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	12/19/2025

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 - Immediate jeopardy to resident health or safety 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

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	12/19/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to protect the resident's right to be free from neglect by not providing necessary care and services for a totally dependent resident and failed to assess, recognize and intervene for changes in condition for 1 of 3 residents reviewed for neglect, out of a total sample of 15 residents, (#2). This failure contributed to the resident being found unresponsive and exhibiting physical signs consistent with having been deceased for some time prior to discovery. On [DATE] just after midnight, resident #2 was found unresponsive and staff initiated cardio-pulmonary resuscitation (CPR). The resident was transferred to the hospital by Emergency Medical Services (EMS). The EMS and hospital records noted resident #2 was very rigid with stiff extremities and core body temperature of 90.7 degrees Fahrenheit. The records indicated the resident displayed signs and symptoms of rigor mortis indicating the resident had been deceased for some time, before staff had identified the resident to be unresponsive and initiated CPR. The facility's failure to provide care, timely assess and recognize a change in the resident's condition and failure to initiate life-saving interventions prior to the resident's death resulted in Immediate Jeopardy starting on [DATE].Findings:Cross reference F684 and F610Resident #2, an [AGE] year-old female, was initially admitted to the facility [DATE] and readmitted from an acute care hospital on [DATE] with diagnoses that included encephalopathy, acute kidney failure, stroke, dysphagia (difficulty swallowing), dementia, and heart failure. The Medicare- 5 Day Minimum Data Set (MDS) assessment dated [DATE], showed resident #2 had a Brief Interview for Mental Status score of 3 out of 15, indicating severe cognitive impairment. The MDS assessment indicated resident #2 was totally dependent on staff for Activities of Daily Living (ADLs), including mobility. She was incontinent of bowel, had an indwelling urinary catheter and received all medications and nutrition by gastrostomy (g-tube) due to dysphagia. Review of resident #2's physician orders revealed orders for continuous tube feeding dated [DATE] routine g-tube flushes for hydration dated [DATE], vital signs every shift dated [DATE], daily indwelling catheter care dated [DATE], anticoagulant monitoring every shift for sudden changes in condition dated [DATE], daily wound care dated [DATE], and nightly g-tube site care dated [DATE]. Resident #2's comprehensive care plan revealed and identified need for assistance with ADLs, initiated on [DATE]. Interventions directed staff to provide total care and reposition the resident at least every 2 hours. The care plan also reflected the residents' advanced directive status as full code, initiated on [DATE]. The goal noted to initiate CPR in the event of cardiac or respiratory arrest. Review of resident #2's medical record, revealed a progress note by Registered Nurse, (RN) B dated [DATE] at 12:30 AM, which read, was notified by the nurse to look at resident as she did rounds to look at enteral feed, patient unresponsive to sternal rub. Code blue initiated and 911 called, CPR performed until police and EMS arrived. EMS arrived and transferred patient to (name of) Hospital. DON (Director of Nursing), on-call provider, and emergency contact were notified.According to the EMS report dated [DATE], dispatch received the call from the facility at 12:33 AM and arrived on scene at 12:40 AM. Upon arrival resident #2 was cold to the touch, pulseless, in asystole (absence of heart activity), and exhibited stiffness of the neck and face preventing intubation. Resident #2 did not respond to multiple rounds of CPR and did not regain consciousness. On [DATE] at 9:00 AM, interview with EMS staff who responded to the facility on [DATE], said they believed resident #2 had been deceased for some time prior to initiation of CPR.Hospital records dated [DATE], revealed resident #2 arrived at the hospital at 1:14 AM via EMS with very rigid extremities, a core body temperature of 90.7 degrees Fahrenheit ( ), and recurrent rigor mortis. According to Medicine Net, after death the body will turn stiff over a few hours. In the stage of rigor mortis, the body begins to harden but is still movable from 0-8 hours and the muscles become fully stiff from 8-12 hours. The stiffness starts on the face/head, neck, chest, and continues down to abdomen and lower extremities. An article by Biology Insights notes that the body cools at an average rate of 1.5 to 2 degrees per hour. (Retrieved [DATE]. https://www.medicinenet.com/what_are_the_stages_of_rigor_mortis/article.htm, https://biologyinsights.com/how-long-does-a-dead-body-stay-warm-after-death/). Normal body temperature is between 97-99 degrees Fahrenheit. Taking the lowest body temperature of 97 degrees F, the estimated time resident #2 had been deceased was at least 3 hours minimum before she was found unresponsive. On [DATE] at 4:34 PM, Licensed Practical Nurse (LPN) F confirmed she was the assigned nurse for resident #2 on [DATE] during the 3-11 PM shift. She said during her initial rounds, resident #2 was peacefully asleep and her vital signs were within normal limits when taken at 4:45 PM. LPN F said she administered medications to

