Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969133	A. BUILDING: _____ B. WING _____	R-C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE SENIOR LIVING	699 N DIXIE FREEWAY NEW SMYRNA BEACH, FL 32168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to the change of ownership survey was conducted at Seashore Senior Living on /2023. Deficient practice was identified at the time of the visit.	{A 000}		
{A 036}	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide services in a manner that reduced the risk of transmission of	{A 036}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 036}	Continued From page 1 . . . . . Direct care staff failed to use appropriate personal protective equipment (PPE) when providing care to a resident on transmission based precautions for (. .), placing all residents receiving subsequent care at risk for further transmission. The findings include: Review of the facility policy and procedure entitled Universal Precautions H-105 revealed it read: Purpose: To prevent the spread of from one resident to another. To protect staff from . To prevent the transfer of communicable . . . . . To prevent the spread of . . C. Advanced Procedures: Once the facility has been instructed by physician that Personal Protective Equipment (PPE) is needed to help prevent the spread of . . . . the following procedure will be implemented. 1. Use appropriate PPE. 2. Do not wear PPE outside of isolation area. 4. After PPE is used it must be placed in the bio hazardous waste basket in Resident room before exiting apartment. Use safe work practices to protect yourself and limit the spread of contamination. Keep away from . . . , limit surfaces touched, change gloves when torn or heavily contaminated, perform hygiene. How to safely remove personal protective equipment. Gloves: Outside of gloves are contaminated! Gown: The gown front and sleeves are contaminated! Fold or roll into a . . . . and discard in a waste container. 5. Wash or use an -based sanitizer immediately after removing all PPE. During an interview on at 10:18 am the housekeeping staff member, Employee D, did not know of any residents currently in isolation. On at 10:25 am, Resident #1's door	{A 036}		

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{A 036}	Continued From page 2 was open. A hospice certified nursing assistant (CNA) was observed with PPE on, and she stated the resident had . . . . She confirmed Resident #1 was in the room with her and he had had an episode of . . . . . she was cleaning up after. An observation was made at the time of the interview, showing the room door had no signage to indicate the resident was in transmission-base precautions (TBP). No PPE apron was hanging on the door. No PPE bins were located outside the room in the hallway, and there was no PPE seen for staff to use when assisting Resident #1. At 10:29 am on , the facility medication technician/caregiver on duty, Employee A, was observed down the hall at the medication cart. She confirmed Resident #1 had . She was observed to be taking a blue PPE gown out of the medication cart. At 10:32 am on . . . . . , Resident #1's door was ajar and the CNA from hospice was observed at the doorway getting items from her bag. She confirmed that Employee A was still in the room with her. She moved the door open wider and Employee A was observed standing in the living room area of the apartment holding a blue PPE gown. She had not donned the gown prior to entering the apartment. She had no other PPE on. She then stated she knew that she needed to don the PPE prior to entering the resident's room. She proceeded to exit the room and don the gown. At 11:50 am on . . . . . , when asked again about Resident #1, Employee D, housekeeper, stated Resident #1 is in isolation. She did know what PPE to use or how to use it, or where to get it when she needed to clean his room. She stated that she could get PPE from the Administrative	{A 036}		

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{A 036}	Continued From page 3 office on the first floor. During an interview on at 2:19 pm with Resident #1's hospice nurse, she confirmed that Resident #1 was in isolation for . Contact precautions were in place. During an interview with Employee A on at 3:20 pm, she stated she confirmed that she did not have PPE on yesterday morning when she entered Resident #1's room. She knew the resident has . Review of Resident #1's record revealed he was admitted on . He was transferred to a higher level of care on and returned . His 1823 health assessment form dated revealed he had diagnoses of of the right and , type II, 's , and . He required one staff for activities of daily living (ADLs). He was independent with eating but required assistance with all other ADLs. He also needed assistance with medication self-administration. Review of the hospice note dated revealed he was on contact isolation due to , and needed evaluation for increased and . On at 3:50 pm, the Administrator and the Health and Wellness Supervisor both acknowledged that the staff were to be wearing PPE when they entered Resident #1's room to provide direct care to him. The Administrator stated that there should have been signage on the door and PPE available outside the room at	{A 036}		

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{A 036}	Continued From page 4 all times. Class III	{A 036}		