

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Seaside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 324 Wilder Blvd Daytona Beach, FL 32114	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48947</p> <p>Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to ensure that a resident who was unable to carry out activities of daily living, received necessary care and services to maintain good grooming and personal hygiene for one (Resident #25) of two residents reviewed for ADL care from 30 residents in the total survey sample.</p> <p>The findings include:</p> <p>On 8/19/24 at 11:44 AM, Resident #25's fingernails were observed to be long and soiled. (Photographic evidence obtained)</p> <p>On 8/21/24 at 3:23 PM, the resident's fingernails were observed to be long and soiled. When he was asked who usually cleaned and trimmed his fingernails, he replied, The girls take care of my nails. (Photographic evidence obtained)</p> <p>A review of the resident's medical record revealed diagnoses including, but not limited to, osteoarthritis, cataracts, major depressive disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>A review of the quarterly minimum data set (MDS) assessment, dated 7/30/24, revealed a brief interview for mental status (BIMS) score of 9 out of 15 possible points, indicating moderate cognitive impairment. The resident was also documented as dependent on staff for personal hygiene.</p> <p>A review of the resident's care plan (initiated 3/15/2024, revised 8/2/2024) revealed the following Focus Areas:</p> <p>Resident needs assistance with ADL (activities of daily living) care related to general weakness and impaired mobility. ADL needs and participation vary. Extensive assistance is required for transfers/toileting with increased incontinence noted. Intervention: ADL Care: the resident may need limited assistance x1 or x2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status.</p> <p>Impaired visual function related to cataracts, glaucoma. Has had surgery to the right eye but with little improvement to vision.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/21/24 at 3:27 PM, an interview was conducted with Certified Nursing Assistant (CNA) F. When she was asked who was responsible for the residents' fingernail care, she replied, We are, the CNAs, it's part of our daily care. She was asked to observe Resident #25's fingernails to determine whether he needed fingernail care. Upon observation of the resident's hands, she stated, Yes he does.</p> <p>On 8/21/24 at 3:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) G. When she was asked who was responsible for providing the residents' fingernail care, she replied, The CNAs do nailcare on the residents' shower days and as needed.</p> <p>A review of the facility's policy titled ADL Care and Services, Quality of Care (issued: 4/2020, revised 1/2024), revealed the following:</p> <p>Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Residents will be provided with care , treatment, and services to ensure that their activities of daily living(ADLs) are met. 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: <ol style="list-style-type: none"> a. hygiene (bathing, dressing, grooming, nail care and oral care) 		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28892</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one (Resident #51) of two residents sampled for respiratory therapy review, from 30 residents in the total survey sample, received oxygen according to their physician's order.</p> <p>The findings include:</p> <p>On 8/19/24 at 11:49 AM, an observation was made of Resident #51 with her oxygen flow rate set at 1.5 liters per minute (L/min). (Photographic evidence obtained) The resident reported that she was not physically capable of adjusting the oxygen concentrator flow rate.</p> <p>On 8/20/24 at 9:49 AM, another observation was made of Resident #51's oxygen concentrator. The oxygen flow rate was set at 1.5 L/min. (Photographic evidence obtained)</p> <p>On 8/21/24 at 3:41 PM, another observation was made of Resident #51's oxygen concentrator. The oxygen flow rate was set at 1.5 L/min. (Photographic evidence obtained)</p> <p>A review of Resident #51's medical record revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), hemiplegia affecting the left non-dominant side, cerebral infarction, epilepsy, schizoaffective disorder, hypertension, depressive disorder, anxiety disorder, and bipolar disorder.</p> <p>A review of the 6/25/24 Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. The resident was documented with upper and lower extremity impairment on one side. She was documented with shortness of breath. A quarterly MDS conducted on 3/26/24 documented the same information.</p> <p>A review of Resident #51's care plan revealed Focus Area for [NAME] for Altered Respiratory Status/Difficulty Breathing related to chronic obstructive pulmonary disease (COPD), at risk for respiratory complications, continuous oxygen (O2) via nasal cannula (NC). Date Initiated: 04/02/24. Revision: 06/28/24. The care plan goal documented the resident would maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rat/pattern through the review date. Date Initiated 04/02/24. Revision: 06/27/24. Care plan interventions included the following: Administer oxygen as ordered. Monitor O2 saturations as ordered and as needed. Change tubing per facility protocol/physician order and as needed. Notify physician as indicated. Date Initiated: 04/02/2024.</p> <p>A review of the resident's physician's orders revealed an active order for: Oxygen (O2) at two liters (L) via nasal cannula (NC) continuous, with a start date of 11/10/22.</p> <p>A review of the medication administration record (MAR) for August 2024 revealed O2 2L NC continuous every shift was documented as having been administered according to the physician's order.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled Oxygen Administration (Issued: 10/2019 and Revised 12/2023), revealed: Review the physician's order or facility protocol for oxygen administration and General Guidelines 1: Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or other device per physician't order.