STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105886	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ansley Cove Healthcare and Rehabilitation	1301 W Maitland Blvd Maitland, FL 32751

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility neglected to identify and implement appropriate fall prevention interventions for a resident with a high risk for falls who also received a combination of high-risk medications, resulting in the resident experiencing a fall with injury.This failure resulted in actual harm to 1 of 4 residents reviewed for Quality of Care, (#1).Findings:Review of the medical record revealed resident #1, a [AGE] year-old female was admitted to the facility from an acute care hospital on 7/28/25 with diagnoses including generalized muscle weakness, difficulty in walking, lack of coordination, and cognitive communication deficit.Review of the most recent Modified Minimum Data Set (MDS) Comprehensive Significant Change Assessment with an Assessment Reference Date (ARD) of 9/05/25 revealed during the look back period, resident #1 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. The Functional Abilities and Goals assessment showed the resident did not use mobility devices such as a wheelchair or walker and required moderate staff assistance to complete Activities of Daily Living (ADLs) and mobility functions. Walking was not assessed due to medical condition/safety concerns. The resident was incontinent with bladder and bowel functions, had a history of falls since admission/entry or re-entry/prior assessment, and she received high-risk antidepressant, opioid (narcotic pain), and antiplatelet (blood clot prevention) medications. The Modified MDS Comprehensive admission Assessment with an ARD of 8/04/25 noted resident #1 scored 8 out of 15 on the BIMS, had at least 1 fall in the last month prior to admission/entry/re-entry, and at least 1 fall in the last 2-6 months prior to admission/entry/re-entry. Both assessments indicated a Care Area was triggered for an identified problem of Confusion/disorientation/forgetfulness, risk of high-risk medication adverse effects including sedation manifested by short-term memory loss, decline in cognitive abilities, drowsiness, and increased risk for Falls with noted positive Care Plan Decisions. On 10/14/25 at 10:45 AM, resident #1 was observed lying in bed in her room with her eyes closed. Observation of the resident's forehead revealed two healing bruises measuring approximately 2 centimeters (CM) in length by 0.5 CM in width. The Hospice provider's Crisis Care Licensed Practical Nurse (LPN) was sitting at the resident's bedside. The nurse said the bruises were from a recent fall, and the resident's status changed to Crisis Care on 10/12/25 during the night shift. On 10/15/25 at 10:52 AM, resident #1 was observed in her room lying in bed. She was awake and somewhat restlessly changing positions. The Crisis Care LPN was sitting at her bedside.The nurse's Clinical admission assessment dated [DATE] noted resident #1 did not have a history of falls in the last month or six months prior to admission/entry/re-entry with one fall prevention intervention to keep the call light within reach. No Safety Education/Notification concerns were identified, and no Care Planning Focus Safety Concerns were indicated.The Care Plan Report's Focuses included: (7/29/25) ADL self-performance deficit related to generalized weakness/medications/effects of medications with an intervention of 1-2 person assistance due to fluctuations of weakness, fatigue, and weight bearing status. On 8/06/25, a Focus was added for an actual fall related to unsteady gait with an intervention for 72 hour neuro-checks, and on 10/03/25, wheelchair to be locked when in use per family request. On 9/16/25 after a second fall, a Focus was added for risk of falls related to impaired balance, impaired cognition, and unsteady gait (walking). Interventions were added for a floor mat while the resident was in bed, neuro checks for 72 hours and keep bed in lowest position while in bed. On 10/06/25, interventions were added to anticipate and meet resident's needs, non-skid footwear when out of bed, ensure the call light is within reach, and encourage the resident to use it for assistance as needed. On 10/06/25, a Focus was added for risk of abnormal bleeding related to use of anticoagulant (blood thinner) medication.There was no fall prevention Care Plan Focus from 7/28/25 to 9/16/25, over six weeks. The Order Summary Report showed resident #1 required monitoring for side effects of opioid medications including sleepiness, dizziness, and confusion. Physician's ordered medications included: (8/05/25) Trazodone (anti-depressant) 25 Milligrams (MG) at bedtime for depression/insomnia, (8/22/25) Oxycodone (opiate pain) 10 MG every six hours for pain, (9/10/25) Methadone (opiate pain) 15 MG twice daily for pain, and (9/17/25) Ativan (anti-anxiety) 0.5 MG twice daily, increased (9/24/25) to 0.5 MG every two hours as needed for agitation and anxiety.MDS Care Area Assessments (CAAs) for Falls with positive Care Plan Decisions in both Modified Comprehensive Assessments with ARDs of 8/04/25 (Admission) and 9/05/25 (Significant Change) had triggering conditions associated with resident #1's history of falls and the use of high-risk medications. Both assessments were modified during the survey to correct

