

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/14/2026
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.			
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an effective pest control program to ensure that the facility was free of pests. This failure affected the facility's kitchen, room [ROOM NUMBER] and the adjoining hallway. The findings include: 1. On 5/11/2026 at 10:50 AM, during the initial kitchen tour, two live insects were observed crawling behind the dishwasher machine near the water drainage pipe. (Photographic evidence obtained) On 5/13/2026 at 11:32 AM, during a follow-up tour of the kitchen, food items were being delivered by the vendor. The facility's back door remained open during the delivery. There was no device in place to help keep pests and flying insects from entering through the doorway into the kitchen. Flies and other flying insects were observed coming in through the open doors. On 5/13/2026 at 11:36 AM, holes were observed in the walls and ceiling near the food serving station. Holes were observed over the frame of the back door. Several potential pest entry points were observed over and behind kitchen equipment and service areas. (Photographic evidence obtained) On 5/13/2026 at 11:54 AM, during an interview with [NAME] D, he stated he had been employed at the facility for about 4-5yrs. There are issues with bugs. There isn't a bug zapper. He said he had never seen a bug zapper since he began working there. Flies and bugs come in through the back door, especially when we get deliveries because they (vendors) keep the door open. We try to keep the door closed and there is a sign to keep the door closed. There are no other procedures to keep them (pests) out; we just have to make sure the door stays closed. Staff are aware of this. On 5/13/2026 at 12:28 PM, a live roach was observed crawling on the metal serving station in the kitchen as food was being plated. (Photographic evidence obtained) There were four kitchen staff members present. The Dietary Director was present and assisting on the tray line by putting the plated meals on the carts for delivery to the nursing units. He used a napkin to grab the crawling roach from the serving station and discarded it into a nearby garbage can. 2. On 5/12/2026 at 10:00 AM, an interview was conducted with several residents in room [ROOM NUMBER] who complained of multiple roaches coming out at night in their room. On the same day at 10:30 AM, a live roach was observed crawling on a picture and went behind the picture in the hallway outside of room [ROOM NUMBER]. A review of the facility's pest control logbooks on 5/14/2026 at 2:45 PM, revealed reports from the Pest Control Provider as follows: (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/2/2026: Treated and inspected all interior areas, common areas, hallways, logbook, and treated room [ROOM NUMBER]. The kitchen was also treated. Need to fix baseboard tiles in kitchen to keep roaches from getting in behind. (Photographic evidence obtained) 2/12/2026: Pest control treated and inspected all common areas, kitchen areas, hallways, and inspected logbook. Rooms treated for roaches were #68, #66, #67, #32 and #40. The rooms need cleaning and sanitized to help with roaches and general pests. 2/20/2026: Pest control provider Inspected logbook and reported room [ROOM NUMBER] and #37 was treated for roaches, along with all common areas including kitchen. A note was included that doorways need grouting in the kitchen and must be fixed and sealed due to retaining water on floor. 4/17/2026: Pest control provider inspected the logbooks. Treated room [ROOM NUMBER] for roaches, and all common areas, dining areas, and kitchen. Broken tiles and baseboards need to be fixed and sealed in the kitchen. 5/12/2026: Baited rooms #64, # 68, # 63, # 62 for ants and roaches. Holes in walls and baseboards need to be fixed and sealed. On 5/14/2026 at 3:20 PM, an interview was conducted with the Maintenance Director and the Administrator. The Maintenance Director stated he had worked in the facility for six years and had two assistants. He reported that logbooks were checked daily the nursing stations. Logbooks were located at all nursing stations. Staff documented maintenance and pest issues and communicated with Maintenance staff. The facility had a long-standing contract with a pest control service who came to the facility twice a month and as needed. He stated there was a problem with gnats and flies, so he asked the pest service provider for recommendations/suggestions. We take the worst room and fix broken coves and baseboards. A contractor was hired for the kitchen who replaced broken tiles by the dish room and grouting was used for loose tiles. Some tiles were replaced in the kitchen 2-3 weeks ago. The Administrator stated he was working with the facility's corporate representatives regarding facility renovations and there was a plan. The renovations were usually done in phases due to expenses. The Administrator stated a roach was coming in the building in front of a surveyor and he killed it. All of the maintenance staff had caulking guns and frequently re-caulked holes, baseboards etc. The Administrator was advised of the observations of multiple places in the kitchen where tile was broken and open areas where pests could enter the facility. The Maintenance Director confirmed the areas observed and mentioned above needed repair.