STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105399	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea Breeze Rehab and Nursing Center	3663 15th Ave Vero Beach, FL 32960

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on the facility shower schedule, record review and interview, the facility failed to honor the shower preferences and schedules for 2 of 7 sampled residents reviewed for choices, Resident #14 and #48. The findings included: 1. Review of the shower schedule revealed Resident #14 was scheduled to receive a shower on the 7 AM to 3 PM shift on Tuesdays and Fridays. A second shower schedule by room number confirmed those days and time. Review of the record revealed Resident #14 was admitted to the facility on [DATE] and moved into his current room on 07/03/24. Review of the most currently completed Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a scale of 0 to 15, indicating the resident was cognitively intact. Review of the most recently completed comprehensive assessment revealed the resident had a lower BIMS of 05, indicating cognitive confusion, but still reported the choice between a bath and a shower was somewhat important. Review of the current care plan initiated on 03/20/24 documented Resident #14 had a self-care deficit and needed limited to extensive assistance of 1 to 2 persons for bathing, dependent upon resident fatigue, weight bearing, and weakness. Review of the Certified Nursing Assistant's (CNA's) documentation in the record revealed in the past thirty days, Resident #14 had received a shower only on 12/16/24, 12/18/24, and 01/03/25. The record lacked any documented refusals for showers. During an interview on 01/06/25 at 10:23 AM, when asked if he was getting baths and or showers as he would like, Resident #14 stated he might get a shower once a month. When asked how many showers he would like, he stated at least a couple a month, but could not quantify any further. When asked if he was aware of any shower schedule, Resident #14 stated he was not. (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
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 01/08/25 at 3:05 PM, when asked the process for resident showers, Staff C, Certified Nursing Assistant (CNA) who worked with Resident #14, stated the computer tells her which resident is due on which day. When asked how she documented the provision of showers for each resident, the CNA stated she puts it in the computer, and further volunteered that if a resident refused a shower, she would document that as well. During a side-by-side record review and interview on 01/08/25 at 4:15 PM, the Director of Nursing (DON) agreed with the lack of documented showers or refusals. 2. Review of the shower schedule revealed Resident #48 was scheduled on the 3 PM to 11 PM shift on Tuesdays and Thursdays. A second shower schedule by room number confirmed those days and time. Review of the record revealed Resident #48 was admitted to the facility on [DATE] and moved into his current room on 12/18/24. Review of the current comprehensive MDS assessment dated [DATE] revealed the resident had a BIMS score of 15, indicating he was cognitively intact. This same MDS documented it was very important for the resident to choose between a bath and a shower. Review of the CNA's documentation in the record, revealed in the past thirty days, Resident #48 did not receive any showers and had not refused any showers. During an interview on 01/06/25 at 2:32 PM, Resident #48 stated he has only had one shower since November (2024). When asked how many showers he would like, Resident #48 stated he would like 2 or 3 a week. When asked if he had spoken with anyone about his showers, Resident #48 stated he spoke with two nurses and some of the CNAs since his move into his current room, and they tell him, It's not your shower day. When asked what his shower days were, the resident stated he was unaware of his shower schedule since moving into his current room, but that it had been on Tuesdays and Thursdays previously. Resident #48 stated he did not care which days, he just wanted showers. During an interview on 01/08/25 at 2:31 PM, Staff D, CNA, confirmed she had worked a double shift the previous day (Tuesday), working from 7 AM to 11 PM. When asked how she knew who to give a shower to, the CNA stated the nurse tells her at the beginning of the shift. When asked if she gave anyone a shower yesterday, the CNA named a resident who was not Resident #48 for her morning shift. When asked if she gave any showers on the 3 PM to 11 PM shift, she stated she had not. When asked if she knew that Resident #48 was scheduled to have a shower Tuesday on the 3 PM to 11 PM shift, the CNA stated she did not know, and further stated she did not offer one because she gave him a full bed bath that morning. The CNA confirmed she documented both the provision or refusal of showers in the computer. During a side-by-side record review and interview on 01/08/25 at 4:12 PM, the DON agreed with the lack of documented showers and refusals in the record.