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement appropriate interventions to include provision of adequate supervision to mitigate the prevention of fall with injury for 1 of 4 residents reviewed for Quality of Care, (#1).The facility's failure to increase supervision for a resident with a history of repeated falls who also received high-risk medications resulted in actual harm.Findings:Review of the medical record revealed resident #1, a [AGE] year-old female was admitted to the facility from an acute care hospital on 7/28/25 with diagnoses including generalized muscle weakness, difficulty in walking, lack of coordination, and cognitive communication deficit.Review of the most recent Modified Minimum Data Set (MDS) Comprehensive Significant Change Assessment with an Assessment Reference Date (ARD) of 9/05/25 revealed during the look back period, resident #1 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. The Functional Abilities and Goals assessment showed the resident did not use mobility devices such as a wheelchair or walker and required moderate staff assistance to complete Activities of Daily Living (ADLs) and mobility functions. Walking was not assessed due to medical condition/safety concerns. The resident was incontinent with bladder and bowel functions, had a history of falls since admission/entry or re-entry/prior assessment, and she received high-risk antidepressant, opioid (narcotic pain), and antiplatelet (blood clot prevention) medications. The Modified MDS Comprehensive admission Assessment with an ARD of 8/04/25 noted resident #1 scored 8 out of 15 on the BIMS, had at least 1 fall in the last month prior to admission/entry/re-entry, and at least 1 fall in the last 2-6 months prior to admission/entry/reentry. Both assessments indicated a Care Area was triggered for an identified problem of Confusion/disorientation/forgetfulness, risk of high-risk medication adverse effects including sedation manifested by short-term memory loss, decline in cognitive abilities, drowsiness, and increased risk for Falls with noted positive Care Plan Decisions. On 10/14/25 at 10:45 AM, resident #1 was observed lying in bed in her room with her eyes closed. Two healing bruises were observed on the resident's forehead, measuring approximately 2 Centimeters (CM) in length by 0.5 CM in width. The Hospice provider's Crisis Care Licensed Practical Nurse (LPN) was sitting at the resident's bedside. The nurse said the bruises were from a recent fall, and the resident's status changed to Crisis Care on 10/12/25 during the night shift. On 10/15/25 at 10:52 AM, resident #1 was observed in her room lying in bed. She was awake and somewhat restlessly changing positions. The Crisis Care LPN was sitting at her bedside.The nurses' Clinical admission assessment dated [DATE] noted resident #1 did not have a history of falls in the last month or six months prior to admission/entry/re-entry with one fall prevention intervention to keep the call light within reach. No Safety Education/Notification concerns were identified, and no Care Planning Focus Safety Concerns were indicated.The Care Plan Report's Focuses included: (7/29/25) ADL self-performance deficit related to generalized weakness/medications/effects of medications with an intervention of 1-2-person assistance due to fluctuations of weakness, fatigue, and weight bearing status. On 8/06/25, a Focus was added for an actual fall related to unsteady gait with an intervention for 72-hour neuro-checks, and on 10/03/25, wheelchair to be locked when in use per family request. On 9/16/25 after a second fall, a Focus was added for risk of falls related to impaired balance, impaired cognition, and unsteady gait (walking). Interventions were added for a floor mat while the resident was in bed, neuro checks for 72 hours and keep bed in lowest position while in bed. On 10/06/25, interventions were added to anticipate and meet resident's needs, non-skid footwear when out of bed, ensure the call light is within reach, and encourage the resident to use it for assistance as needed. On 10/06/25, a Focus was added for risk of abnormal bleeding related to use of anticoagulant (blood thinner) medication.There was no fall prevention Care Plan Focus developed from 7/28/25 to 9/16/25, over six weeks,The Order Summary Report showed resident #1 required monitoring for side effects of opioid medications including sleepiness, dizziness, and confusion. Physician's ordered medications included: (8/05/25) Trazodone (anti-depressant) 25 Milligrams (MG) at bedtime for depression/insomnia, (8/22/25) Oxycodone (opiate pain) 10 MG every six hours for pain, (9/10/25) Methadone (opiate pain) 15 MG twice daily for pain, and (9/17/25) Ativan (anti-anxiety) 0.5 MG twice daily, increased (9/24/25) to 0.5 MG every two hours as needed for agitation and anxiety.On 10/15/25 at 11:05 AM, the Therapy Director recalled resident #1 received skilled therapy services during July-August 2025 after admission to the facility. She checked the medical records and explained the resident had significant memory deficits, inattention, and poor safety awareness with scores that were, very poor with severe

