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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nursing & Rehabilitation Center of Melbourne	3033 Sarno Rd Melbourne, FL 32934

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a complete antibiotic stewardship program for 3 of 4 residents reviewed (#117, #81, and #21) of a total sample of 55 residents and failed to ensure linens and laundry were handled, stored, processed, and transported safely to prevent the spread of infection to the extent possible in accordance with accepted national standards of practice.1. Resident #117 was admitted to the facility on [DATE] from the hospital with diagnoses including chronic pressure ulcer of right ankle with necrosis of muscle, osteomyelitis, peripheral vascular disease, and type 2 diabetes. Review of an Infectious Disease Consult dated 10/28/25 revealed the resident was admitted to the facility with medication orders for Cefepime HCl intravenous 2 grams per 100 milliliters (ml) two times and Daptomycin-sodium chloride intravenous 700-0.9 milligrams per 100 ml once a day following a right lower extremity wound culture which tested positive for Methicillin-Resistant Staphylococcus Aureus (MRSA) and Pseudomonas. Methicillin-resistant Staphylococcus aureus or MRSA is a type of bacteria that's developed defense mechanisms or resistance to antibiotics. MRSA infections are hard to treat because very few antibiotics are effective against them (retrieved on 12/4/25 from https://my.clevelandclinic.org/health/diseases/11633-methicillin-resistant-staphylococcus-aureus-mrsa) Review of the resident's electronic medication administration record (EMAR) for Cefepime HCl for October and November 2025 revealed: On 10/28/25 at 10:00 PM, the MAR was noted to be 'blank' and no documentation of the medication being administered. On 10/29/25 at 6:00 AM, the MAR was noted to be coded '4' with a progress note reading 'not on hand' On 11/3/25 at 2:00 PM, the MAR was noted to be coded '4' with a progress note reading 'on order' On 11/5/25 at 2:00 PM, the MAR was noted to be coded '4' with a progress note reading 'not on hand. Pharmacy called. Will be in next batch delivery' 2. Resident #81 was admitted to the facility on [DATE] from the hospital with diagnoses including pneumonia, hemiplegia affecting left non-dominant side, cerebral infarction due to thrombosis, atrial fibrillation, sick sinus syndrome and cardiac pacemaker. Review of an Infectious Disease Consult dated 11/5/2025 revealed the resident was admitted to the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility with a large wound to his left gluteus with heavy drainage with concerns for an underlying abscess. A wound culture was ordered and intravenous antibiotics of Cefepime 2 grams per 100 ml two times a day for 7 days and Vancomycin 1 gram (gm) two times a day for 7 days to start after culture is obtained. Review of the resident's electronic medication administration record (EMAR) for Vancomycin 1 gram for November 2025 revealed: On 11/09/25 at 6:00 AM, the MAR was noted to be 'blank' and no documentation of the medication being administered. 3. Resident #21 was admitted to the facility on [DATE] from the hospital with diagnoses including lack of coordination, immunodeficiency, type 2 diabetes, chronic kidney disease stage 3B, and severe protein-calorie malnutrition. Review of the resident's EMAR for Amoxicillin 500 mg three times a day for a bacterial infection for 7 days revealed: On 11/17/25 in the morning, the MAR was noted to a code '5' and documentation of out of facility. On 11/17/25 in the afternoon, the MAR was noted to a code '5' and documentation of out of facility. On 11/18/25 in the morning, the MAR was noted to a code '4' and documentation of out of facility. On 11/19/25 in the morning, the MAR was noted to a code '5' and documentation of out of facility. On 11/19/25 in the afternoon, the MAR was noted to a code '5' and documentation of out of facility. On 11/20/25 at 10:08 AM, interview with the Infection Preventionist (IP) confirmed that one aspect of her job was to track and monitor antibiotic use throughout the building. The IP stated she did not realize the residents did not receive a full course of their antibiotics and had missed doses. She stated that she had oversight from the Director of Nursing (DON) and he never made her aware of the missed medications. On 11/20/25 at 10:21 AM, interview with the DON revealed they did not review missed medications during their daily morning meetings. His expectation was for the IP to track and monitor all the antibiotics in the building which included making sure the residents received full course of the antibiotics. He explained his expectation for when a resident's medication was unavailable was for the nurses to first check for the medication in the emergency medication supply and then notify the physician if the medication was still unavailable. He acknowledged that resident #21, #81 and #117 had missed doses of antibiotics and there was no documentation on those dates that the physician was notified. The facility's Infection control prevention and control policy revised 2/1/25 noted antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. The infection preventionist with oversight from the DON serves as the leader of the antibiotic stewardship program. 