STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105251	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockledge Healthcare & Rehabilitation Center	587 Barton Blvd Rockledge, FL 32955

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to conduct a medication self-administration assessment to ensure safety for 1 of 1 residents reviewed for self-administration of medications, of a total sample of 51 residents, (#97). Findings: Resident #97 was admitted to the facility on [DATE] with diagnoses including left tibia fracture, muscle weakness, and polyneuropathy. A review of the Minimum Data Set admission assessment with an assessment reference date of 3/05/25 revealed resident #97 had a Brief Interview for Mental Status score of 15 out of 15, which indicated that he was cognitively intact. On 4/02/25 at 10:09 AM, resident #97 was observed lying on his back in bed watching television. His bedside table was next to his bed with various personal items, including a box of Ocusoft Retaine MGD ophthalmic emulsion that contained 28 single doses (0.01 fluid ounces). The resident said he used the eye drops for his eyes. On 4/02/25 at 10:13 AM, the resident's bedside table was observed with primary Registered Nurse (RN) D, who acknowledged the box of single-dose eye drops at resident #97's bedside. Once outside the room RN D reviewed resident #97's physician orders and acknowledged there were no orders for the eye drops resident #97 had in his possession. RN D explained that residents required a physician's order to self administer medications. RN D stated there was no order for eye drops. On 4/02/25 at 11:16 AM, the Director of Nursing stated residents should have a completed self-administration assessment and a physician's order for self administration of the medication prior to resident self-administering medications. A review of the facility's policy and procedure for Self-Administration of Medications dated 4/1/22 revealed, It is the policy of this facility that residents who wish to self-administer their medications may do so if it is determined that they are capable of doing so.

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

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	105251	A. Building B. Wing	04/03/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to maintain a homelike interior in 1 of 28 rooms, on 1 of 2 units, (East Wing, 103). Findings: On 3/31/25 at 11:45 AM, the first drawer of a nightstand was missing in room [ROOM NUMBER]. Subsequent observations on 4/01/25 at 11:33 AM and 4/02/25 at 3:10 PM, the first drawer of the nightstand was still missing. On 4/02/25 at 3:11 PM, Certified Nursing Assistant (CNA) K explained she entered work orders to alert maintenance of needed repairs in resident's rooms. She stated the first drawer of the nightstand in room [ROOM NUMBER], had been broken for awhile and pointed to the top of a dresser where the drawer had been placed. She indicated maintenance was aware of the needed repair. On 4/02/25 at 4:45 PM, the Maintenance Director stated he was responsible for the functionality of everything in the facility. He explained the staff was supposed to enter work orders to let him know when something needed his attention. At 4:59 PM, the Maintenance Director toured room [ROOM NUMBER]. He acknowledged the drawer needed to be fixed and said it was an easy fix. He stated he had not been aware of the issue. Review of the Work Orders for room [ROOM NUMBER] from January to April 2025 did not reveal a report about broken furniture including the drawer repair. On 4/03/25 at 1:57 PM, the Administrator indicated her expectation from staff was to follow up with maintenance when things were not repaired. She stated staff needed to follow the facility process and inform maintenance electronically or verbally of repairs needed in the facility. Review of the facility's Plant Operations Administrative Overview policy issued on February 2021, revealed the General Maintenance Division functions included the installation of pre-assembled cabinetry and minor furniture repairs.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected Pre-Admission Screening and Resident Review (PASARR) results for 2 of 5 residents reviewed for PASARR, (#6, #8), and use of insulin for 1 of 1 resident (#97) reviewed for insulin, of a total sample of 50 residents. Findings: 1. Review of resident #6's medical record revealed she was initially admitted to the facility on [DATE] and readmitted from an acute care hospital on 7/25/24. Her diagnoses included schizoaffective disorder- bipolar type, bipolar disorder, major depressive disorder and generalized anxiety disorder. Review of resident #6's annual MDS assessment with Assessment Reference Date (ARD) of 8/14/24 revealed question A1500 on Section A read, Is the resident currently considered by the state level II PASARR process to have serious mental illness (SMI) and/or intellectual disability (ID) or a related condition? The documented answer was No. Review of resident #6's medical record revealed a PASARR Level II Determination Summary Report dated 9/07/23. The section Outcome/Disposition showed Meets the state definition of Serious Mental Illness? Yes. 2. Resident #8 was readmitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar type, major depressive disorder and generalized anxiety disorder. Review of resident #8's annual MDS assessment with ARD of 3/31/24 revealed question A1500 on Section A read, Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition? The answered was No. Review of resident #8's significant change in status MDS assessment with ARD of 1/15/25 revealed question A1500 on Section A read, Is the resident currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition? The answer was No. Review of resident #8's medical record revealed a PASARR Level II Determination Summary Report dated 10/24/2023. The section Outcome/Disposition showed Meets the state definition of Serious Mental Illness? Yes. (continued on next page)