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records for 1 of 4 residents reviewed for Quality of Care, (#1). Specifically, the Director of Nursing (DON) incorrectly documented and backdated resident records, resulting in inaccurate information in the clinical record and the Minimum Data Set (MDS) Coordinator inaccurately recorded fall histories. This deficient practice had the potential to affect all residents by compromising the accuracy and integrity of resident medical information used to make care decisions.Findings:Review of the medical record revealed resident #1, a 58-year- old female was admitted to the facility from an acute care hospital on 7/28/25 with diagnoses including generalized muscle weakness, difficulty in walking, lack of coordination, and cognitive communication deficit. Review of the most recent Modified Minimum Data Set (MDS) Comprehensive Significant Change Assessment with an Assessment Reference Date (ARD) of 9/05/25 revealed during the look back period, resident #1 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment. The Functional Abilities and Goals assessment showed the resident did not use mobility devices such as a wheelchair or walker and required moderate staff assistance to complete Activities of Daily Living (ADLs) and mobility functions. Walking was not assessed due to medical condition/safety concerns. The resident was incontinent with bladder and bowel functions, had a history of falls since admission/entry or reentry/prior assessment, and she received high-risk antidepressant, opioid (narcotic pain), and antiplatelet (blood clot prevention) medications. The Modified MDS Comprehensive admission Assessment with an ARD of 8/04/25 noted resident #1 scored 8 out of 15 on the BIMS, had at least 1 fall in the last month prior to admission/entry/reentry, and at least 1 fall in the last 2-6 months prior to admission/entry/reentry. Both assessments indicated a Care Area was triggered for an identified problem of Confusion/disorientation/forgetfulness, risk of high-risk medication adverse effects including sedation manifested by short-term memory loss, decline in cognitive abilities, drowsiness, and increased risk for Falls with noted positive Care Plan Decisions. The Fall Risk Evaluation completed upon admission on [DATE] was marked negative for any history of falls in the previous 3 months and noted that resident #1 was able to walk however, a Gait/balance risk assessment was not done and marked, not able to perform function. The evaluation was scored at 9 (moderate/low) risk because of the questioned responses. A score of 10 or higher indicated a high risk. The Risk for Falls section was not marked for a care Focus nor indicated prevention interventions were needed.A Fall Risk Evaluation backdated on 10/05/25 with an effective date of 9/16/25 completed by the former DON indicated resident #1 was disoriented x 3 (person, place, time) at all times, chairbound, there was no Change in Condition in the previous 14 days, no assistive devices (wheelchair) were used, a Gait/balance assessment was not done, and the Fall Risk was again scored at 9 (moderate/low risk).A Fall Risk Evaluation completed by the former DON was backdated on 10/05/25 with an effective date of 10/03/25 and noted a Gait/balance assessment was not completed (not able to perform). Resident #1's fall risk was again scored as 9 (moderate/low).The Fall Risk Evaluation Graph showed Fall Risk Scores of 9 (moderate/low risk) on 7/28/25, 8/06/25, 9/16/25, and 10/03/25. The scores did not change even after resident #1 had three unwitnessed falls at the facility.Two unsuccessful attempts were made to interview the former DON by telephone on 10/15/25 at 1:25 PM and 10/16/25 at 9:07 AM.In an interview on 10/15/25 at 11:21 AM, the MDS Coordinator explained that fall interventions were mostly entered into the Care Plan by both the DON and the MDS Coordinator. She explained the Care Area Assessments (CAAs) of the MDS triggered fall risk factors and care plan decisions. On 10/16/25 at 9:17 AM, she checked resident #1's medical record and confirmed there was incorrect fall history coding in resident #1's MDS's. She checked the Comprehensive Care Plan and acknowledged a Fall prevention care plan was not entered timely, the fall history prior to admission and risks associated with high-risk medications was missing. She relayed that the previous MDS Coordinator did not thoroughly check all the medical records and must've missed it.No fall prevention Care Plan Focus was developed for resident #1's Plan of Care from 7/28/25 to 9/16/25, over six weeks.On 10/15/25 at 11:35 AM, the DON was interviewed and said she had been in the position for about one week. She said as part of her new role, she recently checked resident #1's records and found individualized care plan interventions were missing, and some Fall Risk Evaluations completed by the previous DON were backdated. On 10/16/25 at 9:57 AM, the DON checked resident #1's Fall Risk Evaluations and acknowledged the risk scores never increased after falls. She said they were incorrectly