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NAME OF PROVIDER OR SUPPLIER Sea Breeze Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3663 15th Ave Vero Beach, FL 32960	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on observation and interview, the facility failed to provide a safe, clean comfortable homelike environment for 1 of 2 units, Unit B. The findings included: Observations on 01/06/25, 01/07/25, and 01/08/25 revealed the following: a. On 01/08/at 9:30 AM: room [ROOM NUMBER]- the IV pole was rusted at base of pole. b. On 01/06/25 at 11:00 AM: room [ROOM NUMBER]A - During an interview with the resident's spouse on 01/06/25 at 11:00 AM, she stated that the chairs in the sitting room next to nurses station are disgusting. She showed surveyor the pictures of the chairs and stated this was from when he first came. She said she told someone but nothing has been done. She stated she was in the sitting room on 12/30/24 and 12/31/24, pulled up the cushion and observed trash and stained seats for 2 of the chairs in the room. The surveyor observed the spouse's concerns via observation on 01/06/25 at 2:20 PM and 01/07/25 at 7:15 AM. The couch had debris underneath the cushions as well as a paperback book that was folded up. c. On 01/07/25 at 12:22 PM: room [ROOM NUMBER] - the bathroom door squeaks. d. On 01/06/25 at 11:24 AM: room [ROOM NUMBER] - A The top of the bed-side table was stained with a white substance and the IV pole was rusted. e. On 01/07/25 at 9:17 AM: room [ROOM NUMBER] - the black caulking around the base of the toilet in the bathroom was coming away from the base and had debris in the gap. The remote control was frayed. The call light cord in the bathroom was wrapped around the handrail and unable to be pulled. f. On 01/08/25 at 9:00 AM: room [ROOM NUMBER]-B - the privacy curtain between beds A & B was stained with a brown substance. During a facility tour on 01/08/25 at 9:02 AM with the Director of Maintenance, he acknowledged the findings. He stated in room [ROOM NUMBER], the black caulking is the normal color to match the floors; and the call light in the bathroom hangs on the floor when unwrapped and would get a different cord. Photographic Evidence Obtained of the above findings.

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39167

Based on policy review, interview and record review, the facility failed to respond to a verbal grievance regarding missing personal items for 1 of 1 voiced grievance, affecting Resident #13.

The findings included:

Review of the policy, titled, Grievance-resident rights, dated 7/2024, indicated the administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Any resident, family member or appointed resident representative may file a grievance or complaint concerning the care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to verbally and/or in writing upon request including a rationale for the response. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a report of such findings to the administrator within five working days of receiving the grievance and/or complaint. In the event the facility investigation exceeds five working days, the resident/responsible party will be notified. The resident, or person filing the grievance and /or in writing as per request of the findings of the investigation and the actions that will be taken to correct any identified problems. The administrator, or his or her designee, will make such reports orally within 10 working days of the filing of the grievance or complaint with the facility.

Record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses that included Depression. Review of the admission Minimum Data Set (MDS) assessment, reference date 11/07/24, recorded a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #13 was cognitively intact. This MDS recorded no mood or behavior concern.

On 01/07/25 at 9:25 AM, an interview was conducted with Resident #13, who voiced that when she sends her clothes to the laundry, she doesn't get them back, she was missing 8 dresses, and 3 skirts, and the facility is aware of the missing clothes, and they haven't replaced or reimbursed her for the clothes.

On 01/09/24 at 9:21 AM, an interview was held with the Director Of Nursing (DON), who acknowledged she was shocked when they informed her the resident reported missing clothes. The DON revealed Resident #13 comes to her office every day and never mentioned anything regarding missing items to her.

At 9:23 AM, the DON and surveyor spoke with Resident #13 together. The resident confirmed that she told the previous Social Worker, and the CNAs about her missing clothes including 8 dresses and 3 skirts. She described the items to the DON. The DON voiced she did not have a grievance for missing clothes for Resident #13, but she would start one today. She also asked the laundry staff to start looking for the missing clothes.

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	105399	A. Building B. Wing	01/09/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25404

Based on observation, record review, and interview, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 3 of 23 sampled residents, as evidenced by improperly coding Resident #14 as comatose, inaccurate dental status for Residents #82 and 87, and an inaccurate hearing status for Resident #87.

The findings included:

1. Review of the record revealed Resident #14 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE], completed for a significant change in status, documented Resident #14 was comatose. Further review of the record lacked any evidence of a comatose status.

Resident #14 was interviewed on 01/06/25 at 10:18 AM, who volunteered an extensive medical history, with no mention of any comatose status.

During an interview on 01/09/25 at 11:50 AM, Staff B, MDS Coordinator, was made aware of the comatose coding. The MDS Coordinator explained that section of the MDS was completed by the previous Social Service Director (SSD), who was no longer employed at the facility. The MDS Coordinator stated they did not have a current SSD so she would look into the coding for Resident #14, as she was fairly new to the facility.

During a subsequent interview on 01/09/25 at 2:03 PM, Staff B stated the correction for the comatose status had been completed, and that she believed the significant change MDS was done related to a small bowel obstruction that may have affected his activities of daily living.

2. Review of the record revealed Resident #82 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 13, on a 0 to 15 scale, indicating he was cognitively intact. Review of the comprehensive admission assessment dated [DATE] documented Resident #82 had some natural teeth, as evidenced by a no answer to the question of is the resident edentulous (without natural teeth or tooth fragments).