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	105251	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/25 at 12:00 PM, the MDS Lead explained she reviewed that PASARRs were present for all newly admitted residents and paid attention to any yes answers. She indicated the PASARR was important because it determined if the facility was an appropriate setting to meet the needs of residents with SMI or ID. She stated Section A of some MDS assessments had a question about PASARR. She reviewed question A1500 on resident #8's annual MDS with ARD of 3/31/24, and confirmed it was answered No. She indicated that resident #8 met the state definition of SMI and the answer on the MDS assessment should have been yes. She also reviewed the significant change in status for the MDS with ARD of 1/15/25. She stated A1500 was also answered no. She reviewed resident #6's Level 2 determination completed on 9/07/23 and the annual MDS with ARD of 8/14/24 and stated it showed A1500 answered no. The MDS Lead stated accuracy of the assessment was important. Later at 3:00 PM, the MDS Lead confirmed the three MDS assessments were coded incorrectly. The Resident Assessment Instrument (RAI) instructions for A1500 read, Review the PASARR report provided by the State if Level II screening was required . Code , yes: if PASARR Level II screening determined that the resident has a serious mental illness and/or ID/DD (intellectual disability/developmental disability) or related condition, and continue to A1510 . Review of the facility's policy titled MDS Assessments dated 4/01/22 indicated, It will be the policy of this facility to complete MDS assessments in accordance with the RAI manual guidelines. 40892 3. Resident #97 was admitted to the facility on [DATE] with diagnoses including left tibia fracture, muscle weakness, and polyneuropathy. A review of the MDS admission assessment with an ARD of 3/05/25 revealed the resident's use of the high risk medication insulin was incorrectly assessed as yes. A review of the resident's physician orders since admission revealed no orders for insulin injections. On 4/03/25 at 1:19 PM, the MDS coordinator accessed resident #97's MDS and explained she was responsible for completing his MDS assessment. She said she reviewed the medication administration documentation before completing the MDS. She acknowledged the MDS indicated the number of days insulin injections were received during the last seven days or since admission if admission/entry or reentry if less than seven days reflected seven. The MDS coordinator printed the Medication Administration Record (MAR) for February 2025 and March 2025, and confirmed there was no documentation of insulin injections being given. The MDS coordinator stated, The resident did not receive insulin; the MDS was incorrect. Review of the Center for Medicare & Medicaid Services (CMS) RAI Version 3.0 Manual Section N: Medications. The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and or select medications were received by the resident. The facility's policy and procedure, MDS, dated [DATE], read, It will be the policy of this facility to complete MDS assessments in accordance with the RAI manual guidelines.

