

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Atlantic Shores Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4251 Stack Blvd Melbourne, FL 32901	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665</p> <p>Based on interview, and record review, nurses failed to follow physician's orders and failed to monitor condition changes in a timely manner for 1 of 3 residents reviewed for Change of Condition, of a total sample of 4 residents, (#4).</p> <p>Findings:</p> <p>Review of the medical record revealed resident #4, an [AGE] year old male was admitted to the facility on [DATE], re-hospitalized on [DATE], and readmitted from an acute care hospital on 12/22/24. The resident's diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke), aphasia (language communication dysfunction), dysphagia (difficulty swallowing), end stage kidney disease, seizures, encephalopathy (brain dysfunction), hypertensive (high blood pressure) urgency, dialysis dependence, anemia, primary hypertension, and coronary (heart) artery disease (CAD).</p> <p>The Minimum Data Set 5-Day assessment with an Assessment Reference Date of 11/06/24 showed during the look back periods, resident #4 scored 13 out of 15 on the Brief Interview for Mental Status exam that indicated he was cognitively intact. The assessment noted there were no behaviors or rejections of evaluation or care, received scheduled pain medications, received one injection, high-risk anti-platelet, and anti-convulsant medications, and hemodialysis while a resident.</p> <p>The Comprehensive Care Plan included focuses, interventions, and goals for altered cardiovascular status related to CAD, hypertension, anemia with interventions for nurses to monitor for changes and complications, and hemodialysis therapy with interventions for nurses to observe and monitor for complications and side effects including elevated blood pressure.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The December 2024 Order Recap report included physicians medication orders for: Carvedilol 25 Milligrams (MG) once daily every Monday, Wednesday, Friday, and Sunday morning, and once in the evening on Tuesday, Thursday, and Saturday for high blood pressure, Clonidine 0.3 MG three times daily every Monday, Wednesday, Friday, and Sunday, and once in the evening every Tuesday, Thursday, and Saturday for high blood pressure, Hydralazine 100 MG three times daily every Monday, Wednesday, Friday, and Sunday, and once in the evening every Tuesday, Thursday, and Saturday for high blood pressure, Isosorbide Mononitrate 30 MG once daily every Monday, Wednesday, Friday, and Sunday morning, and once in the evening on Tuesday, Thursday, and Saturday for angina with a hold for blood pressure parameters, Metoprolol 100 MG twice daily every Monday, Wednesday, Friday, and Sunday, and once in the evening every Tuesday, Thursday, and Saturday for high blood pressure, and Nifedipine 60 MG twice daily every Monday, Wednesday, Friday, and Sunday and once in the evening every Tuesday, Thursday, and Saturday for high blood pressure.</p> <p>Review of the Nurse Progress Note completed by Licensed Practical Nurse (LPN) B on 12/12/24 at 12:48 AM, revealed the nurse received an additional as needed physician's medication order of Clonidine 0.2 MG to treat resident #4's elevated blood pressure reading of 232/91 mmHg (millimeters of mercury).</p> <p>The Order Audit Report noted on 12/11/24 at 11:03 PM, LPN B entered physician's medication orders for Clonidine 0.2 MG every six hours as needed for systolic blood pressure greater than 170 or diastolic blood pressure greater than 90 mmHg.</p> <p>The eINTERACT Change In Condition Evaluation completed by LPN A and the South Unit Manager on 12/12/24 documented the dialysis center contacted the facility to report that resident #4 required emergency transport to the hospital when he arrived at the dialysis center for treatment in the afternoon on 12/12/24.</p> <p>On 1/28/25 at 10:55 AM, in a telephone interview, LPN B recalled that on 12/12/24 during the 11:00 PM to 7:00 AM shift, resident #4 had an elevated blood pressure which she reported to the nurse practitioner by phone. LPN B said she obtained medication orders and administered the medication. She explained she recorded subsequent blood pressures during the night in the medical record.</p> <p>On 1/27/25 at 2:15 PM, LPN A recalled that on 12/12/24, she took resident #4's blood pressure before he went to dialysis and administered medication for an elevated reading. She said the same afternoon, a little while after he left for dialysis, the facility was notified by the dialysis center they had initiated 911 for emergency transport to the hospital. LPN A said LPN B had not mentioned during oncoming report on 12/12/24 that resident #4's blood pressure was high and the provider had been notified.</p> <p>Review of the Weights and Vitals Summary report noted resident #4's blood pressure was recorded as 167/91 on 12/11/24 at 10:47 PM, by LPN B but was not documented again until 12/12/24 at 12:41 PM by LPN A, approximately 12 hours later.</p> <p>The December 2024 Medication Administration Record (MAR) noted the only as needed dose of anti-hypertensive blood pressure medication was the Clonidine 0.2 MG which was administered by LPN A on 12/12/24 at 12:41 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/27/25 at 2:25 PM, the South Unit Manager recalled at lunchtime on 12/12/24, she noticed resident #4 was lying in bed which was different than his normal routine of being out of bed in his wheelchair. She said she thought he may not be feeling great and noticed hadn't eaten any of his lunch. She explained nurses took the resident's blood pressure which was elevated, so an as needed dose of medication was administered before he went to dialysis treatment at approximately 1:00 PM. She said she remembered seeing a note earlier that morning from the night shift nurse about the resident's blood pressure that required a provider notification and additional medication orders.</p> <p>Review of the pharmacy delivery invoice noted resident #4's Clonidine 0.2 MG medication was delivered to the facility on [DATE] at 12:30 PM.</p> <p>On 1/28/25 at 12:07 PM, the South Unit Manager checked resident #4's medical record and acknowledged LPN B had not completed a Change Of Condition evaluation nor did the MAR show she administered the as needed blood pressure medication as ordered by the nurse practitioner. The Unit Manager said she expected nurses to complete the Change Of Condition form and LPN B should have documented any medication that was administered. She said Clonidine 0.3 MG was available in the electronic medication dispensary machine, and questioned that LPN B might have given the medication that was available but did not document it.</p> <p>On 1/29/25 at 12:19 PM, in a joint interview with Director of Nursing (DON) and Nursing Home Administrator, the DON explained she expected nurses to monitor, follow up, and complete a Change In Condition evaluation when the provider was notified of any concerns. She recalled on 12/12/24, resident #4 went to dialysis and stated, I believe he was acting up with the driver. She checked the medical record and could not find any documentation that LPN B administered resident #4's additional order for blood pressure medication nor monitored the resident after the nurse practitioner was notified. The DON conveyed that LPN B may have administered the medication on hand of Clonidine 0.3 MG instead of 0.2 MG and mis-transcribed the order. She said LPN B would be re-educated for the incident.</p> <p>On 1/29/25 at 1:30 PM, the DON stated, there is no policy for change in condition.</p> <p>Review of the Facility assessment dated [DATE] documented the facility provided care for residents with combinations of conditions that require complex medical care and management, . Management of medical conditions, Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions .</p>		