

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105861	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2025
NAME OF PROVIDER OR SUPPLIER  Nursing & Rehabilitation Center of Melbourne		STREET ADDRESS, CITY, STATE, ZIP CODE  3033 Sarno Rd Melbourne, FL 32934	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow their grievance process related to preferences for 2 of 2 resident reviewed for grievances, (#1, #3). Findings</p> <p>1.A review of the medical record revealed that resident # 3 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, major depressive disorder, unspecified psychosis and schizoaffective disorder. According to the Annual assessment of the Minimum Data Set with the assessment reference date of 9/30/25, the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which means he was cognitively intact, and was dependent on staff for hygiene care.</p> <p>On 10/8/25 at 10:06 AM, resident # 3 who was selected from the facility's grievance log was observed being wheeled into the shower room. At 10:50 AM, resident #3 was observed coming out of shower room and answered only yes to everything is okay, staff treated him well him well and could not remember filing a grievance.</p> <p>On 10/8/25 at 1:47 PM the Social Services Director (SSD) was asked about the grievance filed on 9/12/25 for resident # 3 and presented the form. She explained that resident # 3 complained about waiting a long time to get out of bed in the morning and that a staff member kept turning off the call light. She continued to explain that since then, the staff have been educated on call lights and customer service and that the resident had no concerns thereafter. On examination of the form, it showed that the grievance was not resolved from 9/14/25 when the family was informed. The SSD confirmed that the form was incomplete and showed the grievance was not resolved and she acknowledged that it was her fault the form was not signed nor completed.</p> <p>The facility's policy on Resident and Family Grievances dated 1/1/23 stated in section 12 that the facility will make a prompt efforts to resolve grievances.</p> <p>2. Review of resident #1's medical record revealed he was admitted to the facility on [DATE] with diagnoses including dislocation of right ankle, type 2 diabetes, bipolar disorder irritable bowel syndrome with diarrhea and obesity.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15 which indicated intact cognition.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 105861	If continuation sheet Page 1 of 5

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/9/25 at 10:22 AM, resident #1 stated that there was an incident when he requested a shower on a night that was not his scheduled shower night. He stated that the Certified Nursing Assistants (CNA) told him his shower night was the following day and refused to give him a shower. He stated the nurse instructed the CNAs to give him a shower that night and that they were very upset.</p> <p>Review of the grievance log for September 2025 was reviewed and revealed that resident #1 was not listed on the log.</p> <p>Review of a Grievance form dated 9/23/25 filed by resident #1 read, resident reports staff refused to give resident a shower. After resident spoke with nurse, nurse had 3 CNAs assist the resident with shower. After shower, resident reports he was left soiled until a CNA changed him at 7am on 9/24. The person completing this form is indicated as the SSA and the person assigned to investigate the concern was the social service department and the Director of Nursing (DON). The Grievance official follow-up section read, statements obtained from DON (3 CNAs and nurse on 11-7). More frequent interviews with resident regarding care. Resident voices no concerns and room change provided at request. Psych services and follow up provided by outside vendor. The section for the grievance official's signature was blank. The date resolved was 9/24/25. Documents attached to the grievance form included a handwritten statement that has no date or employee name on it. Statement read during second shift on 9/23/25 she was asked by the assigned CNA for resident #1 to witness her offering the resident a shower to which the resident refused. The resident responded that he did not say he wanted a shower. The resident refused to transfer into the shower chair and wanted to remain in his wheelchair. The resident continued to express his displeasure during the entire shower. After the shower, the resident returned to his room and transferred back into his bed. He was then dried and dressed. The second statement attached to the grievance was a phone interview with the assigned nurse taken by the DON dated 9/23/25. The nurse stated he did not hear or witness anything related to the incident but he did know that the resident received a shower that night.</p> <p>On 10/8/25 at 11:45 AM, the Social Service Assistance (SSA) stated she is the person who handled resident #1's grievance since the Social Service Director (SSD) was on leave at that time. SSA and SSD confirmed that the resident's grievance was not on the grievance log and that it should be listed. SSD acknowledged that she did not review the grievance when she came back from leave.</p> <p>On 10/8/25 at 12:17 PM, the SSA stated that she handed this grievance off to the DON since it had to do with nursing. She stated that grievances are distributed to each department depending on the issue. SSA stated that the DON interviewed the staff and that she only dealt with the resident.</p> <p>On 10/8/25 at 12:33 PM, the DON confirmed that he handled the grievance for resident #1 since it was a nursing issue. The DON acknowledged that the handwritten statement attached to the grievance did not have an employee signature nor a date/time. The DON stated that the statement was from a CNA who was involved in the incident. The DON confirmed that there were no other employee statements from the CNAs including the assigned CNA. DON stated that he tried to call the assigned CNA to get a statement, but she did not respond. The DON acknowledged that the assigned CNA is still an employee of the facility and works regularly.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/8/25 at 1:12 PM, the Nursing Home Administrator (NHA) stated that it was the first time she had reviewed resident #1's grievance. She acknowledged that the grievance was lacking and required more information. She stated that there should have been more to the grievance and that there was room for improvement. The NHA stated that typically at the end of each week the management meet as a team and discuss grievances. She acknowledged that the grievance for resident #1 was not reviewed and somehow got missed.</p> <p>Facility policy titled resident and family grievances dated 1/1/23 revealed the facility will support each resident's right to voice grievances without discrimination, reprisal or fear of discrimination. The grievance official will keep the residents appropriately apprised of progress towards resolution of the grievances. In accordance with resident rights, the resident will obtain a written decision regarding his or her grievance at the conclusion of the investigation.</p>		