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	105251	A. Building B. Wing	04/03/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on interview, and record review, the facility failed to ensure the completion and accuracy of Level I Preadmission Screening and Resident Review (PASARR) documents on admission and/or failed to make referrals for newly evident or possible mental disorders/diagnoses to evaluate the need for specialized services or alternative placement for 4 of 5 residents reviewed for PASARRs, of a total sample of 51 residents, (#49,#79, #23, and #34). Findings: 1. Review of the medical record revealed resident #49 was admitted to the facility on [DATE] from the hospital with diagnoses that included enlarged heart, hypertensive heart disease with heart failure, adjustment disorder with depressed mood, sleep disorder, pain and major depressive disorder. Resident #49's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 2/18/25 revealed the resident scored 10 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated he had mild cognitive impairment. The assessment revealed resident #49 felt depressed, had no behaviors nor rejection of care, and had no diagnosis of depression nor mood disorder listed as active diagnoses. Resident #49's had a Plan of Care which outlined the potential for adverse side effects related to the use of psychotropic medications, antidepressant for treatment of depression and insomnia. The plan of care also focused on the potential for or actual psychosocial wellbeing issue due to the depression diagnosis. On 4/03/25 at 4:45 PM, a review of resident #49's PASARR Level I Screen for Serious Mental Illness and/or Intellectual Disability or Related Conditions dated 2/07/25, revealed no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. 2. Resident #79 was initially admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. His diagnoses included metabolic encephalopathy (brain dysfunction), acute and chronic respiratory failure with hypoxia (low oxygen), chronic obstructive pulmonary disease, anxiety disorder, unspecified mood disorder, major depressive disorder, brief psychotic disorder, and primary insomnia. Resident #79's Order Summary Report indicated the resident had an order for Seroquel oral tablet 25 milligrams (mg) to be given three times a day related to brief psychotic disorder and Depakote Sprinkles Oral Capsule Delayed Release 125 mg, four capsules by mouth to be given twice a day related to unspecified mood disorder. Resident #79 had a Plan of Care with the focus for the potential for adverse side effects related to the use of psychotropic medications for the treatment of psychosis. The Care Plan related to resident #79's exhibited behaviors of hallucinations, yelling at staff that they are stepping on the cat, and resident thinks he's going to work. (continued on next page)

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	105251	A. Building B. Wing	04/03/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79's PASARR Level I Screen for Serious Mental Illness and/or Intellectual Disability or Related Conditions dated 12/29/24 revealed no diagnoses listed in Section A for Mental Illness or Suspected Mental Illness. On 4/01/25 at 2:57 PM, the Social Services Director was asked if she was responsible for updating the PASARR forms and said she was not assigned and that she only started working at the facility a few weeks ago but was aware that she will be responsible for them in the future. The Nursing Home Administrator (NHA) said it was the Minimum Data Set (MDS) Coordinator who oversaw PASARR forms. On 4/01/25 at 4:05 PM, the MDS coordinator said that she reviewed the PASARR forms from the admission packet and ensured they were signed. If there was anything that needed to be updated, it would be discussed in their morning clinical meeting and addressed. For example, if it was determined by the psychiatrist that there may be a new diagnosis they will then update the forms. The MDS Coordinator was then asked about resident #79's diagnoses not listed in section A of the PASSARR Level 1 form, and explained he might have another form because he was sent out to the hospital recently and that the Director of Nursing (DON) might be working on it. She was also asked about resident #49 as well and acknowledged that diagnoses were not listed in Section A. On 4/01/25 at 4:22 PM, the DON explained that the process was to look at the forms, ensured they were correct, and updated them in the system if there was a new diagnosis. She continued to explain that she did not have access to update the PASARR forms and would find out from the NHA who was responsible. The DON also mentioned that she had only just started working at the facility for about three weeks. On 4/01/25 at 4:32 PM, the Nursing Home Administrator (NHA)explained they were in a transitional period after the Assistant Director of Nursing (ADON) resigned, and she had been responsible for updating the PASARR forms. She said the ADON had been gone for three weeks and confirmed the forms should have been updated. 40892 3. Review of the medical record revealed resident #23, a [AGE] year-old female, was admitted to the facility from an acute care hospital on 2/27/25 with diagnoses that included multiple rib fractures, severe protein-calorie malnutrition, diabetes, schizophrenia disorder- bipolar type, major depressive disorder, and, post-traumatic stress disorder (PTSD). The MDS Admission assessment with an ARD of 3/06/25 revealed that resident #23 had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated she was cognitively intact. The level I PASARR dated 2/06/25 indicated the finding was based on documented history but did not include the admission diagnoses of anxiety disorder, bipolar disorder, depressive disorder, schizoaffective disorder, and PTSD from 2/27/25. On 4/01/25 at 4:05 PM, the MDS coordinator stated she reviewed the PASARR forms upon admission to ensure their completion. She said the forms were updated as needed. The MDS Coordinator acknowledged that resident #23's PASARR did not include the diagnoses. (continued on next page)

