STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105464	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anchor Care & Rehabilitation Center	1515 Port Malabar Blvd NE Palm Bay, FL 32905

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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** Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessment to ensure safety for 1 of 1 resident reviewed for self-administration of medications, of a total sample of 45 residents, (#62). Findings: Resident #62 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, essential hypertension, anemia, major depressive disorder, anxiety disorder, and sepsis. Review of the Minimum Data Set quarterly assessment with assessment reference date of 5/02/25 revealed resident # 62 was cognitively intact. A review of resident #62's medical record revealed no physician's orders for eyedrops, no assessments for self-administration of medications nor did it contain a care plan which reflected self-administration and storage arrangements. On 6/11/25 at 9:40 AM, resident # 62 was observed in her room seated in a wheelchair with a bedside table in front of her. On the bedside table there was a small green bottle of Refresh eyedrops and the resident stated it was her own eyedrops which she administered by herself in the morning and at night. The resident continued to explain that staff were aware she self administered the bottle of eyedrops and that she had the bottle with her since admission. A few minutes later at 9:45 AM, assigned nurse Licensed Practical Nurse ((LPN) G looked at resident #62's physician orders and confirmed there was no order for eyedrops nor was there an order to self-administer medications. LPN G immediately went into resident #62's room, confirmed the bottle of eyedrops on the table and educated the resident on self-administration of medications. The resident explained to the nurse that her son had brought the eyedrops and continued to explain how she administered it to herself, one drop in morning and one at night in both eyes, ever since I got here. LPN G examined the bottle, verified the expiration date, and explained to the resident that she would need a doctor's order and an assessment completed in order for her to self-administer her own eyedrops. On 6/11/25 at 9:51 AM, the Assistant Director of Nursing (ADON) and the Unit Manager (UM) for the Sea Breeze unit explained that residents were not allowed to have medications at the bedside unless they had a doctor's order and an assessment for self-administration. (continued on next page)

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	On 6/11/25 at 9:53 AM, the Director of Nursing (DON) confirmed eyedrops should not have been left unsecured for the resident to take by herself and acknowledged the resident was not previously assessed for self-administration of medications. The DON stated the unsecured eyedrops would be taken care of immediately, and that a physician's order to assess the resident for self administration of medications was needed. The facility's policy on Resident self-Administration of Medication implemented on November 2020 indicated, It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The policy described, the resident had the right to be assessed for self-administration of medications, directed nurses and aides to report to the charge nurse any medications found at the bedside, and ensure the care plan reflected resident self-administration and storage arrangements for the medications.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and residents' choices for two of two residents reviewed for call bells, of a total sample of 45 residents, (#80 and #259). Findings: 1. Resident #80 was admitted to the facility on [DATE] for hypertension, depression, insomnia, emphysema, and a urinary tract infection. According to the discharge Minimum Data Set (MDS) dated [DATE] for a short-term hospital stay, it indicated the resident was able to make his own decisions regarding tasks of daily life and was able to communicate in a logical and coherent manner. Resident #80's care plan indicated he was at high risk for falls, and his use of his call light was to be encouraged for standing, transferring and ambulation. There was a care plan which included resident was at risk for skin breakdown due to incontinence with an intervention to check for incontinence after meals. The care plan also stated this resident had an active urinary tract infection and was taking antibiotics for it with date initiated 6/02/25. On 6/09/25 at 1:03 PM, after the lunch meal, resident #80 stated he had frequent bowel movements because he took potassium, which he couldn't help. He explained he felt the staff got upset with him due to the frequent need for assistance, but he couldn't help it. Resident #80 stated staff turned off the call light and said they would tell someone to help him, but it sometimes took up to an hour and a half to get the needed help. He added he asked staff to leave the call light on, but they turned it off anyway. The resident had the call light on at that time and stated he was currently waiting for his brief to be changed. On 6/09/25 at 1:08 PM, Licensed Practical Nurse (LPN) A came into the resident's room, turned the call light off and asked the resident what he needed. He told her he needed his brief to be changed. She stated she would get someone to help him. LPN A then left the room and returned shortly after carrying a gait belt. She stated she found out the gait belt needed to be used to transfer the resident, and then assisted him onto his bed. On 6/09/25 at 1:45 PM, resident #80 again requested staff assistance, this time to put his socks back on. He explained he was still waiting for someone to change his brief and was tired of waiting. Resident #80 conveyed he wanted to get back into his wheelchair and would wait until later to be changed. On 6/09/25 at 1:46 PM, LPN A explained she had told resident #80's Certified Nursing Assistant (CNA) to change him, but acknowledged she never provided that care. LPN A apologized to resident #80 and prepared to change him herself. She acknowledged resident #80 had waited over 45 minutes since he first turned on his call light for the requested service. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/09/25 at 1:48 PM, CNA B stated she had just returned from her break. She stated no one had informed her resident #80 needed to be changed, and after she finished care for another resident, she went on break. At 1:49 PM CNA C also stated no one told her resident #80 needed to be changed. A few minutes later at 1:52 PM, LPN A explained she had told CNA C that resident #80 needed to be changed but CNA C replied he was not her resident. LPN A added, she should have just changed the resident herself. On 6/11/25 at 4:18 PM, LPN A stated the expectation was for CNA's to provide assistance to any resident as long as they were not in the middle of caring for another resident. The nurse said she thought CNA C should never have said it was not her resident when asked to provide care. She acknowledged she should have provided re-education to CNA C at that time. LPN A added, when a CNA went on break, they told their hall partner and the nurse assigned to the unit they were going, but did not recall whether CNA B had informed her she was leaving for break. On 6/11/25 at 4:27 PM, the 200's Unit Manager (UM) stated call lights were for all staff to answer and if anyone saw a call light on and asked a resident what they needed, if they could take care of it themselves, they should. She explained if they could not take care of the issue themselves, staff were supposed to turn the light off, timely find someone else to help the resident, and if needed, assist as a 2nd person. The UM added, after a person turned off the call light, even if someone else acknowledged they would take care of the request, it was the responsibility of the person who answered the call light to follow up and make sure the task got done. The 200's UM stated most resident's needs could be provided by any nursing staff and added, if a CNA stated it was not their resident to provide care to, she would tell them that the residents were all of our residents. 2. Resident #259 was admitted to the facility on [DATE] for diabetes mellitus, urinary tract infection, hypertension, anemia, acute kidney failure and muscle weakness. Her admission MDS dated [DATE] indicated the resident had clear speech, could be understood, and was able to understand others. It specified the resident had good cognitive function. On 6/09/25 at 4:30 PM, resident #259 stated when staff responded to the call light, they would turn it off and tell her they would let someone else know her request. She explained the wait time to get the actual service could range between 20 minutes to 2.5 hours. Resident #259 added, the previous evening she put on her call light on three times to request pain medication and the aide told her she would let the nurse know each time. She said she got tired of waiting, so she got out of bed and went to the nurse's station herself to get it. She stated when her nurse, LPN F, saw her, she told her she should have used her call light if she needed something. Resident #259 said the nurse told her since she had refused a different medication earlier, she thought the resident didn't want any medication, instead of coming to find out what she needed. On 6/11/25 at 4:33 PM, in a phone interview, LPN F stated she recalled resident #259 came to the nurse's station for pain medication almost at the end of her shift, on 6/09/25. LPN F could not remember whether a CNA told her that resident #259 had called to request pain medication, and explained it was a busy night. On 6/12/25 at 3:16 PM, the Director of Nursing stated it was not appropriate for a staff member to respond, 'that is not my resident', to a request, and was a pet peeve of hers. She added, it was her expectation that staff who turned off a call light be sure the resident received the care they had requested. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy entitled Call Lights: Accessibility and Timely Response, dated 7/19/22, indicated all staff were responsible for answering call lights when they saw them on. The policy continued, if that staff member was unable to provide the requested service, they should then notify the person who was able.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to provide a system for preventing and controlling infections and communicable diseases for residents by not offering hand hygiene to residents who ate in the dining rooms. This affected approximately 25 residents in the main dining room at lunch and 10 at dinner meals and approximately 10 residents in the small restorative dining room at the lunch meal each day. Findings: On 6/09/25 at 11:12 AM, 20 residents were located in the main dining room in preparation for lunch. Staff was observed as they put napkins on the tables for residents, but no hand hygiene was offered to residents before the meal. On 6/10/25 at 10:53 AM, 20 residents were again seated in the main dining room in preparation for lunch. Staff was seen placing linen tablecloths on the tables. At 11:07 AM, one staff member passed out napkins while another began the meal service by serving soup and another staff served beverages. By 11:13 AM, 25 residents