

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: 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)		
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and record review, the facility failed to respond in writing to repeated grievances identified by resident council over a six-month period, (June to November 2025). Findings: During Resident Council meeting on 12/02/25 at 10:34 AM, members of Resident Council verified they met monthly. The members stated several grievances had been voiced regarding nurse and aide staffing, staff customer service and dietary issues. The residents in attendance agreed the same concerns were voiced month after month without a resolution from the facility. The group expressed no one ever responded to the grievances and informed them of what was done. Review of the grievance log from June through November of 2025 revealed one grievance from the Resident Council dated 11/12/25, in regard to their concerns with staff being loud, rude, and on their cell phones in the dining room. Further review of Resident Council minutes from June through November 2025 revealed the staff customer service concerns about staff on their cell phones was repeated several times. There were also repeat grievances for the cleanliness of the shower rooms. On 12/03/25 at 3:40 PM, the Activity Director stated she attended every Resident Council meeting and helped facilitate conversations between the council and the facility. She stated typically she did not fill out a grievance form unless it was a majority concern for the group, but Resident Council minutes were discussed during the facility's daily morning management meeting. The Activity Director explained they decided as a group how to handle the concerns, then they were handed off to the related department head. She confirmed this process was completed verbally and there was no written documentation of the process. The Activity Director acknowledged Resident Council members reported they did not feel like anyone was listening to them. n 12/04/25 at 9:41 AM, the Nursing Home Administrator explained his expectation related to Resident Council concerns was for the Activities Director to bring their concerns to their daily morning meeting to discuss, then hand the concerns off to the appropriate Department Head. He acknowledged the Resident Council concerns were not written up into a grievance form which would show how or if the concerns were addressed. Review of the facility's policy and procedure for Resident and Family Grievances effective 3/30/12 revealed that grievances which were verbal should be recorded on the grievance form which would serve as communication to other staff members. One of the various forms of grievances included verbal complaints during Resident Council meetings. The policy described that the staff member who received the grievance should complete the grievance form.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain the overall cleanliness of the kitchen and ensure that food was stored and distributed in a sanitary manner. Findings: On 12/01/25 at 10:10 AM, the initial kitchen tour inspection was conducted with the Kitchen Manager. She stated she had been in the position for two years but had been a Certified Nursing Assistant prior to her current position. Initial observation found the floor unclean, as evidenced by stuck on food under the tables and equipment. The Kitchen Manager said the floors were cleaned every night prior to closing the kitchen but once per month the Maintenance Department power washed the floors. She was unsure when maintenance had last done the floors. The shelves directly below the steam table had a sticky residue and stuck on food. Next to the dishwashing sink there was a table used for meal prep that had a top shelf where spices were stored. The spice bottle lids were visibly dirty, sticky, and unable to close due to crusted spice flakes and residue on them. There was a half empty clear container used to store food thickener that was covered in an unknown substance, including the lid and a similar uncleaned container of breadcrumbs. Upon lifting both containers off the shelf, ants crawled all over the shelf which had not been cleaned. The Kitchen Manager stated shelves were wiped daily at the end of the day. A short time later the kitchen equipment was inspected, and it was noted that the oven was dirty with burnt food on both the doors and inside. The Kitchen Manager said the ovens were cleaned daily. Upon opening the walk-in refrigerator, there was a large tray on the bottom left side that had meat juices dripping on the floor and a box on top of that containing defrosted chicken. On the top right shelf there was a clear container with fruit punch that had been dated to be used prior to 11/30/25 and had not been discarded. There was a stainless-steel container with an unknown orange sauce that was labeled to be used prior to 11/28/25 and not discarded. In the walk-in freezer there was a box of sausage patties and a box of frozen empanadas, that had been left open to air, and the items had freezer burn. The Kitchen Manager stated that all staff were responsible for ensuring defrosted meat juices were contained within the drip tray to prevent the spread of bacteria. The manager said staff were supposed to ensure all food items past their use by date were discarded daily and packaged food items had to be securely closed to prevent spoilage and ensure freshness. In the dry storage closet, there were open items such as a bag of sugar, box of potato pearls, and package of gravy mix that had not been appropriately closed and were not dated. The floor in this room had dried, crusted food around the legs of the shelves, that was acknowledged by the Kitchen Manager. On 12/01/25 at 10:30 AM, the Kitchen Manager provided the cleaning schedule for November and December 2025 and it revealed staff were signing off they were conducting the daily cleaning of all areas of the kitchen to include counters, floors, walk-in fridge, and kitchen equipment. The Kitchen Manager stated these areas were not assigned to a specific person on a rotating basis because it was the responsibility of all staff to ensure the kitchen was clean and food items were discarded after their use by date. On 12/04/25 at 1:45 PM, the Maintenance Director confirmed the kitchen floors had been power washed on 11/19/25. He said power washing was conducted monthly and as needed. He said he was not aware of the condition of the floors and agreed that they needed to be cleaned.