

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/04/2026
NAME OF PROVIDER OR SUPPLIER Shores Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 220 Ninth Street Port Saint Joe, FL 32456	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and policy review, the facility failed to provide an environment that is free of offensive odors and failed to maintain a sanitary and clean environment in 7 of 15 rooms on the 300 unit and 8 of 15 rooms on the 400 unit. (Rooms identified are 341, 342, 348, 352, 353, 354, 355, 456, 461, 464, 466, 467, 468, 469, 470, including the patio outside the 400 unit.) The findings include: On 4/29/26 upon entrance to the facility, a strong, pungent urine-like smell was noted. The smell of urine was present throughout the facility but noted to be stronger on the 200, 300, and 400 halls. On 4/29/26 at 10:30 AM, upon entry into the facility and while observing the clinical nursing units, a strong odor of urine was noted. At 10:40 AM an observational tour was conducted on unit 300 and 400 nursing units, where a strong odor of urine was noted. The 300-unit hallway observation revealed torn flooring, food particles, and a butter knife laying in the floor in the hallway. room [ROOM NUMBER] had a straw and multiple food particles lying on the floor and broken blinds on the window. The bathroom had a dark brown color stain on the wall, rusted ceiling tile trim, the toilet has a brownish like substance inside of it, and the floor surrounding the toilet appears wet. No trim was observed around the base of the toilet, exposing a black mold like substance. Corrosion was observed on the sink faucet handles and surrounding area and appears to be leaking at the base of the faucet. There were rusted pipes under the sink with a buildup of corrosion. A rusted sprinkler head was observed in the bathroom. The door facing was rusted and scrape marks were noted on the door jambs, with paint peeling. room [ROOM NUMBER] had a three in one toilet with duct tape noted on the front of it, rusted and corroded pipes under the sink. The door was observed with scuff marks and paint peeling exposing the wood of the door. A black substance that has a mold-like appearance was observed on the bathroom walls. room [ROOM NUMBER] had corrosion on the fixture above the toilet that is brown and blackish in color. A black substance was observed on the bathroom walls. room [ROOM NUMBER] had no cover on the outlet with an oxygen concentrator plugged into the wall. room [ROOM NUMBER] had boards covering the window in the room. room [ROOM NUMBER] and 354 had no coverings on the lights over the bed with sockets exposed. One light fixture had only one light bulb. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]'s resident bed appeared dirty with a black substance noted on the foot of the bed, room [ROOM NUMBER] had a broken cover on the outlet, the dresser drawer facing is sitting on the floor next to the dresser, bathroom fixture above the toilet had a brown substance on it and on the wall below it. room [ROOM NUMBER] had dark colored areas along the side of the wall by the toilet, chipped paint on the wall, and, on the opposite side of the wall in the bathroom, there was scattered black substances on the wall and baseboard trim. An observational tour of the 400-unit hallway revealed: Upon entry through the locked unit doors, a strong odor of urine was noted. room [ROOM NUMBER] bathroom had a missing ceiling tile, broken emergency light covers with no pull string, and the toilet cover does not fit over the back of toilet tank. room [ROOM NUMBER]'s toilet tank cover did not fit properly, exposing the inside of the tank. room [ROOM NUMBER] was observed with torn toilet paper and used briefs lying in the corner of the bathroom floor. room [ROOM NUMBER] was observed with what appeared to be a brown rust- like substance inside the toilet bowl. The bathroom door facing appeared cracked with a brown substance noted along the side. In rooms [ROOM NUMBER], the bathroom toilets appeared to have a brownish blackish substance build up surrounding the bases of toilet with broken, peeling trim. room [ROOM NUMBER]'s light base on the wall appeared to have a rust-like appearance on the light fixture base attached to the wall, broken blinds observed on the windows in multiple rooms, and no outlet cover observed in room with cords plugged into the wall. room [ROOM NUMBER] appeared to have a reddish-brown substance on the wall, and broken blinds in the room. room [ROOM NUMBER] and 470 had no blinds covering windows, beds were unmade, no outlet covers were covering exposed wire coming from the wall. The toilet had a dark brown blackish color ring around the base and flooring, uncovered light fixture on wall above the television. room [ROOM NUMBER]'s bathroom sink appeared to be leaking and the pipes connecting to had a rusted like appearance. room [ROOM NUMBER] had loose flooring in the room, the toilet had a loose cover on the tank and a brown rust like stain substance inside the toilet base with the toilet seat being loose and sitting crooked on the toilet. A dry red substance was noted on the door frame leading into the bathroom. Observation of units made on 4/29/26, 4/30/26, 5/1/26, and 5/2/26 with the same results listed above. (photographic evidence obtained) On 4/30/26 at 10:00 AM the Administrator came to the locked unit; she entered the code into the keypad and walked down the outside patio walkway. She stated there was a pad lock on the gate in the back because the gate code was broken. Observation of the patio and outside back fencing (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed limbs from palm trees lying on the grass next to sidewalk and wooden fence railings. Observation of the wooden fence railings aligning the sidewalk on both sides revealed broken and rotted like boards and unsteady railings, multiple exposed rusted nails sticking up from the railings where boards are broken off and splintered off from base of railings. An overgrowth of tree limbs and bushes from the perimeter surrounding the fencing is observed coming through between the railings of the fence. Upon asking about the condition of the fencing, the