2. On 11/20/25 at 2:31 PM, a laundry room tour was conducted with Laundry Aide O. It was observed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that the laundry room had two doors. There was an open door where laundry staff was observed folding clean laundry and a closed door directly to the right that was unlabeled and had laundry bins blocking the entrance. Laundry Aide O identified the closed door as the dirty room. Upon entering the room, two carts with linen and gowns were noted. Laundry aide O was unable to provide an explanation as to why these carts with clean linen and gowns were stored in the dirty area. The Laundry Aide stated that this was the way they always did it. The room had no space for staff to sort dirty laundry or linen and some of the laundry aprons that were hanging in the room were in disrepair. Laundry aide O agreed that clean and dirty laundry should remain separate from each other to prevent cross contamination. On 11/20/25 at 2:35 PM, the Housekeeping Assistant said the Housekeeping Director was on leave. She did not know dirty laundry had to be processed in a separate dirty room. She said the dirty room was used to store clean linen carts because they were lacking storage. She believed that because the linens were in bags, they were fine being kept in the dirty area. On 11/20/25 at 2:40 PM, the Maintenance Director said he was previously in charge of running the laundry department and had mentioned to staff they could not keep the clean linens in the dirty room because it was an infection control issue. On 11/20/25 at 4:28 PM, the Infection Preventionist (IP) said she was not aware laundry staff stored clean linens in the dirty laundry area. She acknowledged she did not do frequent observations of the laundry room to ensure staff were following infection control practices and said laundry staff were included in infection control education.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents received meals at an appetizing temperature.Findings:On 11/18/25 at 9:35 AM, resident #9 said his food was always cold. He said he complained multiple times in the past, but things never changed. The resident stated, I just eat it.On 11/17/25 at 4:47 PM, resident #160 said her food was cold every day. She said she complained about it and the Kitchen Manager knew. The resident stated, this place doesn't want to get the warm plates; I eat what I can.On 11/20/25 at 11:42 AM, one of two carts (insulated) for the 500-unit resident lunch meal was delivered. At 11:44 AM, the second cart (not insulated) was delivered to the unit.On 11/20/25 at 12:10 PM, the last lunch meal tray was delivered to room [ROOM NUMBER]. At 12:11 PM, a sample tray with the lunch meal of fried chicken, rice, pinto beans, and corn bread was tested by two surveyors. The food was lukewarm and not at a palatable temperature, which was consistent with multiple resident complaints during the survey.On 11/20/25 at 12:05 PM, the Certified Dietary Manager said she was aware of resident complaints about cold food. She said the kitchen needed more insulated carts to help preserve warm food temperatures however they only received one and were required to use non-insulated carts to accommodate all the unit's meal trays.Review of the facility's standards and guidelines titled Administration of Facility dated 3/1/22 noted the facility provided systems to ensure it was administered in a manner that focused on attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility's Administration failed to provide resources and equipment to ensure meals were delivered at palatable temperatures. Findings:On 11/20/25 at 10:55 AM, the Certified Dietary Manager (CDM) said the kitchen utilized heat lamps on the steam table to assist with retaining warm food temperatures. She said the plates did not have metal inserts for heat retention. She said she was aware of ongoing resident complaints about cold food and had requested nine insulated carts to accommodate all three units but received only one new insulated cart. She said non-insulated carts that did not retain heat had to be used to manage all the trays for unit delivery.On 11/20/25 at 11:42 AM, one of two carts (insulated) for the 500 unit resident lunch meal was delivered. At 11:44 AM, the second cart (not insulated) was delivered to the unit. At 11:44 AM, Certified Nursing Assistant (CNA) A was observed distributing meal trays to resident rooms. On 11/20/25 at 11:52 AM CNA B said there was normally not enough help on the unit to deliver meal trays to residents. She said she was unable to remain on the unit to deliver resident lunch meals because she was assigned to go to the dining room to assist and she left to report to the dining room.On 11/20/25 at 11:59 AM, CNA A said the normal daily practice at lunchtime on the unit was that 1 CNA was responsible for delivering resident meal trays and assisting residents to eat.Unit 500 included 13 resident rooms with 26 total residents.On 11/20/25 3:09 PM, the Activities Assistant recalled over the past few months she received several complaints and grievances from residents about consistently cold food. She said that in approximately September 2025, a Food Committee was developed by the Activities Director because there were so many complaints.On 11/20/25 at 3:16 PM, the Activities Director recalled she initiated a Food Committee that met once monthly. She explained the residents complained that CNAs took too long to distribute trays once they were delivered from the kitchen. She said she received positive feedback from the residents who were on the rotation with the one new insulated cart who reported their food was hot. She said her point of contact was the CDM who told her new carts had been requested but only one was sent. She stated, It's been an ongoing issue with cold food. She noted that they had complaints about food temperatures not being warm every month during the Resident Council meetings; it was so time consuming; we started a Food Committee in June 2025.On 11/20/25 at 3:40 PM, the Nursing Home Administrator said the facility needed nine insulated carts. She explained they were trying to purchase two per month and had to work with the Regional Dietary person to get more and stated, that didn't happen. The NHA said they needed to work with Regional to obtain more carts.Review of the Facility assessment dated [DATE] noted the facility's kitchen appliances were all in good condition and have been replaced as needed. The Physical Equipment information outlined that each departmental manager or designee was responsible for assessing the condition of all equipment and determining what equipment was needed. The assessment read, . when equipment is needed, whether new or replacements, each department head follows procedures for obtaining purchase orders or capital expenditure authorizations for obtaining the needed equipment.