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F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide and implement an infection prevention and control program.  (continued on next page)		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by failing to appropriately implement enhanced barrier precautions (EBP) during high-contact care activity for 1 of 6 residents (#5) requiring EBP on the Specialized Subacute Unit (SSU). The facility had a total of 20 residents who required EBP in a census of 154 residents. The facility capacity is 167 beds. On 10/08/25 at approximately 10:50 AM the light above the door to resident #5's was illuminated to indicate the resident was calling for assistance. Certified nursing assistant (CNA)- A was observed to obtain and don a mask from a caddy (container) hanging on the door across the hallway and she entered the room. She was overheard to say to the resident, I will be right back to help you get dressed. The resident was in a private room. A sign on the door to resident #5's room read STOP. ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. A container for personal protective equipment (PPE) for gowns and gloves was not observed on the door. (photographic evidence obtained) At 11:20 AM, after knocking and gaining permission to enter, two staff members, CNA - A and another person who identified herself as a CNA and private sitter, were observed in the resident's room. They were wearing facial masks and gloves. Neither staff member was wearing a gown. They both said they had just provided bathing and dressing for the resident and were preparing to use the mechanical lift to transfer the resident out of bed to the wheelchair to go to therapy. When asked about their knowledge of EBP they both said they are to wear masks and gloves when providing care because the resident has a catheter for his urine. When asked about any requirement to wear a gown, both replied and said they understood they did not need to wear a gown during care. When asked if they are to wear a gown when emptying the urine drainage bag, they both replied, no gown, just gloves and mask. Both CNAs were asked if they were aware of the sign posted on the door to the room. They said they saw it, but they thought they did not have to wear a gown to provide care. On 10/08/25 at 11:30 AM, in an interview with RN-B who was the nurse assigned for the section of the unit that included resident #5, she was asked to explain her knowledge of EBP and how it was to be implemented. She stated staff wear PPE depending on the type of disease the resident has. She checked the electronic medical record and verified that resident #5 required EBP since his most recent admission to the facility on [DATE]. She stated he had a suprapubic urinary catheter, and staff are to wear a mask and gloves when they provide care. When asked when staff would need to wear a gown, she stated they only wear a gown if a resident is on airborne precautions. She confirmed resident #5 was not on airborne precautions. Per Centers for Disease Control and Prevention (CDC) (www.cdc.gov) airborne precautions are used for patients known or suspected to be infected with pathogens transmitted by the airborne route ( e.g. tuberculosis, measles, chicken pox). In an interview on 10/08/25 at 4:39 PM, the Infection Preventionist (IP) stated she also had the job duties for the Assistant Director of Nursing and Staff Development. She described how EBP should be implemented according to the CDC guidelines for Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs). She stated staff have been educated by her for the use of PPE for residents requiring EBP in March 2025 and April 2025. She provided evidence of such education. RN B was listed on the attendance record. The IP was informed of the findings involving staff members caring for resident #5 as they occurred earlier that day. She confirmed the actions and responses by staff regarding EBP and resident #5 were incorrect. She was asked if she had any process surveillance regarding appropriate use of PPE and EBP and she replied she did not. The facility provided a list of residents currently requiring EBP on the SSU dated 10/08/25 with a time of 14:11 (2:11 PM). During the interview the IP acknowledged the list was inaccurate. Two additional residents were not included on the current order listing report, and she confirmed those two residents required EBP. Record review for resident #5 revealed orders dated 6/27/25 for Enhanced Barrier Precautions per CDC guidelines and facility protocol for Suprapubic catheter and History of MDRO. The care plan report with a revision date of 8/04/25 listed a focus for FRP related to catheter. Another area on the care plan report listed a focus that resident #5 needed</p>		