STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105635	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Melbourne Terrace Rehabilitation Center	251 Florida Ave 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 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** 43192 Based on observation, interview, and record review, the facility failed to promote dignity in dining for 1 of 2 residents reviewed for dignity, out of a total sample of 47 residents, (#66). Findings: Review of resident #66's medical record revealed he was initially admitted to the facility on [DATE]. Resident #66 had diagnoses including malnutrition, senile degeneration of the brain and muscle weakness. Review of the Minimum Data Set quarterly assessment with Assessment Reference Date of 9/11/24 revealed resident #66 was dependent on staff for activities of daily living, including eating. On 12/04/24 at 12:19 PM, Certified Nursing Assistant (CNA) D explained she needed to assist three residents with their meals. She said resident #66 was a feeder and she often assisted her feeders. Later at 1:02 PM, CNA D was observed as he entered resident #66's room and noticed he had not yet eaten his lunch. CNA D moved the bedside table closer to resident #66's bed, removed the lid from the plate and began feeding the resident while standing. At 1:55 PM, CNA D validated she was not seated when assisting resident #66 with his lunch and stated she knew she was supposed to sit down, face the resident and be at eye level. She explained during her orientation, she had not learned it was inappropriate to call the residents feeders. On 12/04/24 at 12:47 PM, CNA E stated residents who needed assistance with their meals were called assisted feeders. She explained a lot of them are not exactly feeders because they get finger foods. On 12/04/24 at 2:06 PM, the East Wing Unit Manager (UM) explained there was no specific way to refer to residents who needed assistance with meals. She stated they should not be called feeders due to respect and dignity issues. The UM validated using labels were against their rights. On 12/05/24 at 12:35 PM, Licensed Practical Nurse (LPN) F indicated sometimes CNAs sat and other times they stood up while assisting residents with their meals because sitting was not always conducive to reaching the patient's mouth to get them to eat. LPN F concluded, They should be sitting but [it was] not always feasible, [it] depends on the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER: Melbourne Terrace Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 251 Florida Ave Melbourne, FL 32901	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at 4:59 PM, the Director of Nursing (DON) stated residents who needed assistance with meals should be referred to as assisted diners. The DON explained residents should not be called feeders because it was a dignity issue. The DON indicated CNAs should be sitting next to the resident at eye level, but in resident #66's case, CNA D raised the bed to be at the same level. The DON then clarified CNAs should be sitting when assisting residents to eat. Later at 5:43 PM, the DON stated they had no policy and procedure for dignity or resident rights. Review of the Orientation Education/In-Service Record completed by CNA D on 11/05/24 revealed they included Resident Rights, Dignity and Preferences. Review of the facility's Resident's [NAME] of Rights undated read, Every resident of the Facility shall have the following rights: . The right to be treated courteously, fairly, and with the fullest measure of dignity . Review of the Facility Assessment revised on 2/24/24 revealed all staff received education about resident's rights upon hire, general orientation and annually.

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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** 43192 Based on observation, interview, and record review, the facility failed to ensure a resident was assessed to self-administer medications safely for 1 of 1 residents reviewed for self-administration of medications, of a total sample of 47 residents, (#84). Findings: Resident #84 was readmitted to the facility on [DATE] with diagnoses including type 2 diabetes, dysphagia (difficulty swallowing), lack of coordination, muscle weakness, and cognitive communication deficit. Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of 11/25/24 revealed resident #84 had a Brief Interview for Mental Status score of 6 out of 15 which indicated he was cognitively impaired. The MDS assessment noted no behaviors and no rejection of care necessary to obtain goals for his health and well-being. Review of resident #84's medical record revealed a care plan for impaired cognitive function or impaired thought processes related to (r/t) history of cerebrovascular accident (stroke) revised on 9/21/22. The interventions directed the nurses to Administer medications as ordered . Cue, reorient, and supervise as needed. Another care plan for activities of daily living self-care performance deficit r/t activity intolerance, impaired mobility, left sided hemiplegia r/t history of stroke revised on 9/21/22. The interventions included Provide the amount of assistance/supervision that is needed. On 12/02/24 at 2:31 PM, resident #84 was observed in bed with two pills, a long brown capsule and a round pink tablet, in a disposable medicine cup. A tube of Benadryl cream was also