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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 maintain an effective Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) program by not identifying and addressing repeated deficiencies and by not ensuring complete monitoring documentation for corrective action plans. The deficient practice resulted in a pattern of unresolved quality concerns and had the potential to affect more than a limited number of residents by not ensuring consistent monitoring and follow-up of identified problems.Findings:On a previous complaint survey dated 2/15/25, Centers for Medicare & Medicaid Services (CMS) Enforcements were issued that included F0600 (Free from Abuse and Neglect), F0610 (Investigate/Prevent/Correct Alleged Violation), F0689 (Free of Accident Hazards/Supervision/Devices). On 7/14/25, a recertification survey was conducted, and Enforcements were issued for F0867 QAPI/QAA Improvement Activities.On 10/16/25 at 2:10 PM, the Nursing Home Administrator (NHA) explained that their QAPI program included non-compliance assessments/review, and identification of identified problems reported by each department during their monthly regular and Ad Hoc (when needed) meetings. He recalled the last monthly meeting was held on 9/30/25. The NHA explained that the program's intention was to identify any deficiencies or trends in each department's monthly reported information, and it was collectively determined what issues the committee decided to work on.The NHA explained the last Performance Improvement Plans (PIPs) for F0610 and F0600 and F0689 Enforcements related to Falls in February 2025 were completed as the QAPI committee determined substantial compliance was met effective 4/01/25. He stated there had been three different Directors of Nursing (DONs) since February 2025 and he was unable to locate the POC documents.The NHA said the DON was responsible to ensure nursing related corrective actions were active and sustained. He said he was unaware how substantial compliance for the citations was determined and didn't have the records to review. The NHA stated there was a failure of DONs to track and ensure measures in place were implemented to sustain corrective measures.The facility did not implement an ongoing, systematic QAPI program to ensure that identified problems were corrected and prevented from recurring. The failure of the facility to maintain complete monitoring documentation and address repeated deficiencies demonstrated that the QAPI program was not effective.Review of the facility's standards and guidelines titled, QAPI Monitoring dated 1/20/22 noted the program's intentions were to systematically monitor performance indicators as part of the QAPI program. Data collection activities to track performance indicators based on data analysis are monitored/evaluated monthly for evaluation of progress towards goals and remain active for a minimum of one calendar year.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a Compliance and Ethics Program. Based on observation, interview, and record review, the facility failed to ensure the Director of Nursing (DON) adhered to ethical expectations and professional standards by backdating evaluations with incorrect documentation; lacked evidence of education or competency training for the role, and readily available employee program access. Findings:On 10/16/25 at 12:05 PM, via the telephone, the facility's Human Resource Assistant said she also served the role of Compliance Officer. She explained as part of the compliance program, the facility was expected to have posters readily visible for employees to access contact information and resources. She said she did not attend any clinical or meetings regarding resident care and only visited for employee situations that may include investigations, disciplines, or terminations. She said the Compliance and Ethics Program was outlined with education during employee orientation and included expectations of honesty in documentation and stated, anything that happens to a resident has to be documented honestly and 100% correctly; it affects the care, safety, and health of the residents.On 10/16/25 at approximately 11:00 AM, the DON said the Compliance Program posters were on the Assisted Living Facility (ALF) side of the building, but not on the Skilled Nursing side and provided a rolled-up poster she said the Nursing Home Administrator (NHA) had just received.On 10/16/25 at 12:50 PM, the NHA checked the employee file of the former DON and said he could not locate the signed Job Description, nor the acknowledgement of their Compliance and Ethics Program orientation education.Review of the facility's standards and guidelines dated 1/20/22 and titled Compliance and Ethics Program outlined components that included sufficient resources and authority to assure compliance, ongoing communication through education of standard policies and procedures, and compliance achievement activities, such as monitoring, auditing, reporting systems, and data integrity processes, and annual training all which was meant to promote quality care.