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	12/19/2025

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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	12/19/2025

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to investigate allegation of neglect to ensure staff recognized change in resident condition and provided timely interventions for 1 out of 15 residents reviewed for advanced directives, (#2). On [DATE] after midnight, resident #2 was found unresponsive and staff initiated CPR. The resident was transferred to the hospital by Emergency Medical Services (EMS). The EMS and hospital records noted resident #2 was very rigid with stiff extremities and core body temperature of 90.7 degrees Fahrenheit. The records indicated the resident displayed signs and symptoms of rigor mortis indicating the resident had been deceased for some time, before staff had identified the resident to be unresponsive and initiated CPR. The facility Administration's failure to consider the hospital report findings indicating the resident had been deceased for some time and failure to conduct a complete and accurate investigation resulted in Immediate Jeopardy starting on [DATE].Findings: Resident #2 was originally admitted to the facility on [DATE]. The resident was hospitalized and readmitted to the facility on [DATE] and her diagnosis included encephalopathy, type 2 diabetes, stroke, heart failure and dementia. Medical record review revealed a Minimum Data Set assessment dated [DATE] in which resident #2 scored 3 out of 15 on the Brief Interview for Mental Status that indicated severe cognitive impairment. The MDS assessment also noted, resident #2 was dependent on staff for all Activates of Daily Living care to include mobility and incontinence care. Due to swallowing difficulties, the resident received all medications and nutrition through gastric tube. The resident had a stage 4 pressure wound to the coccyx. The resident's care plan indicated that staff needed to reposition the resident, every 2 hours at a minimum, to off load the pressure to promote wound healing. Review of staff schedules revealed Certified Nursing Assistant, (CNA) C, was assigned to resident #2 on [DATE], on the 3 PM to 11 PM shift. During an interview on [DATE] at 5:33 PM, CNA C verified she was resident #2's direct caregiver on [DATE], on the 3 PM to 11 PM shift. She said she was overwhelmed because there were only 3 aides, herself included, during the shift and she had 12 residents assigned to her. CNA C said she did not see the off going CNA from the 7AM to 3 PM shift and therefore did not receive a report status on the resident #2's condition on her assignment. She indicated during her initial resident round, resident #2 was sleeping. She added she checked on resident #2, three times during the evening of [DATE]. Contrary to CNA C's statement, review of the medical record revealed CNA C documented resident #2 was not available for any care during the 3 PM to 11 PM shift on [DATE]. CNA C added, she found out resident #2 died, when she came to work the next day. On [DATE] at 2:09 PM, Registered Nurse, (RN) B said her assignment included resident #2, on the 11 PM to 7 AM shift. RN B received an unremarkable report from the off-going nurse from the 3 PM-11 PM shift, Licensed Practical Nurse (LPN) F. RN B explained there were 4 nurses on the 11 PM-7 AM shift, that included herself, LPN E and 2 newly hired nurses, that were in training, LPN A and LPN D. She said just after midnight, LPN E told her to check on resident #2 because resident #2 did not look okay. She said LPN E had attempted a sternal rub but the resident did not respond. RN B was not able to recall the exact time but explained sometime shortly after midnight she went to see resident #2 and the resident did not have a pulse. She recalled around 12:35 AM she called a code blue and placed the resident on a back board with the assistance of a CNA, name not recalled and training nurse, LPN D. She said she conducted the code blue without any assistance from the nurses. She indicated she called EMS and the Director of Nursing, (DON), while doing chest compressions on resident #2 but she did not do any rescue breaths. On [DATE] at 3:49 PM, 4 days later, RN B made changes to her first interview and said, LPN E did not perform a sternal rub on resident #2 and that she did rescue breaths with an Ambu bag during the code blue. On [DATE] at 3:45 PM, LPN A indicated she was a newly hired nurse and was being trained by LPN E on [DATE], on the 11 PM-7 AM shift. LPN A stated CNA C, the 3 PM to 11 PM, aide that was assigned to resident #2 was still at the facility when she arrived. She said she was on the medication cart and LPN E rounded on all the residents including resident #2, who was not on their assignment. Shortly thereafter, between 11:30 PM and 11:45 PM, LPN A said she overheard LPN E speaking to RN B and the other nurse that was training, LPN D. LPN E asked them if they had checked resident #2 because she was already deceased when she conducted her initial rounds. CNA C, who was still at the facility, was asked when she last checked on the resident during the 3 PM to 11 PM shift. She recalled CNA C screamed and yelled that she had not taken care of resident #2 because she thought resident #2 was in the hospital. LPN A recalled LPN E saying resident #2 was already in rigor mortis. LPN A