Further review of the admission and readmission nursing assessments for Resident #82 documented on 08/06/24 that he had natural teeth, on 08/17/24 he had natural teeth, and on 09/30/24 that he was edentulous.

During an interview on 01/07/25 at 9:41 AM, when asked if he had any dental concerns, Resident #82 showed the surveyor three metal posts in his mouth and stated he had not had his implants for a long time. An observation revealed the resident did not have any teeth.

During an interview on 01/09/25 at 12:13 PM, Staff B was made aware of the observation of no teeth for Resident #82 compared to the MDS assessment. The MDS Coordinator stated she would do an assessment.

(continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent interview on 01/09/25 at 2:04 PM, Staff B confirmed the resident's edentulous status, and agreed with the inaccurate MDS assessment. 33103 3. Review of Resident #87 medical record revealed she was admitted to the facility on [DATE] with a diagnosis to include Wedge Compression Fracture, Rhabdomyolysis, Muscle Weakness and Abnormalities of Gait and Mobility. Review of the [Company Name] Admission Nursing Evaluation dated 10/16/24 asks the question Does the resident have impaired hearing answer is marked yes, no auditory aides. Review of the Admission MDS (Minimum Data Set) dated 10/19/24 documented under section B for hearing that she has adequate hearing. Review of Section L for Dental, letter B the question asked, No natural teeth or tooth fragment(s) (edentulous Yes, or No? It is marked No. Review of the resident's care plan for dental documented has no natural teeth (Edentulous). During observations and attempted interview of Resident #87 on 01/06/25 at 2:08 PM, Resident #87 stated she couldn't hear in left ear, she is deaf and in the right ear she can only hear if a person is speaking directly into her ear. Further observation of Resident #87 revealed she had no teeth. During an interview on 01/08/25 at 12:37 PM withStaff B, MDS Coordinator, she was asked to review Resident #87's MDS for hearing and dental section. She was asked what the MDS has documented. She said for hearing it documents she has adequate hearing and for Dental it shows the answer No for not having any teeth. She reviewed her medical record and stated Section B should be difficulty hearing and dental section should be a yes under letter B. On 01/08/25 at 1:30 PM Staff B, MDS Coordinator, stated to the surveyor that she evaluated the resident, and she has moderate hearing issues.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on observation, record review and interview, the facility failed to develop and implement care plans for 2 of 23 sampled residents reviewed, Residents #87 and #15, as evidenced by lack of care plans related to hearing for Resident #87 and lack of care plans relating to self-administration of medication for Resident #15. The findings included: 1. Review of Resident #87's record revealed she was admitted to the facility on [DATE] with a diagnosis to include Wedge Compression Fracture, Rhabdomyolysis, Muscle Weakness and Abnormalities of Gait and Mobility. Review of the [Company Name] Admission Nursing Evaluation dated 10/16/24 asks the question Does the resident have impaired hearing, and the answer was marked yes, no auditory aides. Review of Resident #87 care plan revealed that this resident did not have a care plan related to her hearing concerns. During observations and attempted interview with Resident #87 on 01/06/25 at 2:08 PM, the resident stated she can't hear in left ear, she is deaf and in the right ear, she can only hear if a person is speaking directly into her ear. An interview was conducted on 01/08/25 at 12:37 PM with Staff B, Minimum Data Set (MDS) Coordinator, who was asked to locate this resident electronic records. She acknowledged that there should be a care plan for hearing but there was not. On 01/08/25 at 1:30 PM Staff B, the MDS Coordinator stated to the surveyor that she evaluated the resident, and she has moderate hearing issues. 25404 2. Review of the policy, titled, Medication Administration, revised 01/2024, documented, in part, Procedure: . 21. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. On 01/09/25 at 2:39 PM, when asked to locate and provide a policy specifically related to the self-administration of medication assessment and or the process, the Regional Clinical Consultant stated there was none. Review of the record revealed Resident #15 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating she was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physiciains' orders documented as of 09/25/24 that Resident #15 could take 2 capsules of Creon, an enzyme replacement for the digestion of fats, proteins, and sugars, unsupervised, four times a day for pancreatitis (inflammation of the pancreas). Further review of the record lacked any self-administration of medication assessment, care plan, or progress note for the Creon. Review of the current January 2025 Medication Administration Record (MAR) revealed the nurses documented U-SA (unknown - self administration), daily at 9 AM, 1 PM, 5 PM, and 9 PM. The record had two previous orders for the Creon, dating back to the resident's admission to the facility, that not indicate the resident could self-administrate the medication. During an observation and interview on 01/07/25 at 12:23 PM, a nearly full bottle of 225 Creon capsules was noted on the resident's over-the-bed table. When asked about the medication, Resident #15 explained she wanted to have the medication at the bedside because, I need to take one anytime I eat. I can't wait for the nurses to bring it to