

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/11/2026
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)		
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, and interview, the facility failed to maintain a clean and homelike environment for 6 out of 12 resident rooms on the South wing, resulting in an environment that did not promote resident comfort and safety. Findings: During environmental tours conducted between 6/08/26 and 6/11/26 on the South wing of the facility, the following observations were made: 1. In room [ROOM NUMBER]-B, a hole on the wall above the baseboard with crumbling dry wall between beds A and B was observed on 6/08/26 at 9:30 AM, on 6/09/26 at 2:30 PM, and on 6/10/26 at 11:10 AM. On 6/08/26 at 9:30 AM, the resident in room [ROOM NUMBER] bed B said she did not recall how long the hole in the wall above the baseboard was there, but she did not like to see the hole on the wall. 2. In room [ROOM NUMBER]-B, the wall next to the bed had been patched but an area measuring approximately 1 foot by 1 foot was still not sanded nor painted on 6/08/26 at 9:40 AM, on 6/09/26 at 12:47 PM, and on 6/10/26 at 11:25 AM. 3. In room [ROOM NUMBER]-A, the wall by the head of the bed revealed paint had been scraped off but was not painted was observed on 6/08/26 at 9:55 AM, and on 6/09/26 at 2:40 PM. 4. In room [ROOM NUMBER]-B, observed the paint on the wall at the head of the bed was chipped off on 6/08/26 at 11:30 AM, and on 6/09/26 at 9:30 AM. 5. In room [ROOM NUMBER]-B, observed the paint on the wall at the head of the bed was chipped off on 6/08/26 at 11:40 AM. 6. On 6/08/26 at 11:50 AM, on 6/09/26 at 9:22 AM, and on 6/10/26 at 11:30 AM, a hole was on the wall under the window to the left side of the resident in bed B, in room [ROOM NUMBER]-B. The hole was approximately 10 inches long and 3 inches deep with dry wall particles in the wall's edge closer to the floor, the baseboard was bent outwards and the wall had plaster that had not been sanded nor painted. The wall to the right side of resident A's bed was scraped. On 6/11/26 at 10:50 AM, Certified Nursing Assistant (CNA) D said she filled out a maintenance request sheet which was located in a box at the South-wing nurses' station when there were any needs for repairs in the rooms. Review of the blank repair form revealed it was a repair requisition form with blank lines to write the date, location, repair needed, a signature line and an approval line. The repair requisition had two carbon copy pages. The repair forms were kept at the nurses' stations in a plastic box. On 6/11/26 at 10:55 AM, in room [ROOM NUMBER]-B, CNA D explained she was frequently assigned to this room and verified the hole in the wall under the window. CNA D did not recall when but said she thought the hole in the wall had been repaired previously, after she completed a repair request when she saw the hole the first time. She recalled she had not told her supervisor or anyone else about the new hole on the wall. CNA D verified the walls that needed repair and confirmed the resident in 241 bed B was unable to tell anyone herself of the needed repairs. On 6/11/26 at 10:55 AM, the assigned housekeeper on South wing for room [ROOM NUMBER] stated, utilizing CNA D for translation, said room [ROOM NUMBER] was her usual assignment, and she usually spent approximately 30 minutes to clean the room, including cleaning the floors. The housekeeper explained she had not seen the damage on the wall under the window by the B bed, had not reported the damage to her supervisor, and had not filled out a repair requisition form. On 6/11/26 at 11:00 AM, CNA C after visiting room [ROOM NUMBER] and 202, confirmed the damaged walls and said she had previously seen the walls needed repair. She said she (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	thought the Maintenance Department knew about the wall repairs needed in room [ROOM NUMBER] and 202 because they did a deep clean in the rooms not too long ago. On 6/11/26 at 11:15 AM, the Maintenance Director after visiting rooms 200, 202 and 235, confirmed the damaged walls. He said the process for reporting anything that needed repair in the facility was to fill out a repair requisition form and place it in the box at the nurses' stations. He said that previously he received a repair requisition slip for the hole in the wall, and it was fixed but that area on the wall was hit again by a wheelchair. The Maintenance Director explained any repair requisition received for holes in the walls was given priority to be fixed on the day the requisition was received. He said when any repair work was completed, the expectation was for any staff to complete the requisition form and for maintenance staff to complete the repair then sign off with the date and time the repair was completed. He said he was aware that room [ROOM NUMBER] was patched but not sanded nor painted. The Maintenance Director said he did