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility's QAPI Plan revealed the facility would gather information from various sources including past surveys to identify and clarify issues or problems, design and implement interventions, assess results and sustain improvements using a root cause process. During the previous recertification survey conducted 12/11/23 to 12/14/23, the facility had deficiencies cited at F677 for Activities of Daily Living (ADL) care not provided to a dependent resident related to nail care, F695 for tracheostomy care and oxygen therapy not provided as ordered, and at F812 for storage/preparation/service of food in a sanitary manner. During this survey, the facility was found to again be in noncompliance with F677 for ADL care not provided to a dependent resident related to oral care and showers, F695 for respiratory care related to use of a continuous positive airway pressure (CPAP) machine and F812 for store/prepare/serve food in sanitary conditions related to dirty surfaces, presence of insects, opened and undated food and improper defrosting of meat products. As a result of the repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the citation. On 12/04/2025 3:59 PM, the Administrator stated there had been some changes in staff including management staff. He verified that with the changes with staff, some things just got dropped. The Administrator acknowledged that QAPI plans were supposed to continue to exist beyond changes in staff.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity during dining for 1 of 2 residents reviewed for dignity, of a total sample of 49 residents, (#20). Findings: Review of resident #20's medical record revealed he was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE] with diagnoses including quadriplegia (spinal cord injury affecting all four limbs), dysphagia (difficulty swallowing), and type 2 diabetes. Review of resident #20's Minimum Data Set (MDS) annual assessment with an Assessment Reference Date of 9/02/25 revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. The MDS assessment identified impairment of both upper and lower extremities. The assessment revealed resident #20 was totally dependent on staff for all activities of daily living (ADLs) except toileting hygiene, for which he required substantial assistance, and was dependent on staff for mobility. Review of resident #20's comprehensive care plan, revised on 9/04/25, revealed the resident was unable to perform self-care and required total assistance related to quadriplegia. The stated goal indicated his ADL needs would be met within 90 days. Review of resident #20's comprehensive care plan, revised on 9/04/25, identified a problem related to weight loss. An additional care plan addressing potential weight loss indicated the resident was dependent on staff for assistance with all meals and directed nursing staff to allow adequate time for meals to be consumed. On 12/01/25 at 1:48 PM, a female staff member was observed standing while feeding lunch to resident #20. There was no chair in the resident's room for staff to sit during the meal. On 12/01/25 at 4:07 PM, resident #20 stated there used to be an extra chair in his room, however, it was removed a few weeks earlier because his roommate's wheelchair did not fit in the room, and the chair was not replaced. He shared, Certified Nursing Assistants (CNAs) normally stood while feeding him. Resident #20 expressed he preferred staff to sit while assisting him with his meals which allowed them to take their time due to his swallowing difficulties. On 12/03/25 at 11:53 AM, CNA B stated she had assisted resident #20 with lunch the previous day while standing. She indicated she sat sometimes but acknowledged she did not always do so. CNA B explained this depended on the available space in the room. She confirmed she was standing while assisting resident #20 during lunch the previous day and breakfast that morning. She did not recall whether a chair was available in the resident's room. The CNA stated some rooms did not have chairs but acknowledged it was better for the residents to be seated and at eye level of the dependent residents while they ate. On 12/03/25 at 12:50 PM, CNA C stated she typically sat down to assist residents who required help with meals in order to remain at eye level and would obtain a chair if one was not present in the room. She confirmed she stood while assisting resident #20 due to his condition and the presence of special devices attached to his bed. She explained she elevated the head of the bed during meals but remained standing. CNA C indicated she had not discussed or requested guidance regarding resident #20's meal set-up with anyone. On 12/03/25 at 3:53 PM, Licensed Practical Nurse (LPN) C stated resident #20 was dependent on staff for all ADLs. She indicated she did not recall observing CNAs sitting while assisting resident #20 with meals. She stated she had observed most CNAs sitting while feeding other residents but had also observed some standing, noting it depended on chair availability. She stated CNAs preferred to be at eye level with residents and, at times, she had encouraged CNAs to sit. On 12/04/25 at 10:11 AM, during an interview with the C Wing's Unit Manager (UM) and the Director of Nursing (DON), the UM stated CNAs normally sat when feeding residents, however CNAs stood while feeding resident #20 because he liked to watch television while eating. The UM explained CNAs could obtain information on how to care for assigned residents by reviewing the care plan, or consulting nurses or other CNAs familiar with the resident. The DON stated any deviation from standard care should be included in the resident's individualized care plan and confirmed the standing position described as resident #20's (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preference was not documented in the comprehensive care plan. Later, at approximately 3:00 PM, the UM stated there were 25 residents in the facility who were dependent on staff for eating. Review of the admission packet provided to all residents included a list of Resident Rights and read, The Facility strives to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his individuality.		