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	12/19/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	12/19/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services in accordance with the resident's care plan, the resident's choice and as per professional standards of practice for 1 of 6 residents reviewed for quality of care, out of a total sample of 15 residents, (#2). This failure contributed to the resident being found unresponsive and exhibiting physical signs consistent with having been deceased for some time prior to discovery.On [DATE] just after midnight, resident #2 was found unresponsive and staff initiated cardio-pulmonary resuscitation (CPR). The resident was transferred to the hospital by Emergency Medical Services (EMS). The EMS and hospital records noted resident #2 was very rigid with stiff extremities and core body temperature of 90.7 degrees Fahrenheit. The records indicated the resident displayed signs and symptoms of rigor mortis indicating the resident had been deceased for some time, before staff had identified the resident to be unresponsive and initiated CPR. The facility's failure to provide care, timely assess and recognize a change in the resident's condition and failure to initiate life-saving interventions prior to the resident's death resulted in Immediate Jeopardy starting on [DATE]. Findings: Cross reference F600 and F610Review of resident #2's medical record revealed she was originally admitted to the facility on [DATE] and readmitted from an acute care hospital on [DATE] with diagnoses that included encephalopathy, type 2 diabetes, stroke, dysphagia (difficulty swallowing), heart failure, and dementia. Review of resident #2's Medicare 5-Day Minimum Data Set (MDS) assessment with Assessment Reference Date of [DATE] revealed a Brief Interview for Mental Status score of 3 out of 15, that indicated severe cognitive impairment. The MDS assessment noted resident #2 was totally dependent on staff for all Activities of Daily Living (ADLs), including mobility. Resident #2 was incontinent of bowel, had an indwelling urinary catheter and received all medications, nutrition and fluids via a gastrostomy tube (g-tube) due to dysphagia.Review of resident #2's physician orders revealed orders for continuous tube feeding dated [DATE], routine g-tube flushes for hydration dated [DATE], vital signs every shift dated [DATE], daily indwelling catheter care dated [DATE], anticoagulant monitoring every shift for sudden changes in condition dated [DATE], daily wound care dated [DATE], and nightly g-tube site care dated [DATE]. Review of resident #2's comprehensive care plan identified need for assistance with ADLs, initiated on [DATE]. Interventions directed staff to provide total care and reposition the resident at least every 2 hours. The care plan also reflected the resident's advanced directive status as full code, initiated on [DATE]. The goal noted to initiate CPR in the event of cardiac or respiratory arrest. Review of nursing documentation showed a progress note by Registered Nurse (RN) B dated [DATE] at 12:30 AM, which noted the resident was found unresponsive to sternal rub, CPR was initiated, 911 was called, and the resident was transferred to the hospital. Interviews and record review revealed staff failed to identify and respond to a resident #2's change in condition during the 3:00 PM to 11:00 PM shift on [DATE]. The assigned nurse reported administering medications via g-tube and observing the resident with eyes closed but she did not physically assess if the resident was responding or breathing. Staff acknowledged they observed the resident but did not physically assess her to ensure she was breathing. Documentation by the assigned Certified Nursing Assistant (CNA) noted the resident was not available for care during the entire 3 PM to 11 PM shift indicating resident #2 did not receive any ADL care during the shift.On [DATE] at 2:09 PM, Registered Nurse (RN) B stated she received report from the prior shift and no significant concerns about resident #2 were reported. She indicated Licensed Practical Nurse (LPN) E alerted her that resident #2 did not look good shortly after midnight. RN B stated she went to assess resident #2 and found her unresponsive to sternal rub with no palpable pulse and initiated code blue at approximately 12:25 AM, indicating CPR was not initiated timely. She explained staff assisted with positioning the resident and obtained the crash cart. RN B stated there was no one assigned to document the code in real time, and there were no CPR role assignments. On [DATE] at 3:05 PM, during a telephone interview, LPN E stated she entered resident #3's room around midnight while stocking supplies and checking tube feedings. LPN E indicated resident #2 appeared different from how she remembered her, with lips appearing ashen/dry. LPN E stated she immediately reported her concerns to RN B, the assigned nurse. LPN E noted she did not assess the resident but informed RN B. She recalled within 5-10 minutes RN B asked her to confirm code status, and she reported resident #2 was a full code. LPN E stated she did not participate in CPR.According to the EMS report dated [DATE], dispatch received a call from the facility at 12:33 AM and arrived on scene at 12:40 AM. Upon arrival, resident #2 was cold to the touch, pulseless, in

