

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

Printed: 10/09/2026
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 08/13/2026
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.			
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure informed consent was obtained prior to the administration of psychotropic medications for 2 of 6 residents reviewed for psychotropic medication use. (Residents #4 and #11) The findings include: 1. On 8/12/26 at approximately 11:30 AM, a record review for Resident #4 revealed a physician's order of Paroxetine 40 mg once a day for depression, Trazodone 100 mg once a day for depression, Divalproex 500 mg twice a day for Bipolar Disorder (lifelong mental health conditions defined by severe shifts in mood, energy, and activity levels), and Risperidone 2 mg three times a day for Schizophrenia (a severe, chronic brain disorder that affects how a person thinks, feels, and acts). Resident #4 was admitted with diagnoses of major depressive disorder, depression, bipolar disorder with manic severe psychotic features, and Paranoid Schizophrenia. During an interview on 8/12/26 at approximately 1:30 PM, the Director of Nursing (DON) was requested to provide documentation of informed consent for Resident #4's Paroxetine, Trazodone, Divalproex, and Risperidone. The DON was unable to provide evidence that the resident or resident representative had been informed of and consented to the use of the psychotropic medications prior to their administration. 2, On 08/12/2026 at 05:56 PM, a record review of Resident #11 revealed an admission date of 6/2/25 with diagnoses including Traumatic Brain Injury, Schizoaffective disorder-Bipolar type, Major Depressive Disorder, and Paraplegia. Resident #11 is currently receiving the psychotropic medications Haldol 10 mg three times a day and Olanzapine 10 mg at bedtime for schizoaffective disorder (a mental health condition that combines symptoms of hallucinations or delusions with mood disorder such as depression or mania) and Divalproex sodium tablet 500 mg every 12 hours for Bipolar disorder (a lifelong mental health condition that causes extreme shifts in mood, energy, activity level, and concentration). Resident #11 did not have any consent for psychotropic medication use explaining the risks and benefits of the medication prior to administering medication in their record. An interview was conducted on 08/12/2026 at 1:30 PM with the DON requesting consents signed for the use of psychotropic medication for Resident #11. The DON stated that the residents are being seen by the Nurse Practitioner (NP) and she obtains the consents for the medication and treatment consents when she comes to visit the residents. An interview was conducted with the NP on 08/12/2026 at 02:30 PM. The NP stated it is the facility's responsibility to obtain the medication consents when a resident is admitted to the facility on (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications and when there is dosage increase or decrease or change in the medication. The facility policy titled Behavior Management-Psychotropic Medications (with an effective date of 09/01/2024) stated, Psychotropic medication is any medication that affects brain activities associated with mental processes and behavior. These drugs include anti-psychotic, anti-depressant, anti-anxiety, and hypnotic (sleep) medications. The procedure for these medications reveals that residents receiving psychotropic medication to have the risk and benefits reviewed and consent completed prior to initiation of the medication.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure the accuracy of the Preadmission Screening and Resident Review (PASARR) for 2 of 2 sampled resident reviewed for PASARR. (Resident #8 and #22)The findings include: 1. On 8/11/26, a review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Review of the Level I PASARR, dated 10/27/23, revealed the resident was identified with bipolar disorder, was receiving mental illness services, and was identified as requiring a Level II PASARR evaluation for serious mental illness. There was no evidence the facility obtained the required Level II PASARR evaluation and determination prior to the resident's admission or thereafter. The facility did not initiate action to obtain the required Level II PASARR until 8/12/26, during the survey. An interview with the Director of Nursing (DON) was conducted on 8/12/26 at approximately 9:30 AM, the DON stated the facility process for PASARR was a review by the admissions team, social services and audits were currently in place. Review of the documentation provided by the DON revealed a PASARR case was submitted on 8/12/26 at 9:53 AM. She acknowledged that the Level II PASARR review was overlooked. 2. A record review was conducted for Resident #22 on 08/12/2026 at 09:00 AM. Resident #22 was admitted to the facility on [DATE] with the diagnoses including Major Depressive Disorder, Personality Disorder, Psychoactive Substance Abuse, and Post Traumatic Stress Disorder (PTSD). He has a plan of care for communication difficulty with word sequencing and processing and alteration in mood and behaviors with physical and verbal aggression toward others, prefers to wear dresses and believes he is a woman. Resident #22 was admitted with a Level I PASARR completed on 07/09/2026 revealing he had received previous services for mental illness issues. Resident #22 's PASARR indicated a Level II PASARR evaluation must be completed prior to admission. An interview was conducted with the DON on 8/12/26 at 1:02 PM, who stated she is the one who completes the PASARR and reviews them for correct information upon admission to facility. The DON reviewed Resident #22's Level I PASARR and confirmed that it is incorrect and should have been caught when it was reviewed on admission and upon review when an audit was completed and that a Level II PASRR evaluation should have been initiated. The facility policy PASARR Guidance (effective 11/8/21) states that all residents with Serious Mental Illness (SMI) or Intellectual Disabilities (ID) receive appropriate PASARR screenings before admission, following federal and state requirements. The center must obtain Level I or II screening results prior to admission and place them in the resident's medical record. Certain individuals may be exempt from PASARR (e.g., recent hospital discharge under 30 days, terminally ill, comatose, certain severe neurological conditions, or dementia with proper documentation).		