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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. Review of the facility's survey history revealed repeat deficiencies related to accuracy of assessments, quality of care and infection control during the current survey ending on 11/02/23. Past deficiencies revealed systemic concerns with similar findings on the previous recertification survey dated 11/2/23.On 11/20/25 at 6:15 PM, the Nursing Home Administrator (NHA) indicated repeat deficiencies regarding infection control, and quality of care were different from the issues from the previous survey. Their current Performance Improvement Plan (PIP) initiated from February 2025 and still ongoing included hand hygiene; glucometer disinfection; blood pressure monitoring/parameters/orders; point of care documentation; oxygen discontinuation and order accuracy. The NHA explained that they meet monthly and they would create PIPs from grievances, mock survey results and issues identified by department heads during round table discussions. She continued to explain she was not aware of the issues found during this survey, as being a current issue, but will begin facility wide all residents for trauma informed assessments. The Facility's policy on QAPI Monitoring revised 8/1/24 state It is the policy of the facility to systematically monitor performance indicators as part of the QAPI program.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected Pre-admission Screening and Resident Review (PASARR) results for 1 of 6 residents reviewed for PASARR of a total sample of 55 residents, (#94).Findings: Review of resident #94's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included mood disorder, schizoaffective disorder, bipolar type, anxiety, major depressive disorder, and intellectual disabilities.Review of resident #94's MDS Annual assessment with Assessment Reference Date (ARD) of 10/05/24 revealed question A1500 on Section A read, Is the resident currently considered by the state level II PASRR process to have serious mental illness (SMI) and/or intellectual disability (ID) or a related condition? The answered selected was NO.Review of resident #94's MDS Annual assessment with ARD of 10/06/25 revealed question A1500 on Section A was also answered NO.Review of resident #94's medical record revealed a Florida Preadmission Screening and Resident Review (PASRR) Level II Determination Summary Report dated 4/19/23. The Outcome/Disposition section showed resident #94 met the state definition of SMI and ID and was appropriate for a Nursing Facility. The form showed Socialized Services were not deemed necessary, but it was recommended rehabilitative services of a lesser intensity were added to the comprehensive person-center nursing care plan.On 11/20/2025 at 1:12 PM, the MDS Lead stated she was responsible for the creation, updates and timely submission of resident assessments. She explained accuracy of assessment was important to create an appropriate care plan. She indicated the care plan was used by the interdisciplinary team to provide holistic care to the resident. The MDS Lead validated both of resident #94's MDS annual assessments dated 10/05/24 and 10/06/25 were answered incorrectly, and question A1500 should had been answered Yes, which would have prompted a response to questions A1510 and A1550 related to SMI and ID conditions.Review of the facility's policy titled MDS 3.0 Completion revised on 1/01/24 revealed an intent to assess residents using a comprehensive assessment process to identify care needs and develop an interdisciplinary care plan. The guidelines included conducting initial and periodic standardized assessments of each resident's functional capacity comprehensively and accurately.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the State mental and intellectual disability authority after a significant change in the resident's mental condition for 1 of 6 residents reviewed for Pre-admission Screening and Resident Review (PASARR) of a total sample of 55 residents, (#94).Findings:Review of resident #94's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included mood disorder, schizoaffective disorder, bipolar type, anxiety, major depressive disorder, and intellectual disabilities.Review of resident #94's medical record revealed a Florida PASARR Level II Determination Summary Report dated 4/19/23. The Outcome/Disposition section showed resident #94 met the state definition of Serious Mental Illness (SMI) and Intellectual Disabilities (ID) and was appropriate for a nursing facility. The form showed Socialized Services were not deemed necessary, but it recommended rehabilitative services of lesser intensity be added to the comprehensive person-center nursing care plan. The form included, Should there be a significant change in his mental status, it is recommended that an additional Level II review be conducted.Review of resident #94's medical record revealed a SBAR (Situation, Background, Appearance, and Review) Communication Form dated 3/25/25 related to changes in behavioral symptoms. The form indicated a new order for a Haldol injection every 60 days for hallucinations/agitation.Review of resident #94's medical record revealed a SBAR Communication Form dated 4/07/25 related to disorganized thinking and hearing things. The Mental Status Evaluation section included increased confusion or disorientation, new or worsened delusions or hallucinations, and other symptoms or signs such as inability to pay attention. Review of a Certificate of Professional Initiating Involuntary Examination dated 4/07/25 revealed resident #94 became increasingly psychotic and paranoid over the past two weeks and was delusional and hallucinating, banging on other resident doors and making threats. The supporting evidence section included, Without higher level of care there is a significant concern pt (patient) may harm himself or others.Review of the Discharge Plan from the psychiatric facility dated 4/08/25 revealed treatment recommendations which read, Please follow all treatment recommendations . Please seek additional long term mental health programs and treatments as needed. Consider additional counseling to gain insight and develop healthy coping skills for ongoing stressors. Utilize the community resources listed below for additional treatment as needed.On 11/20/2025 at 1:12 PM, the Minimum Data Set (MDS) Lead stated her responsibilities included resident assessments and care plan meetings. She shared she attended daily clinical meetings which included discussions of changes in residents' conditions, discharges, admissions and readmissions. She explained the Social Services Director (SSD) was responsible for reviewing the PASARRs but she assisted this week because the SSD was out. She described how to complete a Level I PASARR and indicated some residents required a Level II. She stated this week she noticed resident #94 had a Level II in his medical record and she updated his care plan to reflect this information. She indicated she was not the MDS Lead back in April when resident #94 was [NAME] Acted. She recalled he exhibited auditory hallucinations, kept on banging on other resident doors, thought a female resident was his girlfriend, and refused medications. She stated he was evaluated by the psychiatrist, who determined he needed a higher level of care and was transferred to a psychiatric hospital for evaluation. He returned the next day and there were changes to his medications. She indicated she was not involved in the PASARR review process at that time and could not explain why the state mental authority was not informed of his change in mental status.On 11/20/2025 at 3:52 PM, the Director of Nursing (DON) stated the SSD was responsible for reviewing the PASARRs. He stated the PASARRs were reviewed for every admission during clinical meetings and if incorrect, re-processed. He recalled back in April resident #94 was more aggressive, followed by psychiatry and changes of medications were made. He stated since (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there were no changes to resident #94's diagnoses as identified in the PASARR, there would not have been a need to re-do the PASARR. The DON confirmed a new PASARR was not completed at that time.