on his bedside table. When asked, resident #84 stated he asked his nurse to leave the medicine cup with the pills there for him to take later. He mentioned whenever he asked the nurses to leave his pills, they did, but sometimes they watched him until he took the medications. He indicated he applied the Benadryl cream on his left buttock two times at night. On 12/02/24 at 2:37 PM, Licensed Practical Nurse (LPN) F entered resident #84's room and noticed the medication cup with the pills in it and told him, You got me in trouble. I am getting written up, [resident #84's name]. LPN F stated the pills were Gabapentin and Hydralazine. She said, I know better. When asked about the Benadryl cream at the bedside table, LPN F said, Oh, I do not even know where that came from. LPN F handed the tube to the surveyor and stated it was empty and discarded it. The tube read, Benadryl extra strength itch stopping gel. Outside the resident's room, LPN F stated she left the pills at bedside about 10 minutes ago because someone else called for help and she left them for resident #84 to take. She explained resident #84 had taken the cup in his hands but, he did not take them, I guess and she left his room prior to ensuring he took them. She indicated before today she always made sure he took his medications before she left the room. LPN F stated she was supposed to ensure the resident took his pills before she left the room because someone else could wander into his room and take them and it was also important for him to take his medications. She mentioned no one on her assignment was authorized to self administer medications for themselves. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #84's physician's orders included Gabapentin 300 milligrams (mg) three times a day (TID) for neuropathy (nerve pain) and Hydralazine 10 mg TID for hypertension. The Medication Administration Record showed Gabapentin was scheduled to be given at 9:00 AM, 2:00 PM and 6:00 PM. Hydralazine was scheduled for 6:00 AM, 2:00 PM and 9:00 PM. Review of the Medication Admit Audit Report showed Hydralazine and Gabapentin were administered on 12/02/24 at 2:09 PM and 2:10 PM respectively. On 12/03/24 at 10:14 AM, the East Wing Unit Manager (UM) stated medications were not kept at bedside for residents' safety. She indicated resident #84 was not deemed safe to self-administered medications. She explained if a resident refused his medications, she expected the nurse to discard the medications, notify the physician and document the refusal. On 12/04/24 at 4:01 PM, the Director of Nursing (DON) explained if a resident wanted to self-administer their medications, a nurse would complete a self-administration evaluation to determine if it was safe for the resident to take by themselves. She indicated after the assessment, the nurse would obtain a physician's order and the care plan would be updated to reflect this. The DON indicated her expectation was nurses stayed with residents until medications were taken and not left at bedside. Review of resident #84's medical record did not reveal a Self-Administration of Medication Evaluation or a physician's order for self-administration of medications. Review of resident #84's physician's orders did not include an order for Benadryl extra strength itch stopping gel. Review of the Employee Coaching Report for LPN F on 12/02/24 included a document titled, Principles of Medication Administration which directed nurses to give medication administration complete attention and to never leave medications unattended, even for a moment. Review of the facility's policy and procedures titled Self Administration of Medication dated 2008 revealed one of the purposes was, To provide evaluation process to determine if a resident is capable of self-administration . To maintain the safety and accuracy of medication administration. The procedure list included the interdisciplinary team (IDT) would assess the competence of the resident to participate by completing a Self Administration of Medication Evaluation and based on the IDT assessment, a decision was made as to whether or not the resident was a candidate for self-administration. Then the nurse would obtain a physician's order and educate the resident regarding reaction and side effects of the medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 1 of 1 resident reviewed for hearing, of a total sample of 47 residents, (#25). Findings: Review of resident #25's medical record revealed he was initially admitted to the facility on [DATE] and readmitted from a short-term, acute hospital on 9/17/23. His diagnoses included dementia, anxiety, dysphagia (difficulty swallowing) and speech and language deficits following cerebral infarction. Review of the Annual Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 8/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated moderate cognitive impairment. The MDS assessment showed resident #25 had moderate difficulty hearing and did not use hearing aids or other hearing appliances. The Quarterly MDS assessment with ARD of 11/21/24 revealed a BIMS score of 12 out of 15. The assessment noted moderate difficulty hearing and no use of hearing aids or other hearing appliances. On 12/02/24 at 12:31 PM, resident #25 stated he could not hear well. He reported to be deaf on his left ear. He mentioned he needed a hearing aid. Review of resident #25's discontinued physician