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow generally accepted accounting principles in the management of resident personal funds for 1 of 2 residents reviewed for personal funds, of a total sample of 49 residents, (#13). Findings: Review of resident #13's medical record revealed she was readmitted to the facility on [DATE]. Her diagnoses included Parkinsonism, chronic obstructive pulmonary disease, and neuropathy. Review of the Minimum Data Set quarterly assessment with an Assessment Reference Date of 9/29/25 revealed resident #13 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating mild cognitive impairment. A BIMS score of 12/15 indicates the individual has a relatively good level of cognitive function, (retrieved on 12/17/25 from www.clevelandclinic.org). On 12/02/25 at 9:17 AM, resident #13 stated she had not received bank statements or the facility's financial statements. She shared the facility managed her finances and she would like to receive monthly statements to know her balance. She stated she was schedule to have her hair done that day and did not even know whether she had sufficient funds in her account to pay for the service. On 12/03/25 at 10:21 AM, Financial Specialist Assistant A stated she managed resident trust accounts. She indicated quarterly statements were mailed to residents or resident representatives. She confirmed resident #13 had a resident trust account. She explained earlier in the year the facility learned resident #13 maintained an external bank account and received a pension from the Veterans Administration. She stated the facility assisted resident #13 with transferring those funds into her resident trust account and with reapplying for Medicaid. She further mentioned resident #13 had a Power of Attorney (POA) added to manage her affairs effective 5/27/25. Financial Specialist Assistant A explained when a resident served as their own responsible party, quarterly statements were mailed to the facility and delivered to the resident's room. She stated she failed to mail statements to the POA because the address on file listed the resident and the facility's address. She explained the appropriate process when a POA was added was to update the POA address in the system so quarterly statements would be automatically mailed to the POA. She confirmed resident #13 would have been mailed the first quarter 2025 statement in April and stated statements could be provided upon request, despite the presence of a POA. Financial Specialist Assistant A was unable to provide evidence resident #13 or her POA received any quarterly statements during 2025. On 12/03/25 at 10:37 AM, Financial Specialist Assistant F stated resident #13 requested a copy of her trust account statement earlier that morning but she had not yet provided one. She said she notified resident #13's POA of the resident's request. Review of the current admission packet provided to all residents revealed a list of Resident Rights which included the management of personal funds which read, Your individual financial records will be available to you through quarterly statement and upon the written request of you or your Responsible Party.		

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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. Based on observation, interview, and record review, the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior in 2 of 2 shower rooms, on 1 of 3 units, (B-Wing). Findings: On 12/02/25 at 10:03 AM, resident #33 shared there was a black substance above the door in one of the B wing shower rooms. On 12/04/25 at 1:28 PM, the Housekeeping Director stated he was responsible for managing housekeeping and laundry services. He shared he performed monthly audits of residents' rooms to ensure conditions were in good order. An observation of the east individual shower room in the B-wing was conducted with the Housekeeping Director at 1:48 PM. A black substance was observed on the ceiling near the air conditioner vent and on the vent itself (photographic evidence obtained). The Housekeeping Director stated the black substance resulted from condensation from the air conditioner vent. He indicated housekeeping staff were responsible for cleaning the exterior of the vent, while maintenance staff were responsible for the ceiling. An observation of the B-wing north-side individual shower room was also conducted, during which a similar substance was observed near the shower area. The Housekeeping Director stated housekeepers checked the showers every morning and performed a deep clean weekly. He explained special chemicals were used to remove mildew and acknowledged the condition of the showers was not acceptable. He said his expectation was for shower rooms to be clean. On 12/04/25 at 1:59 PM, the Maintenance Director stated he expected staff to inform him of maintenance needs, as staff were in resident rooms and common areas more frequently than he was. The Maintenance Director stated he was unaware of the black substance found in the east individual shower room on the B-Wing. He explained the substance was caused by the dust mixed with condensation from the vent. He reiterated no one had reported the condition of the shower room ceiling. The Maintenance Director said his expectation was for shower rooms to be clean and homelike for residents. On 12/04/25 at 2:16 PM, the Administrator reviewed the photograph obtained from the shower room and confirmed he expected the shower rooms to be kept clean. Review of the facility's policy titled Resident Environment Quality dated 3/01/10 revealed its purpose was to protect the health and safety of residents, personnel, and the public. The policy process included the directive, Preventive maintenance schedules, for the maintenance of the building and equipment, should be followed to maintain a safe environment.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the grievance process by not making a prompt effort to resolve a grievance and not keeping the resident apprised of the progress toward resolution for 1 of 3 residents reviewed for personal property, of a total sample of 49 residents, (#20). Findings: Review of resident #20's medical record revealed he was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE] with diagnoses including quadriplegia (paralysis of all four limbs), dysphagia (difficulty swallowing), and type 2 diabetes. Review of resident #20's Minimum Data Set (MDS) annual assessment with an Assessment Reference Date of 9/02/25 revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. The MDS assessment noted it was very important to resident #20 to take care of his personal belongings. On 12/01/25 at 4:33 PM, resident #20 stated approximately three months earlier, while being moved from the A wing to the C wing, facility staff were moving his dresser and pushed it forcefully, causing his television (TV) to fall and break. He indicated the TV was a 55-inch (name brand) smart TV that cost approximately \$1,600.00 and stated he would accept a replacement costing \$900.00 if it had the same features. Resident #20 mentioned he was asked to provide a copy of the purchase receipt for replacement purposes which he did. He further stated the Social Services Director (SSD) later informed him the Administrator (NHA) said the amount was too much to reimburse for a TV. Review of resident #20's medical record revealed an interdisciplinary progress note dated 12/17/24 documenting a care plan meeting held at the resident's bedside with his fiancé participating via telephone. The note read, Resident received a big screen TV this quarter from his brother. He and roommate watch it together. Review of a Grievance/Complaint Form dated 6/12/25 described the concern as, During care, resident's personal TV was knocked over and broke. Staff confirmed that they