

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Melbourne		STREET ADDRESS, CITY, STATE, ZIP CODE 606 E Sheridan Rd 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)		
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** Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessment to ensure safety for 3 of 3 residents reviewed for self-administration of medications, of a total sample of 41 residents, (#8, #86 & #113).1.Resident #8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral palsy, acute kidney failure, unspecified glaucoma, type 2 diabetes mellitus, blindness to the left eye and dysphagia. A review of the Minimum Data Set (MDS) admission Five-day assessment with assessment reference date (ARD) of 6/19/25 revealed resident # 8 had a Brief Interview for Mental Status (BIMS) Score of 14 out of 15 which indicated she was cognitively intact. The MDS assessment revealed the resident had no behaviors, nor rejection of care and her vision was highly impaired. A review of resident #8's electronic medical record revealed no physician's order to self-administer medications, no care plan for self-administration of medications, nor an assessment completed to indicate it was safe for resident #8 to self-administer her medications. A review of the Medication Administration Audit report for 9/22/25 revealed documentation that Licensed Practical Nurse (LPN) A administered the Omega 3 Oral Capsule 1000 milligrams (mg) at 10:57 AM, along with all of resident #8's other morning medications between 10:56 AM and 10:59 AM. On 9/22/25 at 12:05 PM resident #8 was in her room with a friend standing at her bedside. There was a large, clear yellowish capsule in a medication cup with some applesauce in another medication cup on the resident's bedside table. The resident stated the medication was fish oil and that because this was such a large pill, she took a long time to swallow it. Resident #8 said she had asked the nurse to leave the pills because she understood the nurses were quite busy and did not want her to be held up. She explained her friend would assist her with the medications. The resident's friend said it was okay; she would help administer the pills. The friend continued to explain that resident #8 took the small pills with no problem, but the fish oil took a while to swallow, which was why it was still there on the bedside table. On 9/22/25 at 3:48 PM, LPN A explained for resident #8 that today was the only time she did that [left the medication at the bedside] because she was called away by the Unit Manager (UM). The nurse confirmed that even though she was called away, she should not have allowed resident #8's friend to help administer the medication. The UM for the 300 and 400 halls joined the interview and LPN A explained that because the UM called her away, she left the medication with the resident's friend. The UM confirmed the resident did not have a self-administration assessment completed nor was she care planned to allow her friend to assist with self-administration of medications. The UM continued to explain that the assigned nurse, LPN A, should have not allowed the resident's friend to administer medications even if she was called away. She said LPN A should have taken the (continued on next page)		

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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication with her or else remained and completed the administration herself. On 9/22/2025 at 4:40 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) acknowledged the situation, stated it was not their normal standard of practice to leave medications at bedside and acknowledged it should not have happened. 2. Resident #86 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, generalized weakness, insomnia and depression. A review of the MDS Quarterly assessment with ARD of 6/28/25 revealed resident # 86 had a BIMS Score of 14 out of 15 which indicated she was cognitively intact. The MDS assessment revealed the resident had no behaviors, nor rejection of care. A review of resident #86's Plan of Care revealed the resident had actual impairment to skin integrity related to seborrheic dermatitis of the face and head which was initiated on 3/07/25 and included interventions that read Treatment as ordered. On 9/22/25 at 11:48 AM, resident # 86 was in bed, alert and oriented. There was a tube of Hydrocortisone cream without a cap on her bedside table, and she stated that she used it a while ago for a rash on her face. The resident continued to explain she applied the cream to her face twice a day but stopped using it after she had lost the cap. On 9/22/25 at 3:55 PM, LPN A verified the hydrocortisone cream at resident #86's bedside. LPN A said she did not know about the Hydrocortisone cream for resident # 86 at the bedside. The UM walked into resident #86's room and verified the Hydrocortisone cream. The resident stated to the assigned nurse and the UM that the cream was given to her by the Dermatologist a while back and she used it for the rash on her face. A short time later the UM confirmed in the electronic medical record no self-administration assessment had been completed for resident #86 and said they did not even know resident #86 had an order for Hydrocortisone cream. The UM explained it was probably an old order since there were no current orders for Hydrocortisone cream. She then found an order dated March 2025 from a Dermatologist note. The UM said that resident #86 should have an order to self-administer medications and should have had an assessment completed in order to do so. On 9/22/25 at 4:40 PM, the DON and NHA said it was not the facility's standard of practice to have medications at the bedside unless the resident had an order to self-administer medications. The NHA confirmed the nurse required education on self-administration of medications. 3. Resident # 113 was admitted to the facility on [DATE], with most recent readmission 6/27/25. Her diagnoses including fibromyalgia, anxiety, depression, myocardial infarction, and low back pain. A review of the MDS quarterly assessment, with an assessment reference of 9/17/25, revealed that resident #113 had a BIMS score of 11 out of 15, indicating she was moderately cognitively impaired. On 9/22/25 at 3:26 PM, resident #133 was lying back in bed watching television. The resident's overbed table contained personal items, including a 30 milliliter (ml) bottle of Systane Lubricant eye drops. The resident stated she bought eye drops for her left eye because it gets scratchy. On 9/22/25 at 3:30 PM, Registered Nurse (RN) B, the primary care nurse, entered the room. He (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged the Systane lubricant eye drops, 30 milliliters on the residents table. Outside of the room a review of the resident's physician orders with RN B revealed no orders for the Systane lubricant eye drops, nor did the resident have a completed medication self-administration evaluation. On 9/23/25 at 10:12 AM, the DON stated she spoke with resident #113, and the resident did not wish to administer eye drops on her own. She explained a physician's order was obtained for the nurse to administer the eye drop to the resident. A review of the facility's policy and procedure for Self-Administration of Medication dated 9/16/24 revealed, The facility will determine through an interdisciplinary assessment if the resident is able to either safely administer medications that are requested from a central location (e.g. medication cart or medication room) or the resident is able to safely store the medication in a secure location in room, and safely administer the medication as prescribed.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the policy and procedure, Quality Assurance and Performance Improvement (QAPI) dated 12/20/19, revealed the purpose of the facilities QAPI program was to promote excellence in quality care, quality of life resident choice and person-centered care. The document indicated the facility conducted Performance Improvement Plans (PIP) to examine and improve care or services in areas the facility identified as requiring attention. The facility had deficiency cited at F554 related to resident self-administration of medication during the previous recertification survey conducted 5/06/24 through 05/09/24. The same deficiency had also been cited during the recertification survey conducted the year before, on 02/05/23 through 02/08/23. During the current survey, concerns were again found with resident self-administration of medication, and the facility was found to be in noncompliance with F554. Insufficient auditing and oversight by the facility to prevent the citation was identified to be a factor in the repeated deficiency. On 9/25/25 at 3:02 PM, the Administrator stated the QAPI committee met monthly and reviewed different areas such as grievances, reportable events and deficiencies from previous surveys and complaints. She acknowledged medications were found left at the bedside by staff during this survey and said they had been working on the issue because they had been cited for this on the last survey. The Administrator produced an undated Performance Improvement Plan (PIP) for medications with actions for nursing education related to medications at the bedside and weekly random audits performed by the Unit Managers. The section titled Evaluation date and Results indicated continue PIP, minimal progress, will need to reeducate. The section was undated. The bottom of the PIP listed the action plan was completed on February 2025, to be followed up monthly at QAPI. The Administrator verbalized they were working on the issue, and she confirmed it continued to be a problem at the facility.		