orders showed orders dated 1/19/23 and 2/08/23 for consults with audiology. An order dated 4/03/23 and 4/11/23 indicated appointments with the audiologist scheduled for 4/06/23 and 6/29/23 respectively. Review of resident #25's comprehensive care plan revealed hearing was not a focus area developed after the completion of the annual MDS assessment on 8/21/24 or the quarterly MDS assessment on 11/21/24. Review of the Hearing section of the Admission / Readmission Evaluation dated 9/17/23 included resident #25 hears only when the speaker makes special efforts (e.g. louder voice) and he used no hearing aids. Review of the Nursing Quarterly Evaluation dated 5/22/24, 8/21/24 and 11/21/24 revealed resident #25 had hearing impairment. The evaluation date 5/22/24 included a comment he was not a candidate for hearing aids per audiology. Review of the Speech Therapy Screen forms dated 2/29/24, 5/15/24, 7/30/24 and 10/22/24 read, The resident is hard of hearing and hearing aides are not currently used. Review of the Social Service Initial History form dated 9/28/23 showed resident #25's sensory impairment was hearing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Psychiatric Follow Up Encounter progress note dated 9/18/23 read, Patient is hard of hearing and communication was difficult though achieved through talking loudly. On 12/05/24 at 11:17 AM, the MDS Lead explained whoever completed the MDS assessments determined what would be included in the care plan. She indicated each care plan was specific and individualized. She stated staff referred to the care plan for any questions about the resident's care. She indicated a communication care plan would be created for a resident with a hearing impairment. After reviewing Section B of the last two most recent MDS assessments for resident #84, the MDS Lead validated there should had been a care plan addressing the hearing impairment. She explained there was a care plan for hearing, but it was resolved on 6/06/23 because the MDS assessment with ARD of 5/31/23 was coded with adequate hearing. She validated there was documentation in the medical record that showed hearing impairment and therefore the care plan should include it. She stated it was important to include it in the care plan because the deficit may affect communication with others and the staff needed to know what interventions to use. On 12/05/24 at 11:51 AM, during a telephone interview, the Social Services Director (SSD) stated resident #25 was beyond hard of hearing. She explained he was seen by audiology last year and was told he was, beyond help because his hearing was that bad. The Administrator, present during the telephone interview, explained resident #25 was not included in the current list of residents to be seen by their new audiology provider because of his previous exam results. The SSD stated resident #25's hearing was far gone, and hearing aids would not benefit him. Review of the audiologist visit note dated 6/29/23 revealed the Chief Complaint was difficulty hearing in the right ear within 1-2 years. The Assessment/Plan section included, Sensorineural hearing loss, bilateral - pt (patient) has severe hearing loss in both ears with no speech discrimination in right ear and only 16% in left ear. Pt is not a hearing aid candidate. On 12/05/24 at 1:34 PM, Certified Nursing Assistant (CNA) G stated resident #25 was able to communicate his needs but, You have to talk loud to him because he is hard of hearing. She said, He always says he cannot hear. but sometimes he can hear her. She shared he has asked her to speak a little louder. She indicated she had never seen him wearing hearing aids. She explained she would ask the nurse or refer to the care plan if she was not familiar with the care of one of her residents. On 12/05/24 at 2:05 PM, the East Wing Unit Manager stated resident #25 was hard of hearing but could communicate with her. She indicated hearing impairment affected communication with others, hearing music, or alarms. On 12/05/24 at 2:42 PM, the Director of Nursing (DON) stated the care plan included all information pertaining to the resident's care. The DON indicated there should have been a care plan to correlate with the hearing impairment. Later at 3:26 PM, the DON stated the facility did not have a policy and procedure for care plans. Review of the Facility Assessment revised on 2/24/24 revealed the facility provided person-centered/directed care. The document read, Find out what resident's preferences and routines are; what makes a good day for the resident; what upset him/her and incorporate that information into the care planning process. Make sure staff caring for the resident have this information.