were giving care and broke the TV. The action to resolve the concern read, Resident was notified that TV will be reimbursed. The form documented the resolution as, Resident stated that reimbursement will be sufficient and was signed by the SSD on 6/13/25. Attached to the Grievance/Complaint Form was a receipt showing the TV cost of \$1,299.95 and the sales tax of \$88.44. Also attached was a Request for Payment form dated 8/15/25, which indicated the SSD requested a check payable to resident #20 in the amount of \$1,388.37. The explanation of the expenditure read, TV was broken by staff while giving care, and the form was signed by the NHA. On 12/03/25 at 5:29 PM, the SSD stated resident #20 was provided another TV in the interim and the NHA was working on obtaining a replacement. The SSD acknowledged there should have been timely follow-up with resident #20 and documentation regarding the status of his grievance. On 12/04/25 at 2:20 PM, the NHA stated it should not have taken this long to resolve resident #20's grievance. The NHA acknowledged the grievance process was not followed but stated the issue was now being addressed. Review of the facility's policy titled Resident and Family Grievances, dated 3/30/12, revealed the Social Service designee was responsible for taking steps to resolve grievances and documenting actions taken in the social service progress notes. The policy further indicated the NHA was responsible for following up with the resident, with the assistance from the Social Service designee, to discuss actions taken to resolve the grievance. Review of the admission packet provided to all residents included a list of Resident Rights outlining the Grievance Procedure. The procedure stated the facility would investigate and attempt to resolve all grievances promptly and provide investigative findings and a plan of action.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop a comprehensive person-centered care plan for a resident with antipsychotic medications for 1 of 5 residents reviewed for high-risk medications, of a total of 49 residents, (#116); the facility failed to develop an individualized care plan to include paranoid schizophrenia for 1 of 5 residents reviewed for Pre-admission Screening and Resident Review (PASARR), (#103), of a total sample of 49 residents. Findings: 1. Review of resident #116's medical record revealed she was readmitted to the facility on [DATE] with diagnoses of hypertensive heart disease without heart failure, Alzheimer's disease, dementia with psychotic disturbances, major depressive disease and anxiety. Review of resident #116's admission Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 11/16/25 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. The assessment showed resident #116 received high-risk medications including anti-psychotics, anti-anxiety and anti-depressants. Review of resident #116's electronic medication record revealed medication orders for Quetiapine 25 milligrams (mg) twice daily for dementia with psychotic disturbances. Review of resident #116's medical record revealed a comprehensive care plan for anti-psychotic medications was not developed for the resident after the completion of the admission MDS assessment. Review of a pharmacy recommendation dated 11/04/25 revealed the recommendation for guidance for the interdisciplinary care plan related to the anti-psychotic, Quetiapine. The recommendations included: identifying common behavioral expressions, implementing and reassessing appropriate person-centered interventions, and discussing the appropriateness of the current dose with the provider. On 12/04/25 at 11:21 AM, the MDS Coordinator explained her responsibilities included to oversee the MDS assessments and development of care plans. She stated that she reviewed hospital records, progress notes and facility assessments to develop a resident's care plan. She stated that resident #116 was a new admission and her comprehensive care plan was not finished yet. She acknowledged that a comprehensive care plan needed to be completed within seven days of the admission assessment which for resident #116 was 11/26/25. The MDS Coordinator stated she did not review pharmacy recommendations and confirmed the recommendation from 11/04/25 was not passed along to her. She validated a care plan for anti-psychotic medication was not created for the resident. Review of the facility's policy and procedure titled Person Centered Care Plans reads the facility develops a comprehensive centered plan of care for each resident that includes measurable objectives and timelines to meet a residents medical, nursing and mental needs. The policy stated that a comprehensive care plan should be completed within seven days of admission Resident Assessment Instrument assessment. 2. Review of the medical record revealed resident #103, a [AGE] year-old male was admitted to the facility from an acute care hospital on 5/13/23 with diagnoses that included diffuse traumatic brain (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury, major depressive disorder, persistent mood disorders, brief psychotic disorder, mood affective disorder, generalized anxiety disorder, pseudobulbar affect, and paranoid schizophrenia. The most recent MDS Quarterly Assessment with an ARD of 11/03/25 noted the resident had a BIMS score of 3 out of 15 which indicated severe cognitive impairment. Active diagnoses included seizure disorder, anxiety disorder, depression, and schizophrenia. The resident received high-risk medications that included anti-anxiety, anti-depressant, and anticonvulsant medications during the look back period. The medical record showed resident #103 had active diagnoses that included paranoid schizophrenia. Review of the Comprehensive Care Plan Report revealed no plan of care for the issue of schizophrenia with anxiety with potential for complications until 12/04/25, the last day of the survey. On 12/04/25 at 10:50 AM, the MDS Coordinator explained she was responsible for developing and updating comprehensive care plans. She said resident #103 had an active diagnosis of paranoid schizophrenia which she confirmed was a serious mental illness. Later, at 11:14 AM, the MDS Coordinator said she checked the care plan, and she had just created a missing problem for potential for complications of schizophrenia with anxiety care plan. She explained the problem was missing and should have been included in the care plan for resident #103. Review of the facility's standards and guidelines titled Person Centered Care Plans dated 8/15/18 outlined the facility developed a comprehensive person-centered plan of care for each resident to meet medical and mental/psychosocial needs identified in the comprehensive assessment. The guidelines noted ongoing reviews were conducted and individualized interventions were entered to meet residents' care needs.		