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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. Based upon interviews and record review, the facility failed to ensure adequate monitoring for behaviors and side effects were documented for 3 out of 6 residents reviewed. (Resident #1, #4, and #11). 1. On 8/12/26, a chart review for Resident #1 revealed an admission date of 7/4/25 with diagnoses including dementia, seizure disorder, psychotic disorder, anxiety disorder, and depression. Resident #1's physician prescribed the psychotropic medications Olanzapine Oral Tablet 20 mg, 1 tablet by mouth at bedtime for restlessness, agitation, generalized anxiety disorder, and depression; Haloperidol Oral Tablet 10 mg, 1 tablet by mouth three times daily for intermittent explosive disorder; and Ativan Oral Tablet 0.5 mg, 1 tablet by mouth three times daily for anxiety. No orders directing staff to monitor Resident #1 for behaviors or side effects related to these psychotropic medications was found. On 8/13/26 at approximately 9:40 AM, an interview with Staff A, Licensed Practical Nurse (LPN), was performed. Staff A was asked if orders were in the electronic medical record (EMR) to monitor Resident #1 for psychotropic medication behaviors or side effects. Staff A checked the medication administration record (MAR) and Treatment Administration Record (TAR), confirmed no such orders were in the chart. On 8/13/26 at approximately 11:30 AM, an interview with the DON revealed that after reviewing Resident #1's EMR and TAR, that staff missed restarting Resident #1's behavioral and side effect monitoring orders for psychotropic medications following the resident's readmission from the hospital. 2. A record review was conducted for Resident #11 on 08/12/2026 at 05:56 PM revealed an admission date of 6/2/25 with diagnoses including Traumatic Brain Injury, Schizoaffective disorder -Bipolar type, Major Depressive Disorder, and Paraplegia. Resident #11 has physician's orders including the antipsychotic medications Haldol 10 mg three times a day and Olanzapine 10 mg at bedtime for schizoaffective disorder (a mental health condition that combines symptoms of hallucinations or delusions with mood disorder such as depression or mania) and Divalproex sodium tablet 500 mg every 12 hours for Bipolar disorder (a lifelong mental health condition that causes extreme shifts in mood, energy, activity level, and concentration). The record did not have an order for behavior monitoring (tracking and assessing behaviors over time) or to assess side effects of anti-psychotic medication (medications used to treat mental health conditions) use. On further record review, Resident #11 did not have a behavior monitoring flow record sheet in the electronic medical record. Resident 11 has an AIMS assessment that was completed on 3/29/26 indicating Resident 11 has no abnormal movements from the use of psychotropic medication use. Medication Haldol had an increase in dosage on 5/29/26 and an increase in dosage for Divalproex on 5/18/26 with no AIMS assessment completed for dosage increase or for the scheduled quarterly assessment in June 2026. 3. On 8/12/26 at approximately 11:30 AM, a record review for Resident #4 revealed physician's orders (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Paroxetine 40 mg once a day for depression, Trazodone 100 mg once a day for depression, Divalproex 500 mg twice a day for bipolar disorder (lifelong mental health conditions defined by severe shifts in mood, energy, and activity levels), and Risperidone 2 mg three times a day for Schizophrenia (a severe, chronic brain disorder that affects how a person thinks, feels, and acts). Resident #4's Medication Administration Record (MAR) revealed the psychotropic medications were administered as ordered. Review of the resident's clinical record, including nursing documentation, behavior monitoring records, and medication-related documentation, revealed no documented behaviors, symptoms, frequency, severity, or other clinical indicators demonstrating the continued need for psychotropic medications. During an interview on 8/12/26 at approximately 1:30 PM, the Director of Nursing (DON) was asked to provide documentation of monitoring related to Resident #4's target behaviors related to the use of the above medications. The DON was unable to provide documentation demonstrating that the resident's behaviors or symptoms were routinely monitored to evaluate the effectiveness and continued clinical need for psychotropic medications. Facility policy Behavior Management & Psychotropic Medications, effective 9/1/24, requires staff to monitor behavior and side effects every shift using the electronic Behavior Monitoring Flow Record.