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50401 Based on observation, interview, and record review, the facility failed to ensure food items were stored in a safe manner by failing to accurately label and date food items, keep food items properly contained, and used by the discard date. This failure had the potential to negatively affect all 165 of the 165 residents who consumed food by mouth at the facility. Findings: 1. On 12/02/4 at 10:15 AM, during the initial kitchen tour with the Certified Dietary Manager (CDM) in the walk-in refrigerator, a previously opened plastic container of chicken base and another of beef base were noted to not have dates as to when they had been opened. The CDM verified this and removed these from the refrigerator to discard. She stated all opened food items were to be dated with the date when they were opened. Two of five previously opened mayonnaise containers were found to also be undated. The CDM verified this and removed them to discard. A previously opened and undated container of barbeque sauce and one of garlic cloves were also noted and removed from the refrigerator by the CDM to be discarded. A large, deep steamtable pan which held several previously opened cheese products was noted. It contained one undated plastic bag with about 15 slices of Swiss cheese and one resealed package of about 20 Swiss cheese slices dated 11/20 (13 days previous). The CDM verified these findings and stated their policy was to use an opened package of cheese within seven days of opening. She removed these items along with an undated plastic bag of approximately 25 slices of American cheese and another with 10 slices dated 11/02 (31 days previous). There was also a previously opened, resealed and undated half-full bag of shredded mozzarella cheese which the CDM removed to discard. There were three unlabeled and undated 1/3 size steamtable pans noted, each contained a resealed plastic bag of an unrecognizable food item. The CDM stated the first one contained leftover scrambled eggs that were from breakfast and the other two bags contained pureed bread. She removed these items to discard. An unlabeled, undated, and unsealed (open to the air) plastic container of soup, which the CDM stated was chicken enchilada soup was also found and removed by the CDM along with a 1/2-size steam table pan that contained an unlabeled, undated, and unsealed (open to the air) bag of diced chicken. A cardboard box contained two plastic bags of hot dogs which were open to air and undated so staff would know when they had been opened. The CDM removed the hot dogs along with a box containing two packages of unsealed and undated pork sausages. A pre-prepared plastic container contained approximately two cups of chicken salad which was dated 11/21 (12 days previous) along with another container that held approximately four cups of egg salad that was dated 11/23 (10 days previous). These were verified by the CDM who removed the items to discard. The CDM stated their policy was to use or discard these products within seven days of being opened. A resealed, unlabeled and undated approximately 1 by 3 cube of cream cheese was noted along with an undated plastic bag of whipped topping. These items were also verified by the CDM and removed to discard along with an unlabeled and undated sheet pan of a prepared, leftover fish dish. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. A short time later at approximately 10:45 AM on 12/02/24, the dry storage room was toured with the CDM. Spaghetti noodles, egg noodles, and elbow macaroni were seen in their original but previously opened plastic bags, now wrapped in plastic wrap along with 2 cardboard boxes that contained dry oatmeal and a previously opened package of mashed potatoes. None of these food items had been dated with the date when they were received or when they were opened. There were also three boxes of paper supplies (drinking cups and wrapped eating utensils) found stacked on the floor in the overflow paper product storage area. 3. At approximately 11:00 AM on 12/02/24 in the walk-in freezer, a half steamtable pan of an unrecognizable, unlabeled and undated food item was found. The CDM thought it might be chicken and removed it from the freezer to discard. On a shelf in the lower left corner of the walk-in freezer, were three full-sized steamtable pans of unrecognizable food items dated 11/28 and labeled, only Tavern. The foil covering for one of these pans had ripped and the food was exposed, open to the air. The CDM was not able to identify what the food items were, but stated the employee responsible for preparing the meals for the Tavern food service area would know what they were. She agreed all leftover food items should be labeled with their contents in case another staff retrieved them for service. The CDM acknowledged this would be important for resident safety including food preferences and/or possible food allergens. In the same corner of the freezer were two unlabeled, sealed plastic bags of what the CDM stated was chicken. The bag of chicken had an imprinted date of [DATE]. The other bag she said she thought was beef, was dated December 2022, both dates over two years ago. The CDM was not able to verify when these items were received but stated their policy was to use or discard food from the freezer within one year of receiving it. The CDM stated the cooks and dietary aides were adults and should be responsible to follow the department's policies for food storage including the labeling and dating of food items. On 12/05/24 at 1:52 PM, the Assistant Administrator stated their research did not provide any information as to when the meats found in the freezer with dates from 2022 were received by the facility. He stated it was important to know when all food received into the facility should be used or discarded by to prevent foodborne illness and keep the residents safe. He explained the guidelines and policies were so foods could be tracked and handled properly. He stated the cooks were responsible for dating foods when they opened a container, but the facility