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	105251	A. Building B. Wing	04/03/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/02/25 at 5:40 PM, the Administrator stated that the Assistant Director of Nursing (ADON) was responsible for PASARRs. When the facility was aware of a new admission, the ADON and Social Service Director collaborated to ensure completion of the PASARR. 4. Review of the medical record revealed resident #34, a [AGE] year-old male, was admitted to the facility from an acute care hospital on 1/29/25 with diagnoses that included Parkinsonism, major depressive disorder, schizophrenia disorder-bipolar type, and brief psychotic disorder. The MDS Admission assessment with an ARD of 2/04/25 revealed that resident #34 had a BIMS score of 14/15, which indicated he was cognitively intact. The level I PASARR dated 1/14/25 indicated finding is based on documented history and medications but did not include admission diagnoses of major depressive disorder, schizophrenia disorder- bipolar type, and brief psychotic disorder from 1/29/25. On 4/01/25 at 4:05 PM, the MDS coordinator stated she reviewed the PASARR forms upon admission for completion. The forms were updated as needed. The MDS Coordinator acknowledged resident #34's PASARR did not include any diagnoses. On 4/1/25 at 4:22 PM, the Director of Nursing, (DON) explained that level I PASARRs were reviewed for completion and accuracy upon admission. The document was updated as needed to reflect the resident's medical record. 04/02/25 at 5:40 PM, the Administrator stated that the ADON was responsible for reviewing PASARRs. The Administrator said when the facility was aware of a new admission, the ADON and Social Service Director collaborated to ensure completion of the PASARR which included reviewing all PASARRs for completion and accuracy. The Facility's Policy issued 4/01/22 indicated the facility will ensure each resident in a nursing facility is screened for a mental disorder or intellectual disability prior to admission.

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	105251	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to follow the physician's order for oxygen (O2) for 1 of 3 residents reviewed for O2 use, of a total sample of 50 residents, (#8). Findings: Review of resident #8's medical record revealed she was readmitted to the facility on [DATE] with diagnoses including acute respiratory failure, congestive heart failure (CHF), anemia, and shortness of breath. Review of resident #8's significant change in status Minimum Data Set assessment with Assessment Reference Date of 1/15/25 revealed she used O2. Review of resident #8's medical record revealed a physician's order dated 12/30/24 which read, Oxygen at 2 liters/minute (LPM) continuous, via NC (nasal canula) every shift. A care plan for a potential for complications of respiratory distress related to CHF and respiratory failure was initiated on 5/17/23. The interventions included, Administer medications as ordered; observe for effectiveness and for SEs (side effects). Administer O2 as ordered. On 3/31/25 at 11:36 AM, resident #8 was lying in bed with her eyes closed, wearing a NC in her nose. The NC was connected to an O2 concentrator set at 4 LPM. A second observation on 4/01/25 at 11:36 AM, revealed resident #8's O2 concentrator was set at 3.5 LPM and later on 4/01/25 at 3:38 PM, the O2 concentrator was at 4 LPM of O2. On 4/01/25 at 3:47 PM, Licensed Practical Nurse (LPN) L stated she had five residents in her assignment using O2. She explained she checked the concentrator when she gave the medications to those residents. She indicated her assessment included ensuring the tubing was changed once a week, the NC was on the resident properly, and checking the resident's oxygen saturation. She mentioned resident #8 was not ambulatory and was always in bed. She stated the nurses were responsible for ensuring the O2 concentrator was set at the rate ordered by the physician. Later on 4/01/25 at 3:55 PM, LPN L walked into resident #8's room and checked the O2 concentrator. She acknowledged the O2 was set at 4 LPM. On 4/01/25 at 4:00 PM, the Director of Nursing (DON) checked resident #8's physician orders and confirmed the order for O2 was 2 LPM. She went to resident #8's room, confirmed the O2 was set at 3.5 LPM and changed it to 2 LPM. Later on 4/01/25 at 4:08 PM, the DON explained she expected the nurses to check the O2 concentrator at the beginning of their shift and periodically throughout their shift to ensure it was correct. She indicated it was important to follow the physician's orders accurately. Review of the facility's policy titled Oxygen Administration issued on 4/01/22 read, It is the policy of the facility to provide guidelines for safe oxygen administration. The procedure listed O2 was administered as ordered by physician.

