

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2025
NAME OF PROVIDER OR SUPPLIER  West Melbourne Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2125 West New Haven Ave West Melbourne, FL 32904	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility, for 1 of 1 resident reviewed for discharge, of a total sample of 49 residents, (#151). Findings: Resident #151 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, intervertebral disc degeneration of lumbar region, major depressive disorder, and essential primary hypertension. Review of the Minimum Data Set quarterly assessment with assessment reference date of 5/08/25 revealed resident #151 had Brief Interview for Mental Status score of 5 out of 15 which indicated severe cognitive impairment. Review of resident #151's medical record revealed her daughter, Jeannelle [NAME], was resident #151's guardian, emergency contact, responsible party for decision making, durable power of attorney (POA) - financial and received the financial statements. Review of resident #151's medical record revealed she was discharged home on 5/19/25. In a phone interview on 12/04/25 at 2:27 PM, resident #151s guardian explained her mother had been out of the facility more than 30 days and the facility had not refunded the money in her accounts. She explained she reached out to the facility multiple times in the summer of 2025 and met with the Nursing Home Administrator (NHA) in September 2025 to discuss the positive balance but had not received the refunded money. Review of emails dated 6/20/25 to 7/07/25 from resident #151's guardian to the facility revealed she requested the refund and verified her home address. On 12/03/25 at 10:51 AM, Business Office Staff A reviewed resident #151's financial records and stated she had Medicaid as the primary payor when she discharged home on 5/19/25. She reported there was a positive balance in the primary account and stated they didn't normally issue the refund until all payor sources were paid. Business Office Staff A explained resident #151's Medicaid Aetna had not been paid. She stated, when there was a positive balance, they gave it to the Business Office Manager (BOM), who issued the refund if necessary. Business Office Staff A provided a current financial statement dated May 2025 for resident #151 which indicated a positive balance of \$517.06. On 12/03/25 at 11:34 AM, the Regional NHA reviewed resident #151's financial records, stated she still has some open claims, and acknowledged the positive balance on her account. On 12/03/25 at 12:28 PM, the facility NHA acknowledged resident #151's positive balance had not been refunded. Review of the facility policy, [NAME] and Refunds with revision date 6/04/12, revealed: Refunds will be issued in accordance with both State and Federal guidelines.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105376
		If continuation sheet Page 1 of 1