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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 and implement a comprehensive person-centered care plan for 1 out of 1 resident of a total sample of 55 (#164).Resident #164 was readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, nicotine dependence, cigarettes, uncomplicated dependence on supplemental oxygen and chronic pain syndrome. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed resident #164 was cognitively intact with a brief interview of mental status score (BIMS) of 15 out of 15.Review of the smoking assessment listed resident #164 as a safe smoker on 4/15/24 it also included the verbiage smoking is always supervised; the smoking attendant holds cigarettes and lighter.A review of the social services notes on 11/5/25 at 4:00PM stated It has been reported that a strong cigarette odor has been coming from resident #164's bathroom. She has previously been caught smoking inside the facility, causing her smoking privileges to be revoked. Smoking policy reviewed, including no smoking within the facility. Resident verbalized understanding and stated she would not be smoking within the facility.On 11/17/25 at 5:30 PM, she was observed in the facility's parking lot smoking, and she had an oxygen concentrator attached to her wheelchair.On 11/19 at 3:06 PM, the receptionist was asked if she was aware of resident #164 smoking in the parking lot while having her oxygen tank at the back of her wheelchair and stated, we talk to her, but she don't listen . administration is aware. On 11/19/25 at 3:31 PM, both the nursing home administrator (NHA) and the Director of Nursing (DON) said that resident #164 had the right to leave the premises and if she chose to abandon all rules they could not stop her from leaving the premises. They said that there was no supervision provided after the front door and whenever a resident signs out on leave of absence (LOA) the intent is that they leave the property. They explained resident #164 lost her smoking privileges on 11/5/25 but had orders for LOA and residents on LOA have no restrictions. They added, the doctor determined that resident #164 had a BIMS of 15 without restrictions, she was her own responsible party and they would not revoke her LOA. On 11/19/25 at 4:24 PM, CNA G, the smoking attendant in the smoking patio said that resident #164 does not come out here to smoke, instead she goes in front and the facility was not holding any supplies except a vape. CNA G said, when resident #164 would come here, she would leave her wheelchair and oxygen and walk outside to smoke, they have to leave the oxygen tank inside. A review of resident #164's Plan of Care initiated 5/1/24 revealed that she was a smoker and required supervision while smoking however, nowhere did the care plan address her non compliance with facility's rules for smoking nor did it address her behaviors of smoking in her room, smoking with oxygen nearby nor smoking in the parking lot while having the oxygen tank on her wheelchair. On 11/20/25 at 9:40 AM, the MDS coordinator said she updated Care plans quarterly and as needed. For resident #164, she explained she was not aware of her smoking with the oxygen in parking until yesterday nor was she aware that her smoking privilege was revoked for smoking in her room . if she knew, she said that she would have updated the care plan.On 11/20/25 at 11:11AM the DON said that he did not oversee care plans and it was the responsibility of the MDS coordinator and would have expected the care plan to be updated. On 11/20/25 at 2:20 PM, the NHA said she was not aware that resident #164's care plan did not reflect noncompliance with smoking policy and thought it should have been updated.The facility's policy on Comprehensive Care Plans revised 3/1/25, stated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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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 implement resident-directed care and treatment consistent with the resident's physician orders for 1 out of 2 residents, (#164), failed to ensure medications were administered and provided per physician orders to prevent missed doses in accordance with professional standards of practice for 1 of 1 residents, (#99), reviewed for quality of care, out of a total sample of 55 residents. Resident #99, a [AGE] year-old male, was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included acute transverse myelitis in demyelinating disease of central nervous system, generalized anxiety disorder, and major depression. Review of resident #99's admission Minimum Data Set assessment dated [DATE], revealed he had a Brief Interview of Mental Status score of 13 out of 15, which indicated intact cognitive function. He had no rejection of care behavior and received scheduled pain medications for occasional pain that affected his sleep and daily activities. He required partial to moderate assistance for Activities of Daily Living and utilized a wheelchair for mobility. On 11/17/25 at 12:28 PM, resident #99 said he was concerned about missing some doses of a new medication, Gabapentin, that had just been prescribed for pain on 11/14/25. He said the medication was prescribed to be given three times per day and he had last received it on 11/16/25 at around lunch time. He explained that on 11/15/25 he received his first three doses and then on 11/16/25, after his second dose, the nurse told him he had run out of the medication. He was not sure if the nurse had reordered the medication, but he said he never received his third dose that night. He said he received his morning medications, but the Gabapentin had not been included, and he knew what it looked like. According to WebMD, Gabapentin was commonly used to treat and prevent seizures in people with epilepsy, but it was also prescribed to treat nerve pain or neuralgia. (https://www.webmd.com/drugs/2/drug-14208-8217/gabapentin-oral/gabapentin-oral/details; retrieved 11/25/25). Resident #99's progress notes revealed he was seen by the Nurse Practitioner on 11/14/25 and she noted he had complained of difficulty ambulating and was compliant with his medications. She ordered Gabapentin to be started on that day for nerve pain. A nursing note entered on 11/16/25 at 4:42 PM, by Registered Nurse (RN) L noted Gabapentin was on order from the pharmacy. Review of resident #99's medication orders, revealed an order dated 11/15/25 for Gabapentin 100 milligram (mg) tablets three times per day for pain related to myelitis. Further review of the Medication Administration Record for November 2025 revealed the following: on 11/15/25 he received three doses of Gabapentin, 11/16/25 he received two doses, but the third dose was documented as refused, and 11/17/25 the nurse documented he had received the morning dose. On 11/17/25 at 11:54 AM, the resident's assigned nurse, Registered Nurse (RN) M said resident #99 had received his morning dose of Gabapentin but would not be receiving the second dose because he had run out of it. She stated that the blister pack only had one pill left but was unable to show me the empty pack because she had discarded it already. She noted that he would miss his second dose of the medication because she was unsure when the pharmacy would deliver the medication. She was (continued on next page)