Administrator stated that the area was not safe for residents, but they are planning to have it all redone this summer, (photographic evidence obtained). On 4/30/26 at approximately 4:00 PM, Staff L, Licensed Practical Nurse (LPN) was interviewed on hallway 200 regarding the urine odor. Staff L stated that the facility usually smells like urine. Staff L stated that the 200 hall residents defecate and urinate on the floor. She stated that housekeeping staff should clean those rooms more frequently and that the building is old and the smell has seeped into the floor and walls. On 4/30/26 at approximately 9:30 AM. Staff Q, Housekeeping was interviewed about the strong urine odor. Staff Q stated that staff clean resident rooms daily, but the disinfectant cleaner used has no air freshening effect to help mask odors. On 4/30/26 at 11:00 AM, an interview was conducted with Staff R, Housekeeping. She revealed that she had been employed at the facility for about a month and she worked 5 days per week on the 400 unit. She described her work duties as standard cleaning, of rooms, hallway, and common areas that involves sweeping, mopping, cleaning the bathrooms, and removing the trash from the rooms. Upon asking what her responsibility was when she saw broken equipment, broken blinds, or anything in residents' rooms that required repairs, she stated, I put it in the work order book at the nursing station, or I will text maintenance with my concerns. Upon asking if she has noticed any concerns with stains or appearance of biohazard materials on the walls and door frames, anything that requires repairs of the residents' rooms and bathrooms? She stated, No, I'm in there pretty much in the rooms every day to clean them. On 4/30/26 at 2:00 PM, an interview was conducted with the facility Maintenance Director, who revealed that he has been employed since September 2025. He stated that he and one other maintenance person worked at the facility. He stated they checked the work orders daily and throughout the day, but sometimes the staff would tell them verbally something needed to be repaired. In that instance, he said he would remind the staff to write what needed to be fixed in the work order book at each nurse's station. When asked if he was aware of the rooms and equipment on the 300 and 400 units that required repair, he stated he was not aware of the issues listed above. On 5/1/26 at approximately 9:45 AM, an interview was conducted with the facility Environmental Services Director regarding the persistent odor of urine throughout the facility. The Environmental Services Director stated the smell was not due to a lack of cleaning because staff cleaned resident's rooms daily. She stated that the nursing staff must clean potentially infectious waste before housekeeping can sanitize the area. She stated delays by care staff postponed housekeeping arrival to the site. She further stated that it is an old building, the odor has seeped into the floors, and the cleaning chemicals disinfect and sanitize but do not deodorize. On 5/2/26 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). When asked about the broken blinds, leaking faucets, and environmental concerns observed on 300 and 400 units, she stated they had changed out blinds, about 20 of them and they have bought new cabinets and door (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based upon interviews and record reviews, the facility failed to notify state and federal agencies of an incident involving elopement of a resident from the facility for 1 of 2 residents reviewed for elopement. (Resident #5) The findings include: During review of facility incidents, it was documented that on 2/28/26 at approximately 12:15 PM, Resident #5 exited the facility building from his bedroom window and walked across the facility property toward the perimeter fence. It was documented that a CNA saw Resident #5 and called out for assistance. It was documented that staff were able to redirect Resident #5 and escort him back to the facility where he was placed on one-to-one supervision for safety. It was documented that facility maintenance conducted an inspection on all window seals in Resident #5's room to ensure proper securement was in place. It was noted that this investigation did not include any staff or witness statements for review. An interview was conducted with Resident #5 on 5/1/26 at 10:30 AM concerning his leaving the facility on 02/28/26. Resident #5 remembered the event and was able to retell the details of what happened. He also recalled that he was brought back to the facility by staff and the police man. Upon returning to the facility, he stated, the police informed me that I shouldn't be leaving the facility like that and that I did not need to do it again. Upon request, the local police department shared a police report which documented they had an encounter outside the facility with Resident #5 on 2/28/26. The report confirmed a police officer helped facility staff escort Resident #5 back to the facility without incident. An interview was conducted with Staff G, Maintenance on 4/30/26 at 2:00 PM regarding the elopement investigation for Resident #5. Staff G confirmed that he was working on 2/28/26. Staff G stated he was the staff member who saw Resident #5 outside of the facility and escorted him back to the facility with a police officer. He recalled that Resident #5 exited the facility by climbing out of the window of his room. Staff G stated Resident #5 then went through the gate located at the back of the facility's property and left the facility premises. Staff G stated, I was able to reach [Resident #5] down the road. I was able to get [Resident #5] to stop walking and I re-directed him back to the facility with the assistance of law enforcement. Law enforcement spoke with [Resident #5] at the facility in regard to the incident and why he left the facility. An interview was conducted with the facility Director of Nursing (DON) on 4/30/26 at 3:00 PM. The DON confirmed an incident that occurred in late March or early April where [Resident #5] climbed out the window and was seen outside by a staff member. The staff member alerted other staff of the resident being