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	105251	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to maintain adequate communication with the dialysis center, follow the comprehensive person-centered care plan and ensure post-dialysis assessments were completed for 1 of 2 residents reviewed for dialysis, of a total sample of 51 residents, (#655). Findings: Review of the medical record revealed resident #655 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included end-stage renal disease (ESRD) with dependence on dialysis, and type 2 diabetes. Review of the Minimum Data Set Medicare 5-day assessment with Assessment Reference Date of 3/27/25 revealed resident #655's Brief Interview for Mental Status score was 11 out of 15 which indicated moderately impaired cognition. The assessment showed the resident had no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. The assessment revealed resident #655 required hemodialysis. Review of resident #655's care plan for hemodialysis dated 3/24/25 included complete dialysis communication tool on dialysis days and review upon return from dialysis. Monitor for bruit and thrill at shunt site. A shunt is a connection between a vein and artery that helps your body create the flow of blood it needs for dialysis to work (retrieved from https://www.bmc.org on 4/04/25). On 4/01/25 at 9:15 AM, resident #655 stated the staff did not take vital signs or check her dialysis site when she returned from dialysis. Review of the Dialysis Communication Form showed three sections, the first section was to be completed prior to leaving the facility for dialysis, the second section to be completed by the dialysis center and the third section to be completed by the facility post dialysis. Review of current physician orders revealed resident #655 went to dialysis three times per week, Monday, Wednesday and Friday. Review of the Dialysis Communication Forms revealed resident #655 went to dialysis six times between 3/21/25 and 4/02/25. The forms indicated that only one day (3/21/25) were all three sections completed by nurses. On 3/24/25 only the first page was completed, on 3/26/25 only the first and third pages were completed, the form on 3/28/25 was missing, for 3/31/25 and 4/02/25 only the first page was completed. Four of the six forms did not contain a post dialysis assessment. Review of the progress notes for that time period did not reveal any facility contact made with the dialysis center. (continued on next page)

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	105251	A. Building B. Wing	04/03/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/03/25 at 11:12 AM, the Unit Manager (UM) for the west wing stated, the process for dialysis was for nurses to complete the first page of the Dialysis Communication Form, the second page should be completed by the dialysis center and the third page is completed by the nurse when the resident returned to the facility. The UM confirmed the forms were not completed for resident #655. She explained that when the dialysis center did not complete the form she would call and request the form to be completed and sent. She stated even when she called the dialysis center, often the completed form did not get sent back. She confirmed the nurse was supposed to ensure the forms were complete. The UM the nurses were educated to complete the form when the resident returned from dialysis. The policy and procedure Hemodialysis dated 4/1/22 described, The facility and the Dialysis Center should maintain regular communication.

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	105251	A. Building B. Wing	04/03/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 The facility failed to label drugs and biologicals safely and accurately, in accordance with currently accepted professional principles for 2 of 7 residents observed for medication administration, of a total sample of 51 residents, (#305, and #7). Findings: 1. On 3/31/25 at 5:14 PM, during medication administration observation with Registered Nurse (RN) A on the [NAME] medication cart 2 it was noted that the medication on the Electronic Medication Administration Record (eMAR) indicated Eliquis 5 milligrams (mg) give 1 tablet. The label on the actual medication instructed that 10 mg of Eliquis was to be administered. RN A did not administer the medication and stated he would call the physician to clarify the order. 2. On 4/01/25 at 9:14 AM, during medication administration observation with Licensed Practical Nurse (LPN) B, on the South medication cart 2, there were discrepancies found with the medication label for two of resident #7's medications. The order on the eMAR read Sodium Chloride 1 gram and one tablet to be given. In conflict with the eMAR, the medication label indicated two tablets, one gram each of the Sodium Chloride were to be given. The second medication on the eMAR instructed nurses to give Levetiracetam (an anti-seizure medication) 1500 mg by mouth every 12 hours. However, the actual medication label indicated two 1000 mg tablets were to be given, for a total of 2000 mg of Levetiracetam. LPN B did not explain why the actual medication labels did not match the physician orders in the eMAR. She did not administer the medications and stated she would call the physician to clarify the orders. On 4/03/25 at 9:25 AM, RN C explained whenever an order was changed, she updated the order, reordered the medication, then removed the old blister pack from the cart and placed it in the return bin to the pharmacy. She explained if it was a case of where the actual medication was the same but the dosage changed, for example the new order said to give two tablets, and the old order said to give one; she would put a sticker that noted the order change on the medication label and continue to use the medication from that blister pack until the new medication came in. On 4/03/25 at 9:31 AM, RN D explained if there was a new order or a changed order, she would take the medication out of the cart to the return bin. She would then send a message to the pharmacy about the changed dosage. If she discovered that the label did not match the order, she would take the medication out of the cart. RN D said that sometimes if you could have used the same medication, you could put a sticker on that read note direction change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105251	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockledge Healthcare & Rehabilitation Center	587 Barton Blvd Rockledge, FL 32955