was responsible for their oversight. He added it was important for food items to be labeled as to what they were when they were stored so when someone went to use it, the user would know what it was and what ingredients were in it so they wouldn't provide it to someone with allergies to a food item. The facility's food storage policy labeled from the Dietary Guideline Manual entitled Food Storage Overview, with a copyright date of 2015, stated for dry storage, plastic containers with tight-fitting covers were to be used for storing cereals and broken lots of bulk foods and their containers were to be labeled. In addition, the policy stated food should be dated with the date received as it was placed on the shelves and all stock was to be rotated with old stock used first. For refrigerator storage, the policy stated leftover food was to be stored in covered containers or wrapped securely, and each item was to be clearly labeled and dated with the month, date and year before being refrigerated. It also stated leftover food was to be used within two days or discarded. For freezer storage, the policy indicated all foods should have a careful rotation procedure and food items should be covered, labeled, and dated to include the month, day and year. The frozen foods including any leftovers should be discarded after six months.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646 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 current QAPI Plan revealed the facility would use a performance improvement focus to increase quality throughout the facility. This process included identifying areas of weakness to create potential solutions. The plan indicated these solutions would be identified on the Performance Improvement Plan (PIP) which would be monitored by associates using specific audit tools to determine if changes were successful. The plan indicated the sources of data monitored through QAPI included quality measures and state and federal survey results. Review of the previous survey results revealed the facility had a deficiency cited at F812 related to food safety during the previous recertification survey conducted from [DATE] through [DATE]. The facility was found to be in noncompliance with holding temperatures for food on the steam table. During the current survey process, concern for food safety at F812 was again determined when numerous food items in the walk-in refrigerator, dry storage and walk-in freezer were found unlabeled, undated, expired and sometimes left uncovered/opened as observed during the initial kitchen tour with the Certified Dietary Manager (CDM) on [DATE]. Meat was found in the walk-in freezer over two years old, pans of unrecognizable and unlabeled food items were partially uncovered with food inside exposed. Previously opened cheese in the walk in refrigerator was found undated and some with dates had been open for over a month. Pans of unrecognizable, unlabeled, and undated leftover food were also found in the refrigerator. The CDM acknowledged the department policy on labeling and dating of foods items and to ensure food safety by discarding foods past the dates determined by their policy and procedures. She said staff were responsible to follow these policies and procedures. As a result of the repeat deficiency, it was identified that audits performed by the facility and reported to QAPI were insufficient and lacked appropriate oversight to prevent the citation. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:42 PM, the Administrator reported QAA/QAPI meetings were held monthly. She explained each department conducted audits and reports that were presented to the committee for review. She stated a PIP would be developed and implemented for any issue identified as needing improvement. She stated audits would be conducted to verify the results. The Administrator was asked if the QAA/QAPI committee was aware of any of the concerns identified during the current survey which included the repeat deficiency at F812 for food safety. She explained the facility developed a plan of correction which included audits to resolve the deficiency. The Administrator described audits performed weekly in the kitchen for sanitation which included labeling and dating of food by the Assistant Administrator and similar audits completed by the Dietitian monthly. The audits revealed open and undated food was observed in the kitchen only in April and [DATE], but could not explain the numerous food items found as a concern during the initial kitchen tour. The Administrator presented education attendance logs dated [DATE] and [DATE] regarding opened and undated food items. She could not explain why numerous opened and undated items were still found after education and audits were being performed. The Administrator acknowledged the CDM let standards slip and the system failed.

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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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43192

Based on observation, interview, and record review, the facility failed to follow appropriate hand hygiene and personal protective equipment (PPE) practices per infection control standards when assisting a resident with his meal for 1 of 12 residents observed during dining, (#66), and 1 of 5 residents observed for medication administration, (#318), of a total sample of 47 residents.