not previously know about the damage in room [ROOM NUMBER], between the A and B beds. He explained he and his assistant did regular rounds in the resident rooms but could not say why he was unaware of the damage in room [ROOM NUMBER], other than staff had not reported it to him. On 6/11/26 at 11:45 AM, the Housekeeping Manager said each housekeeper cleaned each residents' room for 15-20 minutes every day. She said she expected that any repair needed or required was reported to her by the housekeeping staff or a repair requisition slip was filled out. She said she was sure the hole in room [ROOM NUMBER] was reported but could not say why it had not been repaired. On 6/11/26 at 3:52 PM, the Administrator and Director of Clinical Services acknowledged that the observed conditions in residents' rooms did not meet the facility's expectations for maintaining a clean, comfortable environment for the residents. The Administrator said they were working on several projects to improve the environment including residents' rooms.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, and interview, the facility failed to maintain an effective infection prevention and control program to prevent the spread of infection by ensuring staff performed hand hygiene while assisting the residents in the dining room before, during and after lunch, in one of two dining rooms of the facility, (South wing). Findings: On 6/08/26 at 11:30 AM, residents were sitting in the South wing dining room in their wheelchairs waiting for the lunch meal service. On 6/08/26 at 11:52 AM, two Certified Nursing Assistants (CNA)s and the Infection Prevention nurse (IP) were in the dining room providing beverages to the residents, setting up the residents' lunches in preparation for them to eat their meal. Staff placed items from each resident's meal tray to the table, helped to open the condiment packages and cut up food items for several residents. CNA F brought the lunch tray from the tray cart to a resident sitting at a table, cut the resident's food then opened the condiment packages for that resident. The CNA returned to the tray cart where the other residents' lunch trays were waiting to be served. CNA F took another meal tray from the tray cart, then delivered the food items to another resident at the same table, cut the food, then opened the packages but did not wash her hands between assisting the residents. CNA F washed her hands after she assisted three residents. Staff were observed inconsistently performing hand hygiene with either wipes or using the sink. At the sink staff quickly rubbed hands together in the water and did not wash for the appropriate amount of time. Another CNA cleaned her hands with the hand wipes for less than two seconds, then pushed the used hand wipe into a square, white plastic container full of used sanitizing hand wipes on top of the beverage cart. Staff were observed as they quickly swiped the wipe over the surface of the fingers but did not thoroughly utilize the wipe over the hands' surface, then allow them to dry. Review of the undated hand sanitizing wipe packaging directions; hands should be wet thoroughly and allowed to dry without wiping. A short time later on 6/08/26 at 11:55 AM, CNA F cut up the food for one resident with their fork and knife, then moved to the neighboring resident seated at the table. The CNA picked up that resident's fork and knife and cut the neighboring resident's food. CNA F did not sanitize her hands with soap and water or hand sanitizer between the residents. Afterwards CNA F used the sanitizing hand wipes but only wiped off one hand. CNA F assisted several residents to open their butter but did not perform hand hygiene between each resident. On 6/10/26 at 12:15 PM, in the South wing dining room during the lunch meal, CNA F touched a resident's wheelchair handlebars in order to reposition the resident but did not perform hand hygiene, before performing the next task. A few minutes later, CNA F washed her hands with soap and water then picked up a dirty tray but did not perform hand hygiene after touching the dirty trays. She used a hand sanitizing wipe, then carried the wipe she used to the white container on the beverage cart which held the used hand wipes. Next, with her bare hands she pushed down the used wipes further into the container. After discarding the used wipe, CNA F assisted another resident with their lunch but did not perform hand hygiene. At 12:27 PM, CNA F went to the sink to wash her hands on two separate occasions but did not use soap, only water; and washed her hands both times, for less than four seconds. At 12:35 PM, CNA F walked from one table to another speaking with the residents and touched several residents' backs but did not perform hand hygiene. CNA F used the sanitizing hand wipes then placed them in the container by the beverages but with her bare hands pushed down on the already used wipes. On 6/10/26 at 12:57 