outside and was brought back to the facility by [Staff G]. She stated that Resident #5 never left the facility grounds and was brought back to the facility without any injuries. When asked if Law Enforcement was notified of this elopement, the DON stated, No, they were not notified, not that I am aware of. I discussed it with the Corporate Regional Director and, because he never left the grounds and staff had eyes on him the whole time, it was not reportable. The DON further stated, It wasn't something we concentrated on because the staff responded very well to the incident. A follow up interview was conducted with the DON on 5/2/26 at 1:30 PM. She reiterated, I did not have to report this incident due to staff having visual contact with Resident #5 the entire time. I used this incident as a drill and educated staff. Upon asking if law enforcement was notified of the event, she stated, Yes, but they did not do anything, they did not come to the facility or give us a report on it. Upon informing the DON of the police report received by the local police department, she stated, they never came into the facility, they only stood out on the porch and spoke to staff and [Resident #5]. The DON confirmed she was required to report any incident in which law enforcement investigates or responds. Review of the facility policy titled Incidents and Accidents, dated 4/24/25 revealed it is this facility policy for staff to report . any accidents or incidents that occur . on facility property and may involve . a resident and ensure residents receive adequate supervision to prevent accidents.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interviews, and record review, the facility failed to provide the necessary care and services to maintain grooming and incontinence care for 1 of 2 residents sampled for incontinence care (Resident #7). The findings included: On 4/29/26 at 3:45 PM, Resident #7 was observed standing in the doorway of his room holding onto a wheelchair. Resident #7's navy-colored pants were observed to be wet, covering the seat of his pants extending down both legs to the calves. Resident #7 had a strong odor of urine and stated, I have been waiting on them to change my clothes. A follow up observation was made on 4/29/26 at 5:18 PM. Resident #7 was observed to be wearing the same soiled navy-colored pants and red shirt, seated in a wheelchair next to the nurses' station. An observation was conducted of Resident #7 on 4/30/26 at 1:20 PM. Resident #7 was observed wearing the same soiled clothes as the previous day. Resident #7 smelled of urine, and his shirt was soiled with food and a dark liquid. Upon interview, Resident #7 stated that he wanted fresh clothes and that he had asked for assistance from staff, but staff had not come to help. Resident #7's room had a strong odor of urine, and the bed was soiled with urine. Two pairs of pants were observed on the chair in Resident #7's room. No other clothes were observed inside the room. On 5/1/26 at 11:45 AM, Resident #7 was observed to be seated on the edge of his bed wearing khaki-colored pants and no shirt. The sheets underneath him were noted to be soiled and yellow. Resident #7's soiled red shirt and navy-colored pants from the previous 2 days were observed on the floor at the end of the bed. Resident #7 stated that, despite requesting assistance with changing clothes, no staff had come, so he had to change himself. A review of Resident #7's medical record revealed he had a history of a stroke, seizure disorder, anxiety, depression, psychotic disorder, and repeated falls. Review of the most recent Quarterly Minimum Data Set (MDS) revealed that Resident #7 had a Brief Interview for Mental Status (BIMS) score of 10 which indicates he was moderately cognitively impaired. The MDS documented Resident #7 was independent for toileting, showering, personal hygiene, and dressing. The MDS stated Resident #7 was occasionally incontinent of bowel and bladder. Review of Resident #7's Care Plan dated 3/26/26 revealed the care plan did not include what level of assistance Resident #7 required from staff for incontinence care and other activities of daily living. An interview was conducted with Staff O, Licensed Practical Nurse (LPN) on 5/1/26 at 11:50 AM. Staff O stated she was familiar with Resident #7 and that he did require staff assistance with bathing, dressing, grooming, toileting, and incontinence care. Staff O confirmed that Resident #7 did not refuse assistance with personal cares and that he was compliant with requesting staff assistance for activities of daily living. Staff O stated that Resident #7's personal clothing was labelled with his name and washed at the facility. However, Staff O stated the laundry staff did not return the resident's laundry to their individual rooms but rather left the clean laundry in a bag in the linen room for the nursing staff to put back. An interview was conducted with the facility Director of Nursing (DON) on 5/3/26 at 11:40 AM. The DON stated the nurses and Certified Nursing Assistants (CNAs) were expected follow standard best practices when providing resident care. She further explained this included frequent rounding, keeping incontinent residents clean and dry, turning and repositioning of dependent residents, and all other care areas. The DON stated staff were educated during new hire orientation and during morning meetings that the residents required incontinence care every two hours and as needed and that this was best practice and the standard for nursing care in general. When a copy of the facility's policies for incontinence care and activities of daily living care was requested, the DON stated that facility did not have an Activities of Daily Living (ADL) policy, resident care policy, or quality of care policy. The DON stated that the expectation was that nurses and CNAs completed rounds on all residents every two hours and as needed, especially if resident was incontinent. The DON said if a resident was known to be a heavy wetter, the staff were expected to round more frequently. The DON also stated that all of the facility's residents required some level of assistance from staff for care and activities of daily living.		