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, record review and a review of the facility's policies and procedures, the facility failed to ensure each resident a dignified experience and self-determination, by failing to ensure adequate communication interventions were available for one (Resident #38) of 30 residents whose care plans were reviewed. This failure contributed to Resident #38's expression of feeling ignored and forgotten by staff. The findings include: On 05/11/2026 at 12:37 PM, an observation of Resident #38's room revealed no communication board, dry erase board, iPad/tablet, or other communication aid present, despite the resident exhibiting difficulty verbally communicating. On 05/11/2026 at 12:37 PM, an interview with Resident #38 revealed he felt staff often could not understand him, making it difficult to communicate his needs. He further stated he felt ignored and forgotten by staff. On 05/13/2026 at 11:30 AM, a follow-up interview with Resident #38 revealed that in the past, he used an iPad tablet to communicate his needs with staff. When he was asked if he still had access to the iPad, he shook his head, no. When he was asked what happened to the iPad, he frustratedly shook his head no and was unable to answer. Resident #38 stated he was unable to write on the dry erase board in his room. A dry erase board was observed on his dresser without a dry erase marker present. (Photographic evidence obtained) On 05/13/2026 at 12:47 PM, a telephone interview with Resident #38's family member/representative revealed he had provided Resident #38 with an iPad mini (tablet device) to communicate with the staff. The family member stated this method of communication with staff was effective because it was difficult for Resident #38 to type on a smaller screen such as his cell phone. The family member stated the iPad worked well because the keyboard was large enough for him to easily type on. He stated Resident #38 had difficulty speaking and was unable to write. On 05/14/2026 at 12:39 PM, during an interview with Licensed Practical Nurse (LPN) C, she stated the resident had a dry erase board in his room. When she was asked if Resident #38 used the dry erase board to write messages to staff, LPN C replied, Well, it could be used for writing. On 5/14/2026 at 12:45 PM, during an interview with LPN A, she stated she was not aware that Resident #38 had an iPad or tablet for communication. She stated Resident #38 had a communication board and a dry erase board available for communication. LPN A stated the communication board contained pictures the resident could point to in order to communicate his needs, and the dry erase board allowed the resident to write messages. On the same day at 1:18 PM, LPN A stated a communication board had been placed in Resident #38's room. A review of Resident #38's medical record revealed an admission date of 09/19/2024 with diagnoses including hemiplegia/hemiparesis following cerebrovascular disease affecting the left non-dominant side, hereditary and idiopathic neuropathy and neurosyphilis (a potentially life-threatening complication of syphilis that occurs when the Treponema pallidum bacterium invades the central nervous system, affecting the brain and spinal cord). A review of Resident #38's Minimum Data Set (MDS) assessment, dated 03/27/2026, revealed he had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition, and required partial to moderate to total assistance with most activities of daily living. A review of Resident #38's active care plan revealed a focus area for Communication Problems related to slow, low-tone speech, which also stated, can type messages on iPad. The goal for this care plan focus area was to maintain the resident's current level of communication through the review date. The interventions included: use alternative communication tools as needed. A review of the facility's policy and procedure titled Resident Rights (issued: 9/2021, revised: 1/2024), revealed: Standard: A facility must . care for a resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Procedure: Federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the residents' right to: a. A dignified existence. Self-determination. Be supported by the facility in exercising his or her right to see. Retain and use personal possessions to the maximum extent that space and safety permit		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review, interview and a review of the facility's policies and procedures, the facility failed to ensure that a resident who was fed by enteral means received appropriate treatment and services to prevent complications of enteral feeding by failing to ensure that enteral nutrition was administered in accordance with the physician's orders for one (Resident #123) of two residents reviewed for enteral nutrition services from a total of three residents receiving enteral nutrition. Resident #123 was ordered an enteral nutritional formula to be administered at 65 ml per hour and instead was receiving her enteral nutrition at 75 ml per hour. This increases the risk of gastrointestinal discomfort and stomach-emptying delays, which could lead to aspiration pneumonia. The findings include: On 5/12/2026 at 12:04 PM, an observation of Resident #123 revealed that her enteral nutrition bag hanging at bedside was labeled for administration at 75 milliliters (mL) per hour. (Photographic evidence obtained) On 5/13/2026 at 11:25 AM, a follow-up observation of Resident #123 revealed that a new enteral nutrition bag hanging at bedside was labeled for administration at 75 ml per hour. (Photographic evidence obtained) A review of Resident #123's medical record revealed an admission date of 2/21/2017 and diagnoses including anoxic brain damage, gastrostomy status, gastroesophageal reflux disease, and aphasia. A review of Resident #123's active physician's orders revealed an active order for: Enteral feed, three times a day via Percutaneous Endoscopic Gastrostomy (PEG) (feeding tube) Jevity 1.5 @ 65 ml/hr. (milliliters per hour) until total daily volume (1300 ml) is infused. The order had a start date of 4/22/2026 at 1:00 PM. (Photographic evidence obtained) On 5/14/2026 at 11:45 AM, an interview with Licensed Practical Nurse (LPN) C revealed that Resident #123 was nonverbal, received enteral nutrition via a feeding tube, and was totally dependent on staff for activities of daily living (ADL) care. LPN C stated the nurse was responsible