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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	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper and timely assistance with Activities of Daily Living (ADLs) to maintain cleanliness and dignity for 2 of 3 residents reviewed for ADLs, of a total sample of 49 residents, (#20 and #143). Findings: 1. Review of resident #20's medical record revealed he was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE] with diagnoses including quadriplegia (paralysis of all four limbs), dysphagia (difficulty swallowing), and type 2 diabetes. Review of resident #20's Minimum Data Set (MDS) annual assessment with an Assessment Reference Date (ARD) of 9/02/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS assessment indicated no rejection of evaluation or care necessary to achieve goals for health and well-being. The MDS assessment showed resident #20 had impairment of both upper and lower extremities and was totally dependent on staff for all ADLs except toileting hygiene, for which he required substantial assistance. The MDS assessment further indicated he was dependent on staff for mobility. Review of resident #20's comprehensive care plan, revised on 9/04/25, revealed he was unable to perform self-care and required total assistance related to quadriplegia. The stated goal indicated ADL needs would be met within 90 days. Interventions added on 12/24/24 included assisting resident #20 with brushing his teeth and providing oral care. On 12/01/25 at 4:07 PM, resident #20 stated he primarily received bed baths and occasionally received showers. He indicated his scheduled shower days were Mondays and Thursdays and expressed a preference for bed baths. He mentioned Certified Nursing Assistants (CNAs) did not routinely brush his teeth as part of daily care and would only do so occasionally if he requested it. On 12/03/25 at 11:53 AM, CNA B stated she had been assigned to care for resident #20 for approximately two weeks. She shared she provided him with a full bed bath this morning, including washing his hair. She stated she did not brush his teeth during the bed bath and did not recall brushing his teeth the previous day, saying, I probably did not. She acknowledged oral care was not provided and stated she should have brushed his teeth or at least offered it. On 12/04/25 at 10:11 AM, during an interview with the C-Wing Unit Manager (UM) and the Director of Nursing (DON), the UM stated CNAs were expected to provide oral care, encourage showers or provide bed baths, change linens and clothing, and encourage residents to get out of bed. She explained CNAs could obtain information regarding resident care needs by reviewing the plan of care or consulting nurses or CNAs familiar with the resident. The DON stated any deviation from expected care should be documented in the individualized resident-specific care plan. Review of the facility's policy titled Brushing the Resident's Teeth, effective 10/01/10, revealed its purpose was to provide oral hygiene to clean and freshen the resident's mouth and teeth, reduce the potential for oral infections, stimulate the gums, and remove food particles. The policy indicated oral hygiene was to be provided twice daily unless contraindicated by a physician or the resident desired more frequent hygiene. 2. Review of resident #143's medical record revealed he was originally admitted on [DATE] and readmitted to the facility from an acute care hospital on [DATE]. His diagnoses included hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following a stroke, rheumatoid bursitis (swelling of this small sac) of the left elbow, hearing loss, and type 2 diabetes. Review of resident #143's MDS quarterly assessment with an ARD of 8/30/25 revealed a BIMS score of 12 out of 15, indicating mild to moderate cognitive impairment. The MDS assessment indicated no rejection of evaluation or care necessary to achieve goals for health and well-being. The MDS assessment showed resident #143 required partial to moderate assistance with showers and transfers. Review of resident #143's comprehensive care plan, revised on 10/03/25, revealed he required assistance to safely complete daily activities of care. Interventions included bathing per schedule and encouraging the resident to wash, rinse and dry body parts within his ability. Another intervention read, Make bathing process pleasant by ensuring non-hurried atmosphere, give (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance as needed. On 12/01/25 at 2:11 PM, resident #143 stated he went approximately three weeks without receiving a shower or bed bath prior to the previous week. He indicated showers resumed only after he had to throw a fit because he felt stinky. He stated he learned the prior week his scheduled showers days were Tuesday and Friday. On 12/03/25 at 1:12 PM, CNA E stated resident #143 scheduled shower days were Tuesday and Friday morning during the 7:00 AM and 3:00 PM shift. She mentioned resident #143 refused a shower the prior week because he had received one on the previous day with the help of a therapist. She produced shower sheets showing resident #143 received a shower on 12/02/25 and 11/25/25. Review of additional shower sheets revealed no evidence resident #143 received showers on 10/31, 11/4, 11/11, 11/14, 11/18 and 11/28. Shower sheets for 11/7 and 11/21 could not be located by the CNA. She stated showers were documented both electronically and on shower sheets but was unable to explain why showers were not documented as completed. Review of resident #143's physician orders included an order dated 9/11/25 for showers on Tuesday and Friday evening. Review of the schedule for showers on the C-Wing located