</p> <p>On 8/22/24 at 11:10 AM, an interview was conducted with Certified Nursing Assistant (CNA) A, who reported that she had worked at the facility for eight and a half years. She confirmed that Resident #51 had an order for oxygen at a flow rate of 2 L/min. The standard process for checking residents on oxygen was to conduct a visual check to ensure that the oxygen flow rate was set as ordered by the physician. She also noted that Resident #51 was not physically capable of adjusting the oxygen flow rate herself.</p> <p>On 8/22/24 at 11:44 AM, an interview was conducted with Licensed Practical Nurse (LPN) B, who reported that she was an agency nurse and had worked at the facility for three weeks. Her responsibility for residents' oxygen was to follow the physician's order to ensure the oxygen flow rate was set according to the physician's order. She reported that she checked the liter flow for all of her assigned residents receiving oxygen when she started her shift. If the flow rate was not set correctly, she would check the physician's order to see if the order had changed. LPN B could not recall Resident #51's oxygen order. She checked the electronic medical record for the resident and verified the physician's order for oxygen was for two liters per minute.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>48947</p> <p>Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to ensure that its residents had a means of directly contacting caregivers for one (Resident #13) of 30 residents in the total survey sample. The call bell must be placed in a way that makes it accessible to the resident while in their bed.</p> <p>The findings include:</p> <p>On 8/19/24 at 11:52 AM, Resident #13 was observed in bed. She was alert to her name and able to express her needs. She complained of left foot pain. She stated she informed the nurse that she was in pain. When she was asked if she knew how to get help if she needed it, she replied, Yes, I have a bell. When she was asked where her call bell was located, she tried to reach for it. It was observed to be out of her reach on the left side of the bed. (Photographic evidence obtained)</p> <p>On 8/21/24 at 10:39 AM, Resident #13 was observed in bed, alert and able to express pain on her left side, especially her left foot and ankle. On a pain scale of 1-10 with 10 being the highest level of pain, she described her pain as 15. She stated, I get pain medication every four hours, but I need something right now. I'm hurting. The resident's call bell was observed on the left side of her bed. She was unable to reach it. (Photographic evidence obtained)</p> <p>A review of Resident #13's medical record revealed diagnoses including hemiplegia/hemiparesis following cerebrovascular disease affecting the left non-dominant side, and contractures of the left elbow, left ankle, left hand, left wrist, and left shoulder.</p> <p>A review of her quarterly minimum data set (MDS) assessment, dated 7/2/2024, revealed she was able to make herself understood, and understand others. She had a brief interview for mental status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. No behavioral concerns were documented, and the resident was dependent on staff assistance for eating, bed mobility, transfers, toileting, and personal hygiene. She was noted as complaining of frequent pain at a level 10 on a scale of 1-10 with 10 being the most severe pain, that occasionally interfered with sleep. She was also noted as receiving hospice services.</p> <p>A review of the resident's care plan (initiated 4/3/2024, revised 7/3/2024) revealed the following Focus Areas:</p> <p>Hospice: admitted to service of [hospice provider name] related to coronary artery disease, CVA (cerebrovascular accident) left side effect. Resident is at risk for general decline. (initiated 9/21/2023, revised 7/3/2024)</p> <p>ADL/Self-Care Deficit: Needs assistance with all ADLs (activities of daily living). Prefers to stay in bed related to chronic pain.</p> <p>Resident has pain and/or is at risk for pain related to old CVA. Under care of [hospice provider name]. Resident presents with chronic pain, neuropathy, hemiplegia with associated pain to left side, pain left leg, ankle, arm. Continues with routine opioid pain medication.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the resident's physician's orders revealed that the resident was receiving Furosemide (diuretic) 20 mg (milligrams) by mouth daily (6/08/24 10:39 AM), Baclofen (muscle relaxer) 10 mg by mouth three times daily (1/26/22), Lexapro (antidepressant) 20 mg by mouth daily (1/27/22), Morphine Sulfate (narcotic pain medication) 5 mg by mouth every 4 hours for pain/DC Norco (narcotic pain medication) when morphine sulfate arrives (7/31/0224), DNR (do not resuscitate) (7/19/2028), Under care of [hospice provider name] for a diagnosis of CAD (Coronary Artery Disease) (4/8/2024), Monitor pain every shift (4/29/2017).</p> <p>On 8/21/24 at 10:43 AM, an interview was conducted with Housekeeper C. She was observed conversing with Resident #13. The housekeeper was asked about her conversation with the resident. She stated, She told me she was in pain. She was asked what she usually did when a resident told her that they were in pain. She stated, I tell the nurse. Housekeeper C was observed at the nurses' desk reporting Resident #13's complaint of pain at 10:46 AM.</p> <p>On 8/21/24 at 10:52 AM, Licensed Practical Nurse (LPN) E responded to the resident's complaint of pain. The nurse was asked if Resident #13 was able to use her left arm or hand. She stated, No, she had a stroke and has no use of her left side. The nurse was asked if the resident was able to reach her call light if she needed help. The nurse moved the call light from the left side of the bed where it had been since the surveyor entered the room, and stated, It's usually on her right side so she can use it.</p> <p>A review of the facility's policy titled Call lights, Quality of Care (issued: 03/2018, revised: 01/2024), revealed the following:</p> <p>Standard: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met.</p> <p>Guideline: Resident's call light is to be within reach and answered promptly by the facility personnel.</p>		