STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105861	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nursing & Rehabilitation Center of Melbourne	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure proper indwelling urinary catheter care and monitoring was provided to 1 of 3 residents reviewed for catheter, of a total sample of 5 residents, (#2).Findings:Review of the medical record revealed resident #2, an [AGE] year-old female was admitted to the facility from an acute care hospital on 2/02/26 with diagnoses that included anemia, elevated white blood cell count, and complicated urinary tract infection (UTI). The resident discharged home on 2/10/26. The most recent Five-day Minimum Data Set Assessment with an Assessment Reference Date of 2/09/26 noted resident #2 scored 10 out of 15 on the Brief Interview for Mental Status indicating moderate cognitive impairment. The assessment revealed there were no rejections of evaluation or care, the resident was dependent on staff to complete Activities of Daily Living (ADLs), there was an indwelling urinary catheter present, and she received high-risk anticoagulant, diuretic, opioid, and intravenous (IV) antibiotic medications during the look-back period. The Order Summary Report showed physician's orders for continued IV antibiotic medications of (2/03/26) Ceftriaxone 1 Gram once daily for UTI for 10 days, Cubicin 500 Milligrams every 24 hours for UTI for 7 days, and (2/05/26) Urinalysis/Culture and Sensitivity (UTI test). There were no orders or directions to monitor or care for an indwelling urinary (foley) catheter. A foley or indwelling urinary catheter is a thin, flexible tube inserted into the bladder to drain urine, and held in place by an inflatable balloon. The catheter tube connects to a collection bag to collect urine. Risks for foley catheter use are UTIs, bladder spasms, urethral damage, urine leakage and bleeding, (retrieved on 3/27/26 from www.clevelandclinc.org). An admission Note completed by Registered Nurse (RN) B on 2/02/26 noted that resident #2 had a foley catheter. The Care Plan Report did not include the presence, care, or monitoring of an indwelling urinary catheter, a UTI, or IV antibiotics. The nurses Admission/readmission Data Collection assessment completed by RN B on 2/02/26 was marked negative for the presence of an indwelling urinary catheter. On 3/16/26 at 3:40 PM, RN A explained nurses entered batch orders on admission when indwelling urinary catheters were present. The nurse stated, we need to watch for problems; it's noted on the Treatment Administration Record (TAR) to alert us for monitoring and to check. Review of resident #2's February 2026 TAR did not include any orders or directions for nurse care/monitoring of an indwelling urinary catheter. On 3/16/26 at 3:45 PM, RN B explained upon admission, nurses were expected to note indwelling urinary catheters in the records, notify the physician, and enter orders for nurses to monitor and provide care that is carried into the TAR from the orders. From that the nurses were alerted to check for signs of complications or infection to implement interventions or notify the physician. She checked resident #2's medical record and acknowledged she completed the admission and incorrectly documented there was no catheter in the assessment. Upon further review, the RN was unable to locate any orders for catheter care for resident #2. The nurse stated the catheter care orders should have been entered on admission and were missing. She said admission orders were re-checked by nurse managers the following day. On 3/16/26 at 2:25 PM, the Subacute Unit Manager recalled resident #2 had an indwelling urinary catheter and stated, she had it the whole time she was here. Later at 4:05 PM, the (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: 105861	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse manager explained she expected nurses to enter catheter orders upon admission to transcribe to the TAR for prompts so they could monitor it every shift. She explained this was important to avoid serious complications with the catheter. The Unit Manager said during daily clinical meetings, nurse managers re-checked admission orders for accuracy. She checked her handwritten meeting notes and found resident #2's catheter was discussed on 2/03/26. She checked resident #2's medical record and was unable to locate any orders or directions for nurses to monitor or care for the catheter and stated, we missed the orders. On 3/17/26 at 3:32 PM, the Director of Nursing (DON) explained he expected nurses to enter orders to monitor a catheter and document provided care on the TAR. The RN said he was not aware resident #2 had a catheter when she was admitted to the facility. He checked the medical record and found nurses' notes confirming the catheter and stated, I guess we missed that. Review of the facility's standards and guidelines titled Catheter Care and dated 3/01/25 noted the policy was intended to ensure that residents with indwelling catheters received appropriate catheter care every shift, and as needed.