PM, the South Wing Unit Manager (UM) said CNA F was usually assigned to the dining room where she assisted residents with their meals by cutting their food and opening packages. The UM said the expectation for any CNA assisting residents in the dining room was to assist one resident at a time and wash their hands between the residents they assisted. The UM explained hand hygiene was performed with soap and water, alcohol-based sanitizer or sanitizing hand wipes for 20 seconds or more. She confirmed the hand wipes were to be disposed of in the trash by dropping the used items into the receptacle not pushing down on previously discarded refuse. On 6/11/26 at 1:02 PM, the IP nurse said, the expectation for staff assisting in the dining room was for them to wash their hands (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with soap and water or alcohol-based hand rub. The IP said staff may use the sanitizing hand wipes but explained they should saturate their hands with the product, use multiple pieces, get all surfaces of their hands clean, then dispose of the wipes in the garbage and air dry their hands. She said staff should perform hand hygiene for at least 20 seconds and were expected to use soap when they wash their hands with water at the sink. The IP nurse stated she had educated all staff on hand hygiene, and they completed hand hygiene competencies through different shifts. She explained nurses and CNAs were educated about hand hygiene during weekly nurses' meetings and as needed. The IP nurse explained she monitored hand hygiene throughout the facility and reinforced hand hygiene with return demonstration. The IP nurse explained it was important to perform hand washing between residents in the dining room due to potential spread of Multiple Drug-Resistant Organisms, and the elderly were more susceptible to infection. She said handwashing was the first line of defense to prevent the residents, the employee, and the employee's family from getting sick. Review of the facility's Infection Prevention and Control Plan revised June 2024 revealed: An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures. Review of the facility's Hand Washing/Hygiene Policy revised on August 2023 revealed the facility considered hand hygiene the primary means to prevent the spread of infections. The policy indicated it was in accordance with national standards from the Centers of Disease Control and Prevention and the World Health Organization. The document specified all personnel should follow the handwashing /hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy detailed that hand hygiene should be performed before and after assisting a resident with meals, staff should wash hands vigorously for a minimum of 20 seconds (or longer).		

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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** Based on interview, and record review, the facility failed to revise and review a comprehensive person-centered care plan to meet the resident's needs for their highest well-being, for 2 of 2 residents reviewed for hearing/sensory aids, of a total sample of 41 residents, (#88, and #14). Findings: 1. Review of the medical record revealed resident #88 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, diabetes, and brain bleed. Review of the Minimum Data Set (MDS) admission assessment with Assessment Reference Date (ARD) of 8/05/25 showed section B-hearing revealed resident had minimal hearing difficulty/difficulty with some environments and no hearing aids present. Section C for memory recall showed a Brief Interview for Mental Status (BIMS) of 13 out of 15, which meant the resident had normal cognitive function. Review of the MDS Quarterly assessment with ARD of 3/24/26 showed section B hearing revealed resident had a minimal hearing difficulty/difficulty with some environments, and no hearing aid or other hearing appliance used. On 6/09/26 at 12:55 PM, resident #88 was sitting in a wheelchair in her room, with the television off. Resident #88 said she had a hard time hearing and asked for surveyor to come closer to talk by her ear, then pointed to her ear. She explained she had only one hearing aid, but the other hearing aid was lost. She said she could not wear one hearing aid because her hearing would not be balanced. On 6/09/26 at 4:25 PM, resident #88 was again sitting in her wheelchair in her room. She said the one hearing aid was in her nightstand. She wheeled over to the nightstand and looked inside. She pulled out a hearing aid box, but it did not contain any hearing aids. The resident looked in the nightstand but there was no hearing aid. She explained her son would not have taken it, and she did not recall when she last saw the hearing aids. Review of a progress note with documentation by the Director of Nursing (DON) dated 9/25/25 at 3:42 PM, that the resident stated she wanted to get her purse and hearing aids from the drawer