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	105861	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nursing & Rehabilitation Center of Melbourne	3033 Sarno Rd Melbourne, FL 32934

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked if the facility had a medication dispensing system (Pyxis) where they kept extra medication and she said they did but it mostly had narcotics. She confirmed she had not asked her supervisor or Director of Nursing (DON) if the medication was available in the Pyxis. At 1:27 PM she stated she was able to take the Gabapentin out of the Pyxis machine and administered it to resident #99. She said she was not aware that this medication was kept in the Pyxis. On 11/17/25 at 1:30 PM, resident #99 confirmed he received his second dose of the Gabapentin and reiterated that he absolutely did not receive his morning dose. On 11/19/25 at 12:47 PM, a phone interview with RN J revealed that he had been the nurse assigned to resident #99 on 11/15/25. He stated that he worked a double shift on 11/15/25 from 7:00 AM to 11:00 PM and had noticed there was a new prescription for Gabapentin three times per day for resident #99. He explained there was a full blister pack of the medication, which was usually 25 tablets and had administered all three doses to the resident during his shift. He said there was still medication left when he left that night. RN J stated that in the event a resident ran out a medication he would check the Pyxis to see if the medication was available to prevent the resident from missing a dose until the pharmacy delivered the medication but if it was not available in the Pyxis, he would let the doctor know and document in the resident's medical record. On 11/19/25 at 1:29 PM, Licensed Practical Nurse (LPN) K said in a phone interview that he worked with resident #99 on 11/16/25 during the 7:00 AM to 3:00 PM shift. He confirmed there was enough Gabapentin for resident #99 and he administered both doses during his shift. He said he did not recall the medication being low after he administered the second dose. He stated the pharmacy usually sent a full blister pack of medications that were to be given routinely but, in the event, a medication was missing, he would check the Pyxis to see if it was available until the pharmacy delivered to prevent the resident from missing a dose. On 11/19/25 at 3:00 PM, RN L said in a phone interview that she had worked at the facility for over two years. She confirmed she worked on 11/16/25 from 3:00 PM to 11:00 PM and was assigned resident #99. She said that when she went to administer his evening medications, she noticed that he had run out of the Gabapentin but had not been told by the previous nurse during report. She asked the resident if he was aware that he had no more medication, and she alleged he told her that the first shift nurse had told him he would not have any more medication after his second dose and that it needed to be reordered. RN L said she put in an order with the pharmacy and documented in the resident's chart that the medication was on order but did not mean to document that the resident refused the medication in the medication administration record. She did not attempt to get the medication from Pyxis because she had forgotten her code and did not let a supervisor know. She agreed that she should have let a supervisor know but she was being, lazy and said she did not usually work on that unit, so she did not know the resident well. When asked if she believed it was appropriate to not give medication when it was available to give, she said no and that she should have either attempted to get it from Pyxis or alerted the doctor about the missed dose and documented it in the resident's record. On 11/20/25 at 11:52 AM, during a phone interview with the facility's pharmacy provider, it was revealed that they delivered medications to the facility several times a day. He confirmed that the first time Gabapentin had been delivered to the facility for resident #99 was on 11/18/25 at 5:21 AM, and said there had been no prior deliveries of this medication prior to that date. Review of pharmacy invoices from 11/1/25 through 11/20/25, revealed there had been no deliveries (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Gabapentin for resident #99 prior to 11/18/25. A review of all medications dispensed from Pyxis from 11/1/25 through 11/20/25, revealed that Gabapentin had not been dispensed prior to 11/17/25 for resident #99. On 11/20/25 at 2:21 PM, the DON was made aware that resident #99 had been administered Gabapentin starting on 11/15/25 but had then run out of the medication by 11/16/25. He was told that the pharmacy had no record of delivering Gabapentin for resident #99 until 11/18/25 and there was no evidence that the staff was taking the medication from Pyxis prior to 11/17/25. He said he was unsure where the nurses were getting Gabapentin from and said it was not common practice for staff to take medications from other residents. He clarified that the pharmacy never sent more than seven tablets of medication and that it needed to be reordered weekly. He confirmed that all nurses had access to Pyxis and there was no code to enter because it was set up with their fingerprint. He said nurses were given access to Pyxis during orientation and they were told which medications were available but could ask a supervisor if they did not know. He expected staff to follow up with the pharmacy to ensure the medication would be delivered and if it was not delivered on time and it was not in the Pyxis, they needed to let the doctor know about the missed dose as well as document in the resident's medical record. Resident #164 was readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, nicotine dependence, uncomplicated dependence on supplemental oxygen and chronic pain syndrome. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed resident #164 was cognitively intact with a brief interview of mental status score (BIMS) of 15 out of 15. Review of the medical record showed resident #164 was prescribed Xanax 0.5 mg twice daily for anxiety at 6 AM and 1 PM and Gabapentin 600 mg three times a day for neuropathy. On 10/18/25 at 10:55 AM, resident #164 stated the facility runs out of Xanax and Gabapentin and she had missed doses of those medications. She later stated that on the days she missed her Xanax, she was more anxious than usual. A review of the medication administration record (MAR) revealed resident #164 did not receive Xanax 0.5 mg on 11/16, 11/17, 10/13, 10/14, 10/15, 10/16. The MAR also revealed resident #164 did not receive Gabapentin 600 mg on 10/5 and 10/6 which was then discontinued and not restarted until 10/9. A review of the nurses' medication administration notes revealed on 10/17/25 at 7:03 AM, for Xanax 0.5 mg On Order and at 4:29 PM script needed, script signed and sent to pharmacy. On 10/18/25 at 12:10 PM, RN C said that she recalled resident #164 missing one dose on her shift and explained that she could not retrieve it from the Pyxis because the pharmacy requested a script. She explained the psych nurse had sent it, but the pharmacy said they never received it. RN C confirmed she wrote the note on 11/17/25 at 4:29 PM, and that the [NAME] Wing Unit Manager (UM) usually reviewed the medications for reordering. On 11/20/25 at 10:19 AM the [NAME] Wing UM was made aware of the number of times resident #164 did not receive Xanax 0.5 mg and Gabapentin 600 mg. She reviewed the MAR and confirmed the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times the medications were not administered and was asked if she could find the related administration progress note for the days they were missed. The [NAME] Wing UM later said she was unable to produce associated progress notes for the missed does and only found three. She stated her expectation was for nurses to communicate to her if they were having any issues with the process of reordering medications so she could assist with reordering. She explained that she educated the nurses on calling the pharmacy and checking the Pyxis system. On 11/20/25 at 11:11AM, the DON was made aware of the missed doses of Xanax and Gabapentin for resident #164 and stated that his expectation was that nurses would go to the Pyxis for the medication, call the pharmacy, call the doctor and document.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 timely dressing change orders for a peripherally inserted central catheter (PICC), failed to timely change the PICC dressing, failed to obtain timely intravenous (IV) flush orders, and failed to administer the IV flushes in accordance with accepted standards of practice for 1 of 1 residents reviewed for IV antibiotics in a total sample of 55 residents (#52).Findings: Review of resident #52's medical record revealed he was originally admitted on [DATE] and readmitted to the facility on [DATE] from an acute care hospital. His diagnoses included a displaced fracture of the right femur, sepsis, methicillin-resistant Staphylococcus aureus (MRSA), and urinary retention. Sepsis is a life-threatening medical emergency caused by your body's overwhelming response to an infection. (Retrieved from www.clevelandclinic.org on 12/08/25). MRSA is a type of bacteria that many antibiotics don't work on. MRSA most often causes skin infections, but it can also cause serious illnesses that are hard to treat. (Retrieved from www.clevelandclinic.org on 12/08/25).Review of resident #52's admission Minimum Data Set assessment with Assessment Reference Date of 10/02/25 revealed a Brief Interview for Mental Status score of 14, indicating intact cognition. The MDS assessment noted no rejection of care or evaluations necessary to achieve health and well-being goals. A review of resident #52's physician's orders revealed a PICC was ordered and inserted on 10/25/25 to administer IV antibiotics related to a right hip surgical infection. The IV antibiotics ordered on 10/24/25 included Vancomycin 1 gram (gm) twice daily for seven days and Cefepime 1 gm/50 milliliters (ml) three times daily for seven days. Cefepime was discontinued on 10/28/25. An order for Vancomycin 1 gm was restarted on 10/28/25 until 11/02/25, and again from 11/03/25 to 11/13/25. A new order for Vancomycin 1250 milligrams (mg)/250 ml IV once daily was initiated on 11/14/25. Review of resident #52's physician's orders also revealed a PICC dressing change and IV flush orders were not obtained until 11/17/25, twenty-one days after resident #52 returned from the hospital on [DATE]. The orders indicated to change the PICC dressing weekly with Tegaderm every Monday day shift and to flush the IV line with 10 ml of normal saline before and after each medication administration every shift. Review of resident #52's comprehensive care plan revealed a focus for antibiotic therapy related to the right hip infection was initiated on 11/05/25. A focus for IV therapy, including interventions for IV site care and dressing changes, was initiated on 11/17/25, more than 3 weeks after he began receiving IV antibiotics. Review of resident #52's Progress Notes revealed a note dated 11/17/25 which read, IV midline dressing noted to be missing on PCC (PointClick Care) review. No signs of infection or complications observed at insertion site. MD (physician) contacted and informed of missing dressing order. Order obtained for weekly and PRN (as needed) dressing changes. IV midline dressing changed by new order using aseptic technique. Dressing secure and intact. Patient tolerated procedure well. No immediate complications noted. Continue to monitor IV site for signs of infection or dislodgement. Will continue to follow plan of care.Review of the Medication Administration Record showed the PICC dressing change documented as completed 11/17/25 at 11:19 AM.On 11/17/25 at 4:04 PM resident #52 stated he had been receiving IV antibiotic for approximately four weeks to treat his right hip infection. He displayed his left upper arm (LUA) which revealed a single lumen PICC with a non-intact and soiled dressing dated 11/09/25. He stated the PICC line dressing had not been changed in more than a week.On 11/17/25 at 4:14 PM, Licensed Practical Nurse (LPN) N confirmed resident #94 received IV antibiotics and stated the wound care nurse was usually responsible