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/03/25 at 11:01 AM, Consultant Pharmacist G said he completed medication cart audits once a month for storage of medications and verified there were no expired medications. However, he explained he did not check the eMAR to the order to verify that the label on the medications had not changed or were correct. He said he completed a monthly review including pharmacy recommendations and was involved in the facility's Quality Assurance and Performance Improvement meeting every month. Consultant Pharmacist G indicated he audited the nurses' documentation and sent a report to the facility monthly. He stated he was unaware of any discrepancies with medication labels from the last audit and acknowledged that incorrect labels could lead to medication errors. On 4/03/25 at 12:07 PM, the Unit Manager (UM) for [NAME] way explained if an order was changed or a medication dosage was updated, she would put the new order in the computer and send it to the pharmacy. She continued that the section for updated orders allowed them to use or not use the medication on hand. The UM explained if the medication was not used, the process was to discontinue the medication, remove it from the cart and place it in the return to pharmacy bin. If they chose to use the medication on hand, the process was to place a sticker which indicated, see direction change and once the new order came in, the old blister pack was removed from the cart. On 4/03/25 at 12:15 PM, the consulting pharmacy customer representative H said via telephone if an order was changed by the physician, the new order was entered, the old one discontinued and the medication removed from the cart. They explained the facility could reuse the medication on hand, if possible, by placing a sticker for the direction change. He stated Consultant Pharmacist G was responsible for medication label to eMAR checks, and acknowledged administration inaccuracies on medication labels could lead to medication errors. On 4/03/25 at 2:34 PM, the Director of Nursing (DON) stated her expectation was that discontinued medications be removed from the medication cart and if using a medication on hand when there were order changes, the sticker for the direction change should be placed on the medication until the new medication was delivered. She confirmed any medication with a label which was different from the order should be removed. The facility's Policy on Medication/Biological Storage Issued 4/01/22 indicated in the procedure section, The Nursing staff shall be responsible for maintaining medication storage .and Drug containers that have missing, incomplete, improper or incorrect labels should be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated or deteriorated medications, drugs or biologicals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to follow appropriate hand hygiene and personal protective equipment (PPE) practices per infection control standards; and failed to prevent cross contamination when handling trash. Findings: On 4/02/25 at 9:49 AM, Certified Nursing Assistant (CNA) J obtained a pair of gloves from a treatment cart. He donned the gloves without performing hand hygiene and entered a resident's room to assist the wound care nurse. A few minutes later on 4/02/25 at 9:53 AM, CNA J confirmed he was supposed to perform hand hygiene when donning and doffing gloves. He explained he had forgotten to do this but said it was important for sanitation and protection of the residents. On 4/02/25 at 2:58 PM, CNA J was observed at the doorway of room [ROOM NUMBER] holding a clear, plastic bag with trash in his right hand and wearing a personal backpack while talking to a staff member who was inside the room. He then entered room [ROOM NUMBER] and continued talking to the other staff with the bag in his hand. CNA J stepped out of room [ROOM NUMBER] a few minutes later. He explained the bag contained trash he collected from a different room, room [ROOM NUMBER]. He validated he was not supposed to bring trash bag from another room into other resident rooms. On 4/02/25 at 4:35 PM, the Director of Nursing stated she expected staff to perform hand hygiene when donning and doffing gloves. She indicated staff were to discard anything they removed from a resident's room in the soiled utility room and perform hand hygiene before entering another resident's room. She acknowledged entering a resident's room with trash from another room was a problem with cross contamination and was considered a break in infection control process. Review of the facility's policy titled Hand Hygiene dated 4/01/22 read, The facility considers hand hygiene the primary means to prevent the spread of infections.