me. Resident #15 became defensive, so the conversation was dropped at that time. During a follow up observation and interview on 01/08/25 at 11:46 AM, when asked further about how many capsules and how often she takes the Creon, Resident #15 explained she took two tablets with each meal and two with each snack, Just like the label says. Observation revealed the label documented, Take two capsules every day with each meal (three meals) and two capsules with each snack (two snacks per day). Photographic Evidence Obtained. During an interview on 01/08/25 at 11:56 AM, when asked the process and or the needed assessment for a resident who wants to self-administer a medication, Staff A, direct care Licensed Practical Nurse (LPN), for Resident #15 stated, I think the doctor just writes an order. I'm not really sure. During an interview on 01/08/25 at 11:59 AM, when asked the process and or the needed assessment for a resident who wants to self-administer a medication, the B-Unit Manager explained the need for an assessment and to watch the resident take the medication. When asked where the assessment was located for Resident #15, the Unit Manager stated under the assessment tab in the electronic medical record (EMR). When asked to locate and provide the assessment, the B-Unit Manager reviewed the EMR and stated, I don't see it. During an interview on 01/09/25 at 2:22 PM, when shown a paper document provided to the surveyor by the medical records person, the B-Unit Manager explained she did the assessment upon the resident's admission to the facility because the resident and daughter wanted Resident #15 to be able to take her medication as she needed. The B-Unit Manager stated she went into the resident's room, assessed her for the medication, and stated the resident was ok to self-administer. During a side-by-side review of the form, with an effective date of 06/25/24, the B-Unit Manager agreed it lacked who completed the form, the medication that was to be self-administered, and any evidence of IDT participation. The B-Unit Manager stated she would usually do an iPOC (interactive plan of care) note with the staff signatures for evidence of IDT participation in the process. The B-Unit Manager was unable to locate any iPOC note. When asked why she completed the form on paper instead of in the EMR, the B-Unit Manager stated she was having computer problems that day, was running late, and needed to leave the facility, so she did it on paper and sent it to medical records to be scanned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/25 at 2:31 PM, when asked about the process and care planning for a resident who wished to self-administer a medication, the Regional Clinical Consultant explained after a nursing assessment, it would be brought to care planning with the IDT for discussion and decision, and then care planned.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39167 Based on interview and record review, the facility failed to ensure narcotic removal was recorded in the medication administration records (MARs) for 3 of 6 sampled residents reviewed, Residents # 28, # 6 and #9. The findings included: 1. On 01/07/25 at 11:24 AM, medication storage observations were started at the B-unit. Resident # 28's medication records were selected for review. It was revealed Resident #28 had a physician order of Oxycodone HCl Oral Tablet to give 15 mg via peg-tube every 4 hours as needed for moderate-severe chronic pain. Review of the January 2025 medication and treatment administration records (MARs and TARs) were compared against the medication monitoring control record. There was a discrepancy between these records. The medication monitoring control record indicated the medication was removed twice on 01/03/25 at 10:57 AM and 3:36 PM Review of the MARs had no documentation and were not signed for the removal on 01/03/25 at 10:57 AM and administration to the resident. 2. On 01/07/25 at 12:12 PM, medication storage observation commenced at the A-unit. Resident #6's medication records was selected for review. It was revealed there was a physician order for Oxycodone Acetaminophen 5-325 MG 1 tablet every 4 hours as needed for non-acute pain. Review of the January 2025 MARs and TARs were compared against the medication monitoring control record. There was a discrepancy between the records. The medication monitoring control record indicated the medication was removed from the lock box on the following dates: January 4th, at 6:39 AM, 10:39 AM, 2:30 PM, 6:30 PM and 11:00 PM. Review of the MARs had no documentation and were not signed for the removal on January 4th at 6:30 PM and administration to the resident. 3. Record review revealed Resident #9 had a physician order of Hydrocodone-Acetaminophen Oral Tablet 5-325 MG give 1 tablet by mouth every 4 hours as needed for non-acute pain. Review of the January 2025 MARs and TARs were compared against the medication monitoring control record. There was discrepancy between the records. The medication monitoring control record recorded the medication was removed from the lock box on the following dates: January 1st at 8:15 PM, January 2nd at 5:30 PM, January 3rd at 8:29 PM, January 4th at 2:15 PM, 8 PM, 6 PM, 10 PM, January 5th at 9 AM, 12 noon, and 10 PM, January 6th at 6:26 PM, and January 7th at 7:16 PM. Review of the MARs/TARs lacked documented evidence for the removal of the medication on January 1st at 8:15 PM and administration to the resident. On 01/09/24 at 8:54 AM an interview and side-by-side review of the residents' medication records was conducted with the Director Of Nursing (DON). She acknowledged the lack of documentation for the narcotic removal.