because she was going out with her son. This progress note was the only mention of resident #88's hearing aids in her record. Review of resident #88's care plan revised on 8/12/25, revealed she was at risk for impaired communication related to a hearing deficit. The care plan included the resident had hearing aid for the right ear at bedside. Interventions included allowing ample time for resident to respond, and right-side hearing aid, to observe for deterioration in hearing impairment. Further review of the care plan revealed it was not reviewed or revised to reflect the resident had lost her hearing aids, to show how the facility staff would promote proper communication with others without a hearing device. The care plan was not personalized as it did not reflect if the resident required assistance with the hearing aids and if so, who would assist her with them. Review of the Certified Nursing Assistant (CNA) Kardex revealed no entry or documentation for hearing aid use, assistance or care. The EMR revealed no audiology consult despite resident having a hearing deficit and not having hearing aids. On 6/10/26 at 10:35 AM, CNA D said resident #88 was hard of hearing and she talked louder to her so the resident could hear what she told her. CNA D said she did not know the resident wore a hearing aid. On 6/09/26 at 4:28 PM, Licensed Practical Nurse (LPN) E recalled resident #88 had hearing aids a long time ago, but she did not remember seeing them recently. The nurse said the process was for the nurse or the resident to put the hearing aids in their ears. She said she knew when a resident had hearing aids because nurses communicated this to each other during shift change report. The LPN explained some residents had physician orders to put hearing aids in their ears, and the hearing aids would be kept in the medication cart in the narcotic box then the nurses would sign the treatment administration record to show the nurse put in and removed the hearing aids. On 6/09/26 at 5:06 PM, the MDS nurse said the process for residents with hearing/vision/dental problems was to ask the resident if they had problems and if they said they have worn hearing aids then she tried to find out more information. She said if the residents had the hearing aids, they should be care planned to make sure the resident was assisted by staff with the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	devices, but the nurse did not know which staff actually was supposed to assist the residents with their hearing aids. The MDS nurse said the vision, hearing and dental problems were checked by the Social Worker, and she would let the MDS nurses know to put it in the care plan. She said she entered the information in the care plan to be triggered in the CNA Kardex for the residents to be assisted with those devices like hearing aids or dentures. The MDS nurse was not sure if there was a physician order and then explained resident #88 answered questions but missed some of the information due to her cognitive deficit. She said resident #88 could hear if she turned her head but she missed some parts of the conversation. A short time later at 5:28 PM, the MDS nurse said she knew the resident had a hearing deficit but did not know resident #88 had a hearing aid. She said her hearing loss was from a head injury from a fall. The nurse said the resident could communicate better now but she had poor recall. She said she always assumed her condition was from cognitive decline due to her brain injury and not a hearing issue. The MDS nurse acknowledged she was not an audiology specialist who would be able to determine if the resident actually had a hearing deficit. She said a consult was usually arranged by Social Services. 6/09/26 at 5:56 PM, the South wing Unit Manager (UM) said if the resident wore glasses, hearing aids or dentures, the process was for the admitting nurse to complete an assessment/evaluation of the resident to determine if he/she had these items. She explained this information was then placed on the care plan by the admitting nurse. The UM said this information was also placed on the property sheet, and it would generate a task for the CNAs to put in the hearing aids. The UM explained there was no designated person from the interdisciplinary team (IDT) team who held the responsibility to update the care plans with information about a resident's glasses, dentures or hearing aids. She explained that once the care plan was updated it triggered a task for the CNAs. On 6/09/26 at 4:50 PM, the Social Services Director (SSD) said she was aware of a resident having hearing aids, dentures or glasses from the inventory sheet which should be completed on admission by the nurse completing the admission assessment. She said she does not initiate the care plans for residents with vision, dental or hearing problems. The SSD explained that if a grievance is written for a missing item, a search would be done, and