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	12/19/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a Quality Assurance and Performance Improvement (QAPI) meeting when allegations of neglect and concerns were identified related to the death of resident #2. Findings:Cross Reference F600, F684, F610, and F895On [DATE] just after midnight, resident #2 was found unresponsive and staff initiated cardiopulmonary resuscitation (CPR). The resident was transferred to the hospital by Emergency Medical Services (EMS). The EMS and hospital records noted resident #2 was very rigid with stiff extremities and core body temperature of 90.7 degrees Fahrenheit. The records indicated the resident displayed signs and symptoms of rigor mortis indicating the resident had been deceased for some time, before staff had identified the resident to be unresponsive and initiated CPR. On [DATE] at 2:41 PM, the Nursing Home Administrator (NHA) stated he was responsible for the monthly QAPI meetings with the Director of Nursing and the Medical Director. He said that all incidents such as neglect, falls and abuse were brought forth to the meetings. He noted the QAPI program was intended to look at any systemic breakdowns and trends.The NHA spoke about the incident when resident #2 was found unresponsive on [DATE]. He stated that witness statements were collected related to the CPR event and they were used to conduct an internal investigation. He explained the investigation was intended to ensure staff provided timely and effective CPR. The Administrator did not address any timelines of the event or conclusive times the resident was last cared for. He explained the investigation was not brought to QAPI because there were no concerns with staff performance during the code blue event where CPR was performed.Review of witness statements, hospital records, and staff interviews related to resident #2 being found deceased revealed inconsistencies with timelines, CPR recordings, documentation and false witness statements On [DATE] at 11:05 AM, the Medical Director confirmed he attended monthly QAPI meetings. He stated he reviewed resident #2's hospital record, which noted resident #2 had arrived at the hospital with stiff extremities, hyperthermia, and exhibited signs of rigor mortis. The Medical Director said he provided this information to the NHA and DON but did not participate in any QAPI meetings related to the incident nor inquired why the incident was not brought to QAPI.On [DATE] at 1:43 PM, the DON said she was aware resident #2's assigned Certified Nursing Assistant (CNA) had documented, resident #2 was not in the facility during the 3 PM to 11 PM shift on the evening of [DATE]. She did not explain why the CNA documented the resident was not in the facility. Interviews with other staff disclosed the CNA told them she did not provide care to resident #2 as she thought the resident was in the hospital. The Administrator and DON could not provide an explanation for how the facility's investigation demonstrated resident #2 received quality care and timely CPR when the hospital's findings noted the resident had been deceased for some time and was in rigor mortis. The Administrator did not explain how resident #2 was left unattended, died and was in rigor mortis without staff noticing. The Administrator said the facility received a text, alleging the 3 PM to 11 PM CNA had neglected resident #2 by not providing any care to her during the entire shift. The Administrator indicated he was aware of this text and the allegation of neglect on [DATE]. Although the NHA was aware of the neglect allegation, there was no QAPI meeting held to ensure identified concerns were addressed.