in the shower binder at the nurses' station showed resident #143's showers were scheduled for Tuesday & Friday during the day shift. Review of the Point of Care (POC) History document dated 10/31/25 through 12/04/25 revealed CNAs documented functional ability for tub or shower transfer but did not document whether a shower was provided. The document showed first-shift CNAs selected not applicable or did not answer for the bathing transfer task 22 of 32 days. Review of the C-Wing Shower List form used by CNAs instructed staff to sign off as showers are given and nurse to initial, and also read, Hair washed, nail cleaned and clipped if needed, teeth/dentures brushed with mouth care 2 times a day. Review of the shower sheets revealed no staff signature acknowledging resident #143 received showers on the following dated: 10/31, 11/4, 11/11, 11/14, 11/18, and 11/28 of 2025. Shower sheets for 11/7 and 11/21 were not found by facility staff. On 12/03/25 at 4:04 PM, Licensed Practical Nurse (LPN) D stated CNAs were required to sign shower sheets and notify the nurse if a resident refused care. She indicated nurses were responsible for following up on refusals and documenting them in a nursing note. Review of resident #143's Progress Notes from October 2025 through 12/04/25 did not reveal documentation of refusals of showers. On 12/04/25 at 10:44 AM, during an interview with the C-Wing Unit Manager (UM) and the Director of Nursing (DON), the UM stated resident #143's shower days were Tuesday and Friday during the 3:00 PM to 11:00 PM shift, then stated the shower binder reflected the same days but during a different shift. The UM explained if a resident requested specific showers days or times, a physician order would be entered to update the POC. She added CNAs would honor resident requests for showers outside scheduled days. The UM and DON confirmed no shower sheets were found for 11/07 or 11/21 and there was no evidence resident #143 received a shower on his scheduled days on 10/31, 11/04, 11/11, 11/14, 11/18, and 11/28. The DON stated she was unaware the POC did not include documentation of whether a shower or bed bath was provided to resident #143. The DON concluded she expected CNAs to provide showers on assigned days, and document care provided or refusals. On 12/04/25 at 11:50 AM, the Staff Development Coordinator stated all CNAs were trained on the POC system the previous year when it was changed. She explained the shower order was not entered correctly, resulting in the task not appearing on the POC for CNAs to document. Review of the policy titled Bath - Shower or Tub, effective 10/01/10, included showers and tub baths promote resident cleanliness and comfort and residents were to receive showers or tub baths as needed.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the recommended Restorative Nurse Program (RNP) to provide mobility and Range of Motion (ROM) services to improve or maintain functional ability for 1 of 2 residents reviewed for rehabilitation and restorative services, out of a total sample of 49 residents, (#13). Findings: Review of resident #13's medical record revealed she was readmitted to the facility on [DATE]. Her diagnoses included Parkinsonism, insomnia, chronic obstructive pulmonary disease, neuropathy, and schizoaffective disorder. Review of the Minimum Data Set quarterly assessment with Assessment Reference Date of 9/29/25 revealed resident #13 had a Brief Interview for Mental Status score of 12 out of 15, indicating moderate cognitive impairment. The MDS assessment noted no rejection of evaluation or care necessary to achieve goals for health and well-being. The MDS assessment showed resident #13 required partial assistance with oral hygiene, substantial assistance with toileting, shower, and dressing, and was totally dependent on staff for putting on and removing footwear and personal hygiene. The resident utilized a wheelchair for mobility and required supervision and partial assistance for bed mobility and sitting in bed. The MDS assessment further indicated resident #13 did not receive therapy services or RNP during the look-back period. On 12/01/25 at 11:30 AM, resident #13 stated was waiting to speak with her nurse practitioner to request therapy. She shared when she enrolled in hospice, she was told she could not receive therapy; however, she later clarified with hospice staff that she could have some therapy services. She stated she previously worked with therapy on two occasions and felt better afterward, despite being unable to walk. She said she did not recall receiving RNP services after therapy concluded. Review of the Physical Therapy (PT) Discharge Summary with dates of service from 1/23/25 through 3/19/25 revealed a long-term goal to Establish and train nursing with FMP (Functional Maintenance Plan) and RNP. The summary documented Certified Nursing Assistant (CNA) training in slide-board transfers initiated on 3/04/25 and completed on 3/19/25. Skilled interventions included bed mobility and transfer training and the summary showed resident #13 made good progress. Discharge recommendations indicated resident #13 was discharged to nursing care with an FMP and an RNP. The prognosis to maintain current level of function was excellent with participation in RNP, excellent with participation in FMP, and good with consistent staff follow-through. Review of the Physical Therapy FMP form signed on 3/13/25 revealed RNP interventions included active ROM (AROM) and bed mobility. The goal was for resident #13 to perform two sets of ten bilateral lower extremity exercises in the supine (lying back) position within tolerance to improve strength and functional mobility. An additional Physical Therapy FMP dated 