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review and facility policy review, the facility failed to ensure adequate assessment and implementation of smoking safety interventions to reduce the risk of accidents and injury associated with smoking for 4 of 4 sampled residents for smoking safety. (Residents #12, #85, #52 and #11)The findings include: 1. During a review of smoking periods, Residents #12 and #85 were observed smoking in the designated smoking area with staff supervision on 8/10/26 at 2:49 PM, 8/11/26 at 2:30 PM, 8/12/26 at 10:14 AM, 2:44 PM and 8/13/26 at 9:55 AM. Neither resident was observed with a smoking apron although the binder with the smoking assessments stated they needed one. An interview was conducted with the Assistant Director of Nursing (ADON) on 8/11/26 at approximately 2:22 PM while observing the smoking times. The ADON was confirmed the two residents were listed with Apron beside their names. The ADON stated the residents complained about the apron at times but reminds that they should not smoke unless they put it on. The ADON stated he doesn't go out with smokers often and does not know when assessments are completed. A record review of Resident #12 revealed an admission date of 8/2/25 with diagnoses including chronic obstructive pulmonary disease (lung disease that makes breathing hard), muscle weakness, and epilepsy (brain disorder that causes people to have repeated unprovoked seizures). A review of the resident evaluations revealed a smoking evaluation completed on 9/18/25, which stated resident was not a smoker, and 4/28/26, which stated the resident utilizes tobacco and has balance problems while sitting or standing. Smoking was added to the care plan on 6/25/26 with a review date of 8/5/26, which included the need for a clothing protector while smoking. A record review of resident #85 revealed an admission date of 4/24/26 with diagnoses including hemiplegia (the total or severe loss of movement on one side of the body) and right-hand contracture with splint to be worn daily. Review of the residents' evaluations revealed no smoking evaluation. Initial smoking evaluations were created on 4/24/26, which indicates the resident utilizes tobacco with no impairments. Smoking was added to the care plan on 7/22/26 with the review date of 8/10/26, which included a need for clothing protection while smoking. 2. On 08/11/2026 at 4:00 PM, a record review was conducted for Resident #52. Resident #52 was admitted to the facility initially on 10/29/20 and a re-admission date of 6/20/26 with the diagnoses including Cerebrovascular Accident (stroke) with right sided weakness and paralysis, Type II diabetes, mood disorder, history of mental and behavior disorders, major depressive disorder, and contracture (tightening of muscles, tendons, ligaments or skin that prevents normal movement of a joint) of the right hand and upper arm. Resident #52 has a plan of care for smoking and is considered unsafe with the goal that Resident #52 will adhere to the facility smoking policy and will wear a smoking apron for smoking safety. An intervention was initiated on 5/7/2025 for care staff to ensure Resident #52 wears a smoking apron when out to smoke. The facility smoking policy and agreement was signed by Resident #52 on 05/23/2024. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review was conducted for Resident #11 on 08/12/2026 at 05:56 PM. Resident #11 was admitted to facility on 6/2/25 with a diagnosis of Traumatic Brain Injury, Schizoaffective disorder -Bipolar type, Major Depressive Disorder, Paraplegia, and upper extremity contractures of both arms. Resident #11 has a plan of care for smoking with the goal that Resident #11 will not sustain any injury related to smoking. Resident #11's current intervention includes ensuring that Resident #11 wears a smoking apron for safety when smoking. An observation was conducted on 8/10/2026 in the smoking area at 01:30 PM. Resident #52 was observed sitting in his wheelchair smoking a cigarette without a smoking apron in use. Further observations on 8/11/2026 at 1:30 pm and 8/12/2026 at 01:38 pm revealed Resident #52 sitting in his wheelchair in the smoking area without a smoking apron. On 08/12/2026 at 1:45 PM, an observation of Resident #11 was made, revealing he was sitting in his wheelchair in the smoking area without a smoking apron on. The area had a smoking monitor, but no attempt was made to get Resident #11 to put his apron on. On 8/12/2026, an interview was conducted with the Director of Nursing (DON). She provided a list of current residents residing in the facility indicating Resident #52 and Resident #11 are to wear smoking aprons when smoking. The facility policy titled Smoking & Residents (effective date of 8/1/2023 was reviewed on 08/11/2026) states, The policy was established and to maintain safe smoking practices for residents with procedural guidelines listed. Residents who smoke will be educated to the smoking policy upon admission, re-admission, and quarterly. Residents are to be evaluated for smoking upon admission, re-admission, and quarterly.