all staff were notified as well as the information given to the IDT on stand down meeting. She said when a resident has items that are not found such as missing glasses, dentures or hearing aids, a referral would be made for ancillary services. The SSD said resident #88 did not say anything about hearing loss and she was not referred for audiology consultation. On 6/11/26 at 4:18 PM the DON said newly admitted residents were assessed/evaluated by an admitting nurse; the nurse checked resident belongings and completed the inventory form. If the resident had a hearing problem with no hearing aids, the Social Worker would be informed to schedule a consult from audiology services. She said the MDS nurse was to interview the resident and check for the need to refer the resident to audiology services. She said the MDS nurse would edit the care plan or let the UM or herself know if there was a concern related to hearing aids. She stated during the care plan meeting with the resident or representative this information was reviewed. The DON said the nurse and the CNA were expected to make sure the residents had the hearing aids and that they were written in the care plan. 2. Resident #14 was admitted to the facility on [DATE] with diagnoses including hypertension, heart disease, and diabetes. Review of current physician orders included a consult, as needed for Audiology. On 6/09/26 at 10:04 AM, during a telephone interview, the resident's daughter said the facility had lost resident #14's hearing aids four times previously. She explained her father's insurance had replaced them once before. The daughter said she had spoken to the Administrator about replacing the 4th set of missing hearing aids and he told her they would replace the hearing aids and would come up with a plan to keep them from being lost again, but she said she had not been told of what the plan was. Review of the 11/07/24 admission MDS assessment, Section B for hearing revealed the resident was highly impaired in hearing with absence of useful hearing. The section showed the resident used no hearing aids or other appliances. Resident #14's BIMS was 9 out of 15, which indicated moderate cognitive impairment. The 3/17/26 Annual MDS assessment, Section B for hearing showed the resident had minimal difficulty (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with hearing with unclear speech, he was sometimes understood and sometimes understands. The section included a hearing aid was used in completing the previous question regarding ability to hear. Resident #14 had a care plan initiated 11/01/24 and revised on 3/20/26 for a risk for impaired communication related to cognitive deficits, hearing loss and unclear/soft/mumbled speech at times. Care plan interventions included allow the resident ample time to respond and observe for decline in cognitive status, mood, ADLs, and hearing impairment. There was an additional care plan initiated 2/12/25 and revised 4/10/26 for resident #14's behavior which detailed he was resistive to care related to adjustment to placement, and sometimes he declined his hearing aids. There was no care plan related to care or assistance with resident #14's hearing aids, including missing hearing aids. Review of the CNA Kardex did not show any documentation for hearing aids in the communication task. Review of the medical record revealed no personal effects or inventory form for resident #14. Review of the medical record revealed on 9/23/25, resident #14 had an audiology evaluation. The audiologist note indicated the resident's daughter was present for the evaluation and the resident was evaluated because one of his hearing aids was lost. The consult detailed hearing loss severity as moderately severe sloping to severe sensorineural hearing loss in both ears. The note revealed the resident required help from staff to insert and remove the hearing aid daily and change batteries weekly. The note indicated the resident's daughter would assist with weekly battery changes. Review of a psychiatry progress note dated 3/03/26 revealed documentation resident #14 was hard of hearing and had lost his hearing aids. In interviews on 6/09/26 at 1:30 PM, and 2:40 PM, and on 6/10/26 at 10:35 AM, CNA D said the nurse was supposed to put in the hearing aids, but resident #14 did not like to keep them in his ears. She said she had seen resident #14 placed his hearing aids on the bedside table or on the basket on his bedside table previously. The CNA said she knew when a resident had a hearing aid from the task in her computer where she got the residents' information. On 6/09/26 at 4:28 PM, LPN E said resident #14 did not like to put in his hearing aids and he only wanted them when his daughter was there. The usual process, she said, was for the nurse to have them in the medication cart in the narcotic drawer. LPN E said she recalled the resident had hearing aids a long time ago, but unsure what happened to the