3/19/25 included a goal to assist the resident with functional transfers out of bed throughout the week within tolerance, utilizing a sliding board. Review of resident #13's Point of Care (POC) History report for 2025 revealed documentation of AROM on 1/30/25 and 2/17/25, with bed mobility documented on 1/30/25. There was no evidence in the medical record resident #13 received the therapy-recommended exercises initiated on or after 3/13/25. Review of resident #13's Observation Detail List Report dated 7/04/25, completed by the RNP nurse, did not include restorative nursing goals or a restorative plan. The documented care plan action was to Continue Current Care Plan. The RNP was not incorporated in the comprehensive care plan. On 12/04/25 3:14 PM, the RNP nurse stated she had served in the RNP role for the past two years and was responsible for implementing the FMPs recommended by therapy. She indicated two Restorative Certified Nursing Assistants (RCNAs) were responsible for performing ROM exercises, applying splints, assisting residents with dining, and following dietary recommendations. She shared therapy staff completed FMPs upon discharge and provided training to RCNAs. She stated she entered FMP as orders in the medical record, specifying frequency, and expected the RCNAs to document services provided. She indicated (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the FMP duration was 90 days, after which the resident was discharged from the program. She stated residents who declined or failed to improve were referred back to therapy. She stated resident #13 began RNP services sometime in February and was assigned ROM exercises. She acknowledged RCNAs did not document sessions provided. She stated if a resident refused RNP services, RCNAs were expected to notify her and she would speak with the resident, though she acknowledged such conversations were not always documented. She indicated resident #13 refused exercises at times but validated these refusals were not documented. She stated she asked an RCNA whether services were provided to resident #13 and the RCNA stated they were but could not recall if documentation was completed. She indicated she did not recall documenting resident #13's progress or discharge from the RNP and could not state with certainty whether resident #13 received the RNP services as recommended by therapy. On 12/04/25 at 3:33 PM, the Director of Therapy stated if there was a change in a resident's condition requiring therapy, the RNP team was expected to notify her. She indicated there were no regular scheduled meetings with the RNP team. She stated the FMP was reviewed every 90 days by RNP staff and could be continued or discontinued without therapy input. She mentioned FMP recommendations were resident-specific and included ROM, splint use, and ambulation, with the purpose of maintaining gains achieved through therapy. Review of the facility's policy titled Restorative Services, dated 10/01/10, revealed the purpose was to ensure residents received necessary rehabilitative services, prevent avoidable physical and mental deterioration, and assist residents in achieving or maintaining their highest practicable level of functioning and psychological well-being. The policy required review of FMPs to ensure continued appropriateness, daily documentation or restorative services, and to review and update the care plan as needed.		

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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** Based on observation, interview, and record review, the facility failed to obtain physician orders for respiratory treatments for 1 of 2 residents reviewed for respiratory care, of a total sample of 49 residents, (#33). Findings: Review of the medical record revealed resident #33 was admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia (low levels of oxygen), chronic obstructive pulmonary disease (COPD), type 2 diabetes, and Cor pulmonale (enlargement of the right ventricle of the heart due to lung diseases). Review of the Minimum Data Set (MDS) admission assessment with an Assessment Reference Date of 11/13/25 revealed resident #33 had a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. The MDS assessment indicated the resident did not exhibit behavioral symptoms or reject evaluation or care that was necessary to achieve her goals for health and well-being. The MDS assessment revealed resident #33 experienced shortness of breath (SOB) with exertion, used a manual wheelchair for mobility, and received continuous oxygen (O2) therapy. Review of a physician's Progress Note dated 11/03/25, prior to her admission to the facility, revealed resident #33 used a continuous positive airway pressure (CPAP) machine at night. The note included diagnosis of obstructive sleep apnea and obesity hypoventilation syndrome. A CPAP machine is a common treatment for sleep apnea and functions to keep the airway open during sleep to ensure adequate oxygenation. CPAP use can significantly improve sleep quality and reduce the risk of health complications, including heart disease and stroke (retrieved from www.clevelandclinic on 12/12/25). Review of resident #33's comprehensive care plan, revised on 11/24/25, revealed a potential for complications related to COPD, SOB, acute respiratory failure with hypoxia, and chronic Cor pulmonale. The stated goal was for the resident to exhibit no signs of respiratory distress. A care plan addressing the use of O2 therapy was initiated on 11/18/25. On 12/02/25 at 10:03 AM, resident #33 stated she used a CPAP machine at night but had not used it since being admitted to the facility because it had not been connected. She stated she expected nursing staff to address