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review, the facility failed to ensure a medication error rate less than 5 percent. 28 medication opportunities were observed with 3 errors occurring, for a total medication error rate of 10.71 percent. The findings include: A medication administration observation was conducted on 08/12/2026 at 08:00 AM with Staff Nurse A, Licensed Practical Nurse (LPN). Staff A was observed administering prescribed eye drops to Resident #61. Staff A applied 2 drops to Resident #61's right eye and then to the left eye. Staff A did not offer any tissue or instruct Resident #61 not to rub his eyes after administration. Resident #61 immediately rubbed both eyes with the inside of his t-shirt, removing the drops that were instilled. Staff A then pulled out ear drops to be administered to Resident #61. Staff A placed the tip of the dropper inside the ear canal and instilled drops into his left ear. Staff A instructed Resident #61 to lean his head over to the left and repeated the process to the right ear. Resident #61 then used his t-shirt to wipe the drops from his ears. Another medication administration observation was conducted on 08/12/2026 at 08:23 AM for Resident #65. Resident #65 was administered oral medications along with a nebulizer treatment. Staff A set up the nebulizer machine and instilled the nebulizer treatment into the nebulizer cup, handed the nebulizer mask to Resident 65, and instructed him to place on himself. Staff A then washed her hands and left the room, leaving Resident 65 unsupervised during the administration and did not monitor the response to treatment or disassemble and clean the nebulizer mask after use. An interview was conducted with Staff A, who confirmed that the nebulizer administration should not be left unattended with a resident and that she did not perform an assessment of Resident #65 prior to or after administration of medication. A record review was conducted for Resident #61 on 08/12/2026 at 10:00 AM. They had physician's orders for artificial tears to instill 2 drops in both eyes twice a day for the diagnosis of Blepharitis (chronic condition causing red, swollen, itchy, irritation to the eyelids). They also had an order for Carbamide peroxide external solution (ear drops), instill 5 drops in both ears two times a day for 6 days with additional instructions for resident to lay on one side instill the drops, wait 5 minutes and rinse with warm water and then repeat on the other side. A record review was conducted for Resident #65 at 10:30 AM and revealed a physician order for Ipratropium-Albuterol inhalation solution to be inhaled three times a day. On further review, Resident #65 does not have any documentation concerning self-administering medications. The skills competency assessment for nebulizer treatments indicates that the nurse will explain the procedure to the resident, evaluate the resident establishing a baseline respiratory rate, pulse, oxygen saturation, and breath sounds. Then nurse will assemble the equipment, instilling the prescribed medication in the medication cup of the nebulizer mask, and placing the nebulizer mask on the resident. Nurse will then instruct the resident to take slow deep breaths and exhale slowly, then administer the medication until medication is depleted. The nurse is then to assess and evaluate the resident's response to the treatment, disassemble the device, rinse the nebulizer cup and allow it to dry before placing it in a bag that is maintained in the resident's room. On review of the procedural guideline for instillation of eye drops instructs that the nurse will gently pull the lower eye lid down and instruct the resident to look up while instilling the medication into the mid lower eye lid without touching the eye or eyelid with the dropper. Then to instruct the resident to close his / her eyelid to allow for even distribution of the drops, then gently dry the eyelid with a cotton ball if dripping occurs. On review of the procedural guideline for installation of ear drops instructs the nurse to gently cleanse the external auditory canal with [NAME] applicators, draw the warmed medication into the dropper and gently instill the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication into the ear. Then the nurse is to grasp the flap of the ear to straighten the canal and allow medication to enter the ear, then place a small amount of cotton in the external ear canal to prevent medication from running out. Documentation confirmed that Staff A had been reviewed and approved on all of these procedures.