for changing IV dressings. At 4:21 PM, LPN N assessed resident #52's LUA, confirmed the dressing was dated 11/09/25 and acknowledged the dressing was not intact. LPN N stated the dressing was dirty and needed to be changed. She said she needed to check the computer to determine if there was an order dressing changes and the required frequency. After reviewing the medical record, LPN N stated an order had been entered that day to change the dressing every 72 hours. She explained timely dressing changes were important to help protect the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident from infection. On 11/17/25 at 4:29 PM, the Director of Nursing (DON) assessed resident #52's LUA, confirmed the dressing was dated 11/09/25, and noted the presence of dried blood on the dressing. He stated the type of dressing used, which included gauze, required changes every 72 hours. The DON confirmed orders to change the IV dressing and flush the IV line were entered on 11/17/25, and there were no previous orders for IV line care. The DON also reviewed the progress notes and acknowledged there was no documentation of IV dressing changes or flushes. He stated all nurses were expected to assess IV lines and obtain PICC care orders on admission or at the time of insertion if the line was placed at the facility.On 11/20/25 at 10:29 AM, the East Wing Interim Unit Manager (UM) stated orders to maintain IV lines needed to be obtained for any resident admitted with them. She indicated the nurses were responsible for maintaining the IV lines by ensuring patency, confirming the dressing was clean and intact, and administering medications as ordered. She explained they used batch orders that should be entered upon admission or when the IV line was placed. The UM stated these orders should have been reviewed during their morning clinical meetings to ensure accuracy. She explained resident #52 was in the hospital from [DATE] to 10/27/25 and she reviewed his medical record on 11/17/25, noticing there were no orders for IV dressing changes or flushes. She stated she obtained the orders at that time and could not explain why this issue was not identified earlier. She acknowledged the progress note written on 11/17/25 contained inaccurate details regarding the dressing observation and change documented as completed as 11:19 AM. She stated after obtaining the dressing order, she believed a previous order had fallen off and did not recall checking whether an earlier order existed. She explained during review of the hospital discharge packet, they would have seen resident #52 had a PICC line and, if orders were not present, the physician would have been contacted for IV line care orders. Review of the facility's PICC/Midline/CVAD Dressing Change policy revised on 3/01/25 revealed PICC dressings were to be changed weekly or when soiled to decrease the risk of infection and cross-contamination. The policy specified physician orders would include the type of dressing and frequency of changes, and completion of the procedure would be documented.Review of the facility's Intravenous Therapy policy revised on 3/01/25 revealed the intent for staff to adhere to accepted standards of practice regarding infusion practices.

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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 identify and provide ongoing monitoring of identified past trauma for 2 of 2 residents reviewed for Trauma Informed Care, of a total sample of 55 residents, (#25, #84).Findings: 1. Review of the medical record revealed resident #84, a [AGE] year-old male was admitted to the facility from an acute care hospital on [DATE] with diagnoses that included: Alcohol Abuse, Adult Failure to Thrive, Moderate Dementia with Anxiety, Other Psychoactive Substance Abuse, Anxiety Disorder, Convulsions, Weakness, and Post Traumatic Stress Disorder (PTSD). The most recent Comprehensive Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/16/25 noted during the look-back periods, resident #84 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment. Cognitive Patterns were assessed with continuous/non-fluctuating behaviors of inattention and disorganized thinking. The Mood Interview (PHQ-2 to 9) noted the resident felt down, depressed or hopeless for several days, and the Behavior section noted there were no behavioral changes or rejections of evaluation or care. The assessment indicated the resident required moderate staff assistance to complete Activities of Daily Living (ADLs), used a manual wheelchair, and did not walk. The resident had active diagnoses of Non-Alzheimer's Dementia, Seizure Disorder, Anxiety Disorder, Depression, Alcohol and Other Psychoactive Substance Abuse, Weakness, Homelessness, and Post Traumatic Stress Disorder (PTSD). The Care Planning Decisions signed on 10/19/25 did not include Psychosocial Well Being. The Comprehensive MDS admission Assessment with an ARD of 10/19/22 noted Active Diagnoses included PTSD however did not include anxiety disorder or depression. The Electronic Health Record (EHR) showed a diagnosis of Major Depressive Disorder, Recurrent, Moderate was added on 1/23/23 noted as, during stay. The Comprehensive Care Plan Report's focus included: (10/24/24) self-care impairment and required staff assistance for all ADLs, (12/20/22, revised 5/24/23) self-care deficits with history of PTSD, (11/24/22, revised 10/16/25) risk for restlessness, hypervigilance, and mood alterations related to anxiety disorder with an intervention to monitor behaviors and attempt to determine the underlying cause, (12/23/22, revised 10/16/25) risk for mood alterations, isolation feeling of doom related to depression that requires medication, (11/24/22, revised 7/25/24) potential for psychosocial well-being problems related to ineffective coping skills/substance use disorder. The Care Plan did not include a Focus for individualized PTSD/Past Trauma. On 11/18/25 at 1:46 PM, resident #84 was observed sitting in a wheelchair beside his bed alone, with the privacy curtain drawn. On 11/19/25 at 1:20 PM, resident #84 was observed sitting in a wheelchair in the same location with the privacy curtain drawn. The resident was unable to recall his past life history and answered he did, this and that prior to living in the facility. Unsuccessful attempts were made to interview resident #84's court appointed guardian by telephone on 11/19/25 at 1:20 PM and 3:28 PM, and on 11/20/25 at 9:05 AM. On 11/19/25 at 1:22 PM, Certified Nursing Assistant (CNA) E said she knew resident #84 well and he was frequently on her assignment. She said the resident was occasionally irritable, but she was unaware of his history or any unique findings about him. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/25 at 1:09 PM, Registered Nurse (RN) C said she knew resident #84 well, and he was frequently included in her assignment. The nurse explained she was unaware of any special mental health needs or concerns, he mostly preferred to stay alone in his room, and he was quiet and didn't speak much. On 11/19/25 at 1:45 PM, the [NAME] Wing Unit Manager said she knew resident #84 well, he preferred to be alone and kept to himself. She said the resident did not have any special mental health issues or concerns. Review of Social Services Progress Notes dated from 11/24/22 to 10/30/25 revealed there were no entries that addressed care and services for resident #84's diagnosis of PTSD. The EHR included one Community Life Progress Review (Activities) dated 4/12/24 and one Activities Quarterly Participation Review dated 10/13/25 that did not note any awareness for resident #84's PTSD. The medical record did not include a Social Service Department Social History and Initial Assessment required by the facility soon after the resident's admission on [DATE], nor any Social Services ongoing quarterly monitoring/assessments. In an interview on 11/19/25 at 12:10 PM, the Social Services Assistant explained the Social Services Director was responsible for completing resident initial admission assessments and updates quarterly and thereafter. She said the Social Services Director was not at work and unavailable during the survey. She checked resident #84's medical record and was unable to locate any Social Services evaluations. On 11/1925 at 1:49 PM, the Activities Assistant said he knew resident #84 well. He recalled over time, the resident had become more withdrawn from any group activities and had only seen him once in the previous month for an ice cream. He stated he was unaware of any special needs or any history of trauma. On 11/20/25 at 3:27 PM, the Community Life Director (Activities) said she was unaware of any residents in the facility who had PTSD and if she did, she would have created a special program for them. On 11/20/25 at 8:51 AM, the Director of Nursing (DON) explained the Social Services Department was responsible for completion of discipline specific assessments on admission, every quarter thereafter, and as needed for every resident. He said the assessment was important to identify any special psychological/psychosocial needs and PTSD trauma required a separate care plan for triggers, so staff were aware. At 10:47 AM, the DON said he checked resident #84's medical record and was unable to locate any Social Services assessments. He said he could not explain why they were not completed, and the Social Services Director was not available for an interview. Review of the facility's standards and guidelines dated 3/01/25 and titled Trauma Informed Care outlined that the facility screened residents to identify trauma history and asked about triggers or stressors that may prompt recall using tools that included social/history assessments. The policy noted the facility used trigger specific interventions to decrease and mitigate exposure, and those interventions were included in the individualized care plan. (continued on next page)

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated job description titled Social Worker indicated the position was responsible for completing discipline specific assessments that contributed to residents attaining or maintaining their highest practicable well-being. 2. Resident # 25 was readmitted to the facility on [DATE] with diagnoses which included unspecified fracture of the right femur, pulmonary embolism, schizoaffective disorder, major depressive disorder and PTSD. Review of the quarterly MDS assessment with assessment reference date (ARD) of 9/28/25 revealed resident # 25 had BIMS Score of 9 out of 15 which indicated he had moderate impaired cognition, was dependent on staff for activities of daily living and transfers. The assessment also showed that the Psychiatric /Mood disorders included depression, schizophrenia and PTSD. A review of resident #25's Care plan revealed the resident had impaired cognitive function/dementia or impaired thought processes related to dementia/PTSD initiated on 12/27/22 and revised 4/1/25 with no specific interventions addressing PTSD or the triggers. A review of the practitioner's progress notes on 11/13/25 by Psychiatric Nurse Practitioner revealed an excerpt from Assessment and Plan which addressed PTSD for resident #25 .PTSD (Post Traumatic Stress Disorder): The history suggests that this patient has suffered from significant trauma resulting into nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month and have occurred without any substance use or organic brain pathology. Care Plan for PTSD diagnosis: Trauma: Told to notify provider and staff if triggers present Triggers: Denies Care Plan: Told to notify provider and staff if triggers present . On 11/18/25 at 10:30 AM resident #25 was observed in bed with his eyes closed. On 11/19/25 at 4:10 PM, the resident's assigned nurse LPN O said the resident was confused at times, had schizoaffective disorder and stayed in bed. She had never seen visitors or family but knew he had a guardian. She explained he was incontinent, had no wounds, medicated for anxiety and pain and that he can be resistive to care at times with certified nursing assistants (CNAs). The LPN did not explain any mental health issues. On 11/19/25 at 4:15 PM, the resident's assigned CNA P stated the only thing that stood out about the resident was he did not like his private area touched during care. On 11/20/25 at 9:40 AM in the presence of the MDS coordinator, the Psychiatric Nurse Practitioner (NP) said that most days resident #25 was unable to explain anything and on other days, he was actively psychotic. The Psychiatric NP explained resident #25 would say things like, the homosexuals are coming and she said that it should be care planned. She explained she could not determine what trauma the resident faced and the exact circumstances but she had told the team about rape and addressing triggers for resident #25. The MDS coordinator could not find anything addressing resident #25's PTSD or any history of rape. On 11/20/25 at 3:38 PM, the Assistant Director of Nursing acknowledged resident #25's care plan should reflect interventions to address triggers based on his trauma.