Findings:

1. Review of resident #66's medical record revealed he was initially admitted to the facility on [DATE]. Resident #66 had diagnoses including malnutrition, senile degeneration of brain and muscle weakness.

Review of the Minimum Data Set quarterly assessment with Assessment Reference Date of 9/11/24 revealed resident #66 was dependent on staff for activities of daily living, including eating.

On 12/04/24 at 1:02 PM, Certified Nursing Assistant (CNA) D entered resident #66's room and noticed he had not yet eaten his lunch. CNA D moved the bedside table closer to resident #66's bed, then grabbed a pair of gloves from a box inside the resident's room and donned the gloves without washing her hands. CNA D began feeding the resident and stated she needed to put on gloves because sometimes he spits while eating. Later at 1:55 PM, CNA D validated she did not perform hand hygiene prior to donning gloves. She explained she was required to perform hand hygiene when entering a resident's room and when done caring for the residents. She stated she was also supposed to wear a gown and gloves before helping him with his lunch because he was on enhanced barrier precautions. The East Wing Unit Manager (UM), present during the interview, explained there was a green sticker by resident #66's name on the door which indicated he was on enhanced barrier precautions. The UM indicated staff was required to don PPE when providing any direct care to a resident on enhanced barrier precautions. CNA D stated hand hygiene was important to keep all residents safe and using the proper PPE was part of universal precautions.

On 12/05/24 at 12:22 PM, CNA E was near the meal cart and was asked to show how much resident #66 ate for lunch. She took a pair of gloves from a bin near the meal cart and donned gloves without performing hand hygiene. When asked, CNA E stated she forgot but was supposed to perform hand hygiene when donning and doffing gloves.

2. Review of resident #318's medical record revealed she was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, pneumonitis and dementia.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Melbourne Terrace Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 251 Florida Ave 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 9:31 AM, during a Medication Administration pass observation, Registered Nurse (RN) C retrieved a mobile vital signs device with stand from near the nurse's station in the 500 hallway and brought it into resident #318's room. She did not disinfect the mobile vital signs device before using it. She obtained resident #318 blood pressure, heart rate and temperature. She exited resident #318's room and prepared the 9:00 AM medications for resident #318 without performing hand hygiene or cleaning the mobile vital signs device. She returned to resident #318's room with the medications, crushed in applesauce, and administered it to the resident. She noticed applesauce around resident #318's mouth and grabbed a pair of gloves, donned the gloves, without performing hand hygiene, and cleaned the resident's mouth. RN C then removed her gloves and discarded them in a garbage bin inside the resident's room. She exited the room without performing hand hygiene. When asked, RN C indicated she was supposed to perform hand hygiene before and after taking the vital signs, before preparing the medications and when done giving them to the resident. She explained she was supposed to perform hand hygiene before donning and after doffing gloves. She validated she did not disinfect the mobile vital signs device before or after use. She mentioned she did not know if the last person who used it before her disinfected it. She stated wipes were kept in the mobile vital signs device's basket which she could have used. She indicated hand hygiene was important to reduce the risk of infection to the residents and avoid cross contamination. On 12/03/24 at 10:28 AM, the UM stated nurses were expected to perform hand hygiene with soap and water or hand sanitizer before preparing medications, and when entering and exiting resident's room. She explained the mobile vital signs device should be disinfected prior and after each use. She indicated the first line of defense to prevent infection was washing hands which helped avoid the spreading of infection. On 12/04/24 at 4:39 PM, the Director of Nursing (DON) indicated nurses were expected to sanitize their hands before and after medication preparation and administration. She stated staff was expected to perform hand hygiene if they had to don or change gloves during care. She mentioned nurses were expected to clean the mobile vital signs device before and after use. The DON stated these were important for infection control. Review of the policy and procedure titled Infection Surveillance - Infection Prevention Overview dated 2013 read, The facility uses prevention strategies to reduce the risk of transmission of infections including, but not limited to, barrier precautions, immunizing residents, cleaning, disinfecting, and education. Review of the Facility Assessment revised on 2/24/24 revealed all staff received education about Infection Control upon hire, general orientation and annually. The infection prevention and control program education included the written standards, policies and procedures for the program.