total in the dining room had no hand hygiene offered prior to the meal. On 6/11/25 at 3:55 PM, in the main dining room, nine residents watched television while staff placed tablecloths on the tables. Some residents remained in the dining room after participating in the afternoon music activity. At 4:05 PM, staff served soup and drinks to the residents. No hand hygiene was offered to residents. On 6/12/25 at 11:30 AM, in the small restorative dining room, nine residents ate lunch, five were being assisted by staff. At 11:39 AM, Certified Nursing Assistant (CNA) J acknowledged there was no way to know if the residents completed hand hygiene before meals, and hand hygiene had not been offered in the dining room before the meal service. She confirmed it was important for everyone to sanitize their hands before meals to not spread germs. CNA J added residents touched items and then often touched their food when eating, which could spread germs. On 06/12/25 at 12:13 PM, CNA K she had never offered hand hygiene to the residents in the main dining room or in the small restorative dining room. She acknowledged it was important for residents to clean their hands before they ate, in order to not spread germs. On 6/12/25 at 1:51 PM, CNA I assisted a resident with their meal in the small restorative dining room and acknowledged she did not ensure the resident was provided with hand hygiene before she assisted him. She stated she knew residents who needed assistance with meals needed to be provided hand hygiene prior to assisting them from her CNA education. CNA I acknowledged she never considered why hand hygiene was not provided to residents before meals at this facility. On 6/12/25 at 2:25 PM, the Infection Control Nurse stated she trained staff on hand hygiene practices and policies, and staff should make sure residents' hands got washed before they brought residents to the dining room for meals. She acknowledged the facility should offer the residents hand sanitizer or wipes in the dining room as there was no way of knowing if they all washed their hands or if they touched things after they washed them. She stated hand hygiene was important to prevent infection, so germs weren't spread. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/25 at 3:16 PM, the Director of Nursing stated she expected staff to offer to wash residents' hands before and after meals to decrease the spread of infection and so illness was not spread to others. The facility's policy entitled Hand Hygiene, dated 5/21/22, specified staff should wash their hands with soap and water prior to and after eating, but did not specify when staff should offer hand hygiene to residents.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the kitchen freezer (essential equipment), in safe operating condition. This had the potential to affect all 106 residents who ate meals at the facility. Findings: On 6/09/25 at 10:00 AM, during the kitchen tour with the Dietary Manager, it was noted in the walk-in freezer that ice [NAME] had built up on the evaporator and water was dripping onto the boxes stored below it. The Dietary Manager relocated approximately six boxes of food whose tops were covered in ice from the leak to a different shelf. She confirmed she needed to get with the maintenance department to have them come check out and repair the freezer. On 6/10/25 at 11:30 AM, the Director of Maintenance and Regional Manager of Maintenance stated they were not previously aware there was ice buildup and a leak from the evaporator in the freezer. They confirmed none of the kitchen staff had informed them of the issue, but said they would check it out. On 6/10/25 at 4:30 PM, the Director of Maintenance and the Regional Manager of Maintenance stated they had found a crack in the condenser, which they caulked, and would have an outside company come in to assess. On 6/11/25 at 11:00 AM, the Dietary Manager stated she had informed the Director of Maintenance of the leak on 6/09/25 and showed a message sent to him on the facility's manager chat at 10:28 AM that morning, and his response to the request. On 6/11/25 at 2:23 PM, the Regional Manager for Maintenance stated there had been a small crack in the outside wall of the freezer. The freezer's condenser hung from the wall and its weight pulled the sheet of metal away, which allowed hot air to get to the evaporator inside the freezer. The Regional Manager said this caused the water to drip. The Regional Manager stated he could not say why the Director of Maintenance said he had not been informed of the equipment issue before 6/10/25. The Dietary Manager stated maintenance issues were typically handled more quickly when put into the group chat. On 6/12/25 at 2:38 PM, the Director of Maintenance explained he now recalled he had been informed on the morning of 6/09/25 of the freezer issues, and thought it was caused by staff leaving the door opened. He acknowledged he did not personally check out the freezer when he was informed of the problem. He explained he must have forgotten about this request. On 6/12/25 at approximately 3:30 PM, the Administrator stated he and the Director of Maintenance were unable to locate a policy regarding expectations for equipment repair, even after they called other affiliated facilities. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Job Description for the Plant Operations Director, dated April 2020, indicated responsibilities of the position included to maintain the building's equipment in good working order and keep it free of hazards. The policy described this position was responsible to respond to work order requests and to establish policies and procedures of the maintenance department.