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	12/19/2025

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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a Compliance and Ethics Program. (continued on next page)

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	12/19/2025

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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all staff adhered to ethical practices and professional standards by providing inconsistent and misleading statements related to a resident's death in the facility, failed to provide high-level personnel oversight to ensure adherence to ethical standards, and failed to develop effective lines of communication to encourage immediate reporting of violations without fear of retaliation. These failures contributed to the inadequate investigation of resident #2's death. Findings:Cross Reference F600, F684, F610According to the facility's Compliance and Ethics Program policy revised [DATE], the facility is committed to compliance and has designated, implemented, and enforced a compliance and ethics program for promoting quality of care and preventing and detecting criminal, civil and administrative violations. The program's compliance guidelines included compliance activities such as monitoring, auditing, reporting systems, and data integrity. The facility would review the program annually with staff to improve performance in deterring, reducing and detecting violations and promote quality of care. Review of resident #2's medical record, revealed a progress note by Registered Nurse (RN) B dated [DATE] at 12:30 AM which read, was notified by the nurse to look at resident as she was unresponsive to sternal rub. Code blue initiated and 911 called, cardiopulmonary (CPR) performed until police and Emergency Medical Services (EMS) arrived. EMS arrived and transferred resident to (name of hospital). DON (Director of Nursing), on-call provider, and emergency contact were notified.According to the EMS report and hospital records dated [DATE], resident #2 had rigid extremities and hyperthermia consistent with prolonged time of death which indicated she had been deceased for some time prior to staff initiating CPR. The record indicated that facility staff told EMS resident #2 was last observed well by staff at 11:00 PM on [DATE].A discrepancy existed between the time staff reported to EMS resident #2 was last observed well and the time staff provided their witness statements and interviews. The 3-11 PM nurse reported she last saw resident #2 between 10:15 PM and 10:30 PM, however she did not assess resident #2 and the last set of vital signs were taken at 4:45 PM according to Licensed Practical Nurse (LPN) F's witness statement. Based on these findings it was unknown whether resident #2 was well or even observed at 11:00 PM.On [DATE] at 4:34 PM, LPN F, the 3 PM to 11 PM nurse, reported when she arrived for her shift, she did rounds and noted resident #2 was asleep. She obtained vital signs, which she stated were within normal limits, but documented them at 10:35 PM. LPN F confirmed she last saw resident #2 between 10:15 PM and 10:30 PM asleep and in no distress, however LPN F did not assess her to determine if she was even breathing. LPN F documented in the resident's chart at 10:35 PM that resident was alert and oriented X3, communicated verbally, and had warm skin. This documentation was inconsistent with LPN F's statement that she did not do an assessment on resident #2.On [DATE] at 5:33 PM, Certified Nursing Assistant (CNA) C was assigned to resident #2 from 3-11 PM. She said she checked on resident #2 three times during her shift, and she was asleep except when she emptied her urinary catheter bag and the resident opened her eyes slightly and smiled. CNA C's statement contradicted what she documented at 10:59 PM on [DATE] which noted the resident was unavailable for all care tasks throughout the shift including incontinence care. CNA C alleged she confused resident #2 with a resident next door who had been hospitalized for a few days, however the facility's Admissions and Discharges from [DATE] to [DATE], revealed the resident in the next room was at the facility and not in the hospital on [DATE].On [DATE] at 11:30 AM, and during a follow up interview, CNA G stated she arrived for her shift late at 11:30 PM on [DATE] and learned resident #2 was deceased . She said the resident was cold to the touch and her urinary catheter bag was full. CNA G said that during report CNA C revealed she had not provided care for resident #2 the whole shift as she thought the resident was in the hospital. She explained the Administrator and the DON told her to provide false witness statements or she would lose her job. On [DATE] at 2:09 PM, RN B was the assigned nurse for resident #2 from 11 PM to 7 AM on [DATE]. She stated LPN E assisted with rounds that night and stocked the tube feed supplies for resident #2. RN B said LPN E found resident unresponsive at around 12:00 AM. RN B said LPN E attempted a sternal rub on resident #2 to arouse her, however in a follow up interview she retracted her statement alleging LPN E never touched the resident. She maintained that other staff members did not assist with CPR but was unable to explain how she was able to dial 911 and call the DON while performing chest compressions. RN B noted CPR started at 12:25 AM, EMS report showed the call came in at 12:33 AM, the DON reported she received a call from RN B at 12:30 AM, and RN B documented in the resident's chart at