persons for transfers. CNA A recalled that on 11/01/24 at approximately 9:00 PM to 10:00 PM while providing incontinence care for the resident, she turned the resident to her left side away from her, by crossing the resident's legs, and pulling the pad or bedsheet. She said the resident was lying on her left side and demonstrated that she was standing on the right side of the resident's bed. CNA A said resident #1 reached towards the bedside table on the left of her bed and fell from the bed. She said she tried to grab the resident but could not hold on to her, and the resident sustained an injury to her right temple.</p> <p>On 12/02/24 at 4:48 PM, the Evening Supervisor recalled that on 11/01/24 at approximately 10:00 PM-11:00 PM, she was called to the South Wing. She verbalized that Licensed Practical Nurse B, and CNA A were with resident #1, who was lying on the floor on her back. The Supervisor said she observed a scratch to the resident's right temple, and the nurse was applying pressure to the area and monitoring the resident's blood pressure. She recalled CNA A stated the resident rolled out of bed when she was trying to change her. She recalled that after the resident was sent to the emergency room , CNA A re-enacted the scene for her, and she notified the DON. The Supervisor said in the reenactment the CNA had turned the resident away from her to provide care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Bedrock Rehabilitation and Nursing Center at Melbo		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 S Hickory St Melbourne, FL 32901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/03/24 at 8:22 AM, in a telephone interview, the resident's family member stated the resident had dementia, spoke English but had reverted back to her native language Hungarian. The family member said the resident could not move her body, could not grab something or move if asked/told to. She recalled that on 11/01/24 the facility notified the family that the resident had a fall and had to go to the hospital. She said the facility dropped the resident, and recalled the resident's roommate at the time told her that at approximately 10:00 PM, resident #1 soiled herself, and needed changing. The roommate recounted that one CNA came in, pulled the bedsheet, and rolled the resident off the bed, and she hit the ground hard. The family member said she completed a grievance on 11/02/24 and documented negligence in the care of resident #1.</p> <p>On 12/03/24 at 11:38 AM, the DON acknowledged that an Immediate [State Survey Agency] report should have been completed for the incident on 11/01/24. She stated she had access to the reporting system on the weekend, but at the time of the incident she was focusing on the fact that CNA A followed the resident's plan of care pertaining to the number of persons required to provide incontinence care for resident #1.</p> <p>On 12/03/24 at 12:01 PM, the Social Service Director (SSD) recalled that on 11/04/24 she received a grievance pertaining to resident #1 that was documented by the resident's daughter on 11/02/24 at 12:00 PM and placed under the SSD's door. The SSD stated that on 11/04/24 she along with the Administrator and the DON called the resident's daughter, and at that time the daughter wanted to vent her frustration and kept using the word neglect. The SSD stated the facility then decided to do a reportable, since the resident's daughter wanted, more than a grievance process.</p> <p>Review of the grievance documented by the resident's daughter dated 11/02/24 at 12:00 PM, indicated the resident fell out of bed, due to the negligence of her CNA.</p> <p>Interviews with staff involved and record review of resident #1's medical record revealed the incident with resident #1 occurred on 11/01/24 at approximately 10:45 PM. CNA A neglected to use the proper technique for turning/positioning while providing incontinence care for the resident. A grievance alleging negligence was documented on 11/02/24 at 12:00 PM, however this was not acknowledged or acted upon until 11/04/24. An Immediate [State Survey Agency] report pertaining to neglect was not submitted until 11/04/24 at 6:26 PM, 42 hours after the allegation was made.</p> <p>The facility's policy Abuse: Florida dated April 1, 2022, read, The facility will ensure that all alleged violations involving .neglect .are reported immediately, but not later than 2 hours after the allegation is made .or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and other officials (including to the State Survey Agency).</p>		