the issue but no follow up occurred. She pointed to the CPAP machine resting on a nightstand next to her bed. Review of resident #33's Observation Detail List Report dated 11/07/25 revealed documentation of a respiratory system review. The form indicated BiPAP/BPAP was checked as respiratory device used by the resident. Review of a nursing progress note dated 11/08/25 read, . Nasal O2 on at 2l (liters), O2 Sat (saturation) 97%. States at night she sleeps with CPAP on. Review of resident #33's Progress Notes revealed an Activities Note dated 11/10/25, which read, Resident is alert/oriented makes own choices regarding activity involvement, on oxygen, CPAP, utilizes w/c (wheelchair) for mobility admitted to the care for short term rehabilitative care . Review of resident #33's physician orders revealed there were no orders for CPAP use. Review of an admission care conference note dated 11/26/2025 revealed resident #33 was receiving O2 therapy and exhibited SOB. On 12/03/25 at 1:48 PM, Certified Nursing Assistant (CNA) E stated resident #33 used O2, and she reported to the nurse if it was not set up correctly. CNA E indicated resident #33 had mentioned she needed to use her CPAP machine. CNA E reported when she began her shift at 7:00 AM, the resident #33 was sitting in bed or at the edge of the bed using O2 but not the CPAP. On 12/03/25 at 3:43 PM, Licensed Practical Nurse (LPN) D stated resident #33 had recently transferred from another unit and she was not familiar with her care. LPN D indicated she had not previously seen the CPAP in the resident's room. On 12/04/25 at 11:19 AM, the C-Wing Unit Manager (UM) stated new residents were discussed during clinical meetings held the day after admission. She explained admission observations, physician orders, progress notes, and initial labs were reviewed at the meeting. She stated resident #33 was admitted to the B-Wing on 11/07/25 and the B-Wing UM or the weekend supervisor would have reviewed the admission documentation. She mentioned resident #33 transferred to the C-Wing on 11/26/25. She stated she obtained a physician order for CPAP use on 12/02/25 after noticing the machine while (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisting the resident in searching for a ring. She indicated if a nurse observed a CPAP machine in a resident's room, the expectation would be to question its use, review the medical record, and obtain a physician order.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who experienced trauma received trauma-informed care for 1 of 2 residents reviewed for mood/behavior, of a total sample of 49 residents, (#9). Findings: Resident #9 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes and obstructive sleep apnea. The facility added the diagnoses generalized anxiety disorder on 2/27/25, post-traumatic stress disorder (PTSD) on 3/13/25, and major depressive disorder on 3/26/25. Review of the Minimum Data Set (MDS) Annual Assessment with Assessment Reference Date of 11/05/25 revealed resident #9 had a Brief Interview for Mental Status score of 15/15 which indicated she was cognitively intact. The MDS listed PTSD as one of her diagnoses, on 3/13/25. The electronic medical record (EMR) contained a Trauma-Informed Care Observation dated 2/09/25 which revealed resident #9 had personally experienced a natural disaster, witnessed an assault with a weapon, and was a victim of a sexual assault. On 12/02/25 at 12:35 PM, resident #9 reported she and her sister were sexually assaulted by her stepfather and her uncle when they were minors. She stated she still experienced flashbacks and nightmares related to those events. Resident #9 explained there was a male resident in the facility who resembled one of her attackers. She expressed he had never done anything to her but seeing him would sometimes bring back bad memories. Review of resident #9's comprehensive care plan revealed a trauma informed care plan had not been developed to address emotional support, identify triggers, or instruct staff how to assist her to effectively cope with her emotions. On 12/04/25 at 2:16 PM, the Social Services Director (SSD) provided the Psychiatric Mental Health Nurse Practitioner (PMHNP) notes for resident #9. Review of the documentation revealed a note dated on 5/06/25 which indicated resident #9 was seen due to depression, anxiety, mood disorder, psychosis and PTSD. Per the note, resident #9 reported she was not sleeping for more than two hours and felt down. The note also identified possible triggers which included certain scents of cologne, lighting, and loud noises. The PMHNP recommended to add PTSD to the care plan with interventions to provide quiet and consistent environment, and supportive therapy. There was no care plan to address the trauma, or interventions to support the resident, or promote her psychosocial well-being added. On 12/03/25 at 3:16 PM, the SSD reviewed resident #9's medical record. She verified a screening was conducted which indicated resident #9 had experienced trauma. The SSD acknowledged there was no comprehensive care plan for PTSD to address resident #9's trauma, potential triggers, and interventions, and commented the resident absolutely should have had one. In a follow up interview on 12/04/25 at 3:02 PM, the SSD stated it was the responsibility of Social Services and/or nursing to review the psychiatric notes and follow up on any recommendations. The facility's policy on trauma informed care dated 10/25/22 indicated, the plan of care should be developed by the interdisciplinary team. The document advised the Care Plan team should decide which residents needed a behavior management program versus residents that were care planned with appropriate interventions.		