for monitoring, setting, administering, and labeling the enteral nutrition for all residents receiving enteral nutrition services. LPN C stated she knew the frequency and the amount of enteral nutrition to administer based on the physician's orders in residents' electronic health record. When she was asked the rate Resident #123 was supposed to receive, she replied, 65 ml per hour. On the same day at 11:55 AM, LPN C was accompanied to the resident's room, where she acknowledged that Resident #123's enteral nutrition was labeled for administration at 75 ml per hour. A review of the facility's policy and procedure titled Physician's Orders (effective: 10/2020, revised 01/2024), revealed: Guideline: Orders and administration of medications and treatments will be consistent with principles of safe and effective order writing. Procedure: 9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, staff interview and a review of the facility's policies and procedures, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice for one (Resident #145) of one resident reviewed for respiratory care from a total survey sample of 40 residents. The facility failed to obtain a physician's order for oxygen prior to its administration, and Resident #145's oxygen flow rate was inconsistent with what the physician stated in his 5/8/2026 progress note and what LPN B stated during a 5/13/2026 interview. The findings include: On 5/12/2026 at 10:09 AM, an observation was made of Resident #145 in bed wearing a nasal cannula with oxygen infusing. His oxygen concentrator was set at a flow rate of 2.5 liters per minute (LPM). (Photographic evidence obtained) On 5/13/2026 at 11:33 AM, a follow-up observation was made of Resident #145 in bed wearing his nasal cannula with oxygen infusing. His oxygen concentrator was set at a flow rate of 2.5 LPM. (Photographic evidence obtained) On 5/13/2026 at 2:31 PM, an interview with Licensed Practical Nurse (LPN) B revealed that physician's orders for a resident's oxygen could be found in the resident's electronic medical record (EMR) under the Orders section. LPN B stated Resident #145's oxygen was supposed to be set at a flow rate of 2.0 LPM. When she was asked to verify the physician's order in the resident's EMR, she stated there was no oxygen order in Resident #145's EMR. She confirmed that the resident's physician had spoken to her about Resident #145 and advised her to begin weaning him off of his 2.0 LPM supplemental oxygen. On the same day at 2:53 PM, LPN B was accompanied to Resident #145's room and she verified that the resident was receiving oxygen without a physician's order. On 5/13/2026, a review of Resident #145's medical record revealed an admission date of 10/3/2024 and diagnoses including congenital tracheomalacia (condition present at birth making it difficult to breathe), extrapyramidal and movement disorder (involuntary movement). Further review of Resident #145's record revealed a progress note dated 5/8/2026 at 11:53 PM, which read, Pulmonary medicine was consulted due to recent acute, hypoxic respiratory failure. The patient is being worked up by the primary team for the underlying etiology of respiratory failure. He has had two chest x-rays that were reportedly clear; however, the most recent chest x-ray shows worsening diffuse opacities, concerning for pneumonia versus pulmonary edema (excess fluid in the lungs making it difficult to breathe). His lab workup showed mild leukocytosis (elevated level of white blood cells), as well as mild hypercarbia (abnormally high level of carbon dioxide in the blood). There is suspicion of aspiration (accidental inhalation), and of significance, there is mention of tracheomalacia in his EMR (electronic medical record), although the extent is unclear. The patient was seen and examined lying in bed. He was on 2 L nasal cannula. His upper breath sounds were clear, diminished at the bases. No overt edema appreciated in his lower extremities. The case was discussed with the primary APRN (advanced practice registered nurse). Will follow along closely as well. His last oxygen saturation was 96%. Discussed with the bedside nurse that it is okay to wean off the supplemental O2 as long as his threshold is greater than 92%. After discussing with the nurse, it sounds that the patient is moving in the right direction. A review of Resident #145's physician's orders revealed an active order for oxygen: Respiratory-Oxygen: NC (nasal cannula)/Mask Continuous. Encourage and assist resident to use O2 (oxygen) @ 2 Liters via NC continuously for hypoxia (inadequate oxygen). The start date recorded for this order was 5/14/2026 at 3:00 PM, after the observations of Resident #145 receiving oxygen at 2.5 LPM on 5/12/2026 and 5/13/2026. No orders for oxygen were found in the medical record prior to 5/14/2026. A review of the facility's policy and procedure titled Oxygen Administration (effective: 10/209, revised: 12/2023), revealed: Standard: The purpose of this procedure is to provide guidelines for oxygen administration. Procedure: 1. Review the physician's order for oxygen administration. General Guidelines: 1. Oxygen is administered per physician's orders. A review of the facility's policy and procedure titled Physician Orders (effective: 10/2020, revised: 01/2024), revealed: Guideline: Orders and administration of medications and treatments will be consistent with (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	principles of safe and effective order writing.Procedure:1.Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state as soon as practicable.3.Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's electronic chart.5.Verbal orders should be recorded in the resident's chart by the authorized person receiving the order and should include the prescriber's name, credentials, the date and the time of the order.8.Orders for medications should include: a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed.		