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and review of facility policy, the facility failed to ensure medications were stored in a locked secure manner. The findings include: On 08/10/2026 at 2:38 PM while making resident observations on the 300 unit, the medication cart was observed sitting in the hallway outside of room [ROOM NUMBER]. Staff B, a Licensed Practical Nurse, was observed walking from the medication cart to the nurses' station, leaving the medication cart unlocked, the computer screen visible with resident information displayed, and a small clear medication cup was sitting on top of the medication cart with a small greenish-white color tablet sitting inside the cup. Staff B was at the nursing station for approximately 10-15 minutes, out of view of the medication cart. Residents were observed in the hallway passing the cart. Staff B returned to the medication cart at approximately 2:55 PM, when an interview was conducted. Staff B confirmed the cart should have been locked, the computer screen closed, and medication should not have been left unattended prior to walking away. On 08/12/2026 at 09:00 AM, a treatment cart was observed sitting at the nurses' station with prescribed ointments and creams for topical use sitting on top of the cart unattended. There was approximately 6-7 residents sitting at the nurses' station and 2 residents walked by the treatment cart. On 08/12/2026 at 09:30 AM, the medication cart for the 300 unit was observed with the lock halfway pushed in, which left the cart unlocked. No nurse was observed on the unit during this time. An interview was conducted with the Director of Nurses (DON) on 08/13/2026 at 02:00 PM, who confirmed that the medication carts should always be locked when unattended by a nurse, medications should never be stored on top of the medication cart or treatment cart or left unattended by a nurse. The policy Medication Administration General (dated 08/07/2023) was conducted on 08/12/2026. The policy outlined procedures and policies for safe medication preparation, administration, verification, and documentation by licensed nurses in compliance with applicable laws. The policy specifically states, Medication carts are always locked when out of sight or unattended.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents in 7 of 60 rooms. (rooms 341, 342, 343, 344, 345, 346, 347) The findings Include: On 08/10/2026 at 12:25 PM, during an observation of the 300 Hall, the resident bathrooms for Rooms 341-347 were observed to have black and dark-colored filmy growth on multiple surfaces, including the bathroom ceilings, walls, doors, and door frames. The bathroom environments were observed to be warm and had a musty and foul odor. (Photographic evidence obtained) On 08/11/2026 at 8:45 AM, 8/12/2026 at 8:51 AM and 1:33 PM, and 8/13/2026 at 9:03 AM, follow-up observations of the bathrooms associated with Rooms 341 - 347 revealed the black/dark growth remained present on the ceilings, walls, doors, and/or door frames. The bathrooms remained warm and musty, with foul odors noted. On 8/11/2026 at 12:30 PM, the Maintenance Repair/Housekeeping Logs and Work Orders records were reviewed for the facility. The Maintenance Repair/Housekeeping Logs and Work Orders/Repair Requests revealed documentation of environmental, moisture, ventilation, water intrusion, and mold-related concerns predating the survey observations. For room [ROOM NUMBER], on 05/09/2026 a Work Orders/Repair Requests form revealed a request stating, Mold in bathroom (resident complaining). For room [ROOM NUMBER] on 05/22/2026, another maintenance/work-order log stated, Air filters need to be replaced, windows need cleaning/mold on ceilings. The reviewed entry did not contain documentation demonstrating completion of the identified work. The Maintenance Repair/Housekeeping Log revealed an entry dated 04/24/2026 for room [ROOM NUMBER] documenting: A/C/heat not working. room [ROOM NUMBER] was among the rooms where a warm, musty bathroom environment and dark growth were observed during the survey. The Maintenance Director reviewed the entries and acknowledged that they did not contain documentation of a date of completion.		