current pair. She said staff knew if a resident had hearing aids from what was communicated via the change of shift report. The nurse explained sometimes nurses signed off on the Treatment Administration Report that they had put them in or removed them to the narcotic box. In interviews on 6/09/26 at 5:06 PM, and 5:20 PM, the MDS nurse said the process for residents with hearing/vision/dental problems was to ask the resident if they had problems and if they said they wore hearing aids she tried to find out more information. The nurse said if the resident had the hearing aids, they should be care planned to make sure the resident was assisted with these devices, as needed. The MDS nurse was not aware of which staff actually assisted the residents with their hearing aids. She said vision, hearing and dental problems were checked by the Social Worker, who would let her know to put in the care plan. Next, she said she entered the information in the care plan to be triggered in the CNA Kardex for the residents to be assisted with the hearing aids or denture cleaning. The MDS nurse was not sure if there was a physician order and then explained resident #88 answered questions but missed some of the information due to her cognitive deficit. She explained any problem identified by a team member was care planned since information was obtained from different sources taking an interdisciplinary approach. The MDS nurse said they also got information for care planning from observations, interviews, therapy evaluations, past histories especially behaviors and observation of behaviors. She said her interviews included the resident, family, guardians, and she explained a problem was identified or communicated via verbal communication from the CNA to the nurse to the UM for example, for order changes like antibiotics, or falls. The MDS nurse said, usually on the Quarterly MDS assessment, she or the other MDS nurse would ask about hearing, and the Social Worker had a book for these services. The MDS nurse explained if there was an issue, Social Services was informed to refer the resident for a consult with audiology care. The MDS nurse said she did not know (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything about resident #14 having hearing aids and did not know when they were brought in for him. She acknowledged there was a behavior care plan for him which indicated he declined the hearing aids but did not recall that he did not wear the hearing aids. She said she was not familiar with resident #14 but knew he did not like to wear his hearing aids but was unaware as to why he did not like to wear them. She agreed staff should have personalized direction for how to care for each resident's hearing aids. On 6/09/26 at 5:56 PM, the South wing UM said for a resident who wore hearing aids, the process was for the admitting nurse to do an assessment/evaluation of the resident to determine if he/she has these items and this information will be placed on care plan by the admitting nurse. UM said this information was placed on the property sheet, and this generated a task for the CNAs to put in the dentures or hearing aids and put on the glasses. The UM said for resident #14, the nurse put in the hearing aids because he has misplaced the hearing aids before. The UM said she wrote a progress note about this and she wrote a note at the nurse station. She said she did not write an order and explained there is no designated person from the IDT team who holds the responsibility to update the care plans with information about a resident's glasses, dentures or hearing aids. She explained that once the care plan is updated it will trigger a task for the CNAs. UM explained the process to report missing items is when an item is reported to nursing then they will do a search for the item and if not found, a grievance is generated. On 6/09/26 at 4:50 PM, the SSD said she knew a resident had hearing aids, dentures or glasses from the inventory sheet which would be completed on admission by the nurse completing the admission assessment. She said she did not initiate the care plans for residents with vision, dental or hearing problems. The SSD explained if a grievance was written for a missing item, a search would be done, and all staff were notified as well as the information given to the IDT on stand down meeting. She said when a resident had items that could not be found such as missing glasses, dentures or hearing aids, a referral would be made for ancillary services. On 6/10/26 at 1:57 PM, the Administrator said resident #14 had a hearing evaluation done at the facility recently by the contracted audiologist group and they were replacing the hearing aids. He confirmed he told resident #14's daughter a plan would be in place to prevent future loss of the hearing aids but acknowledged there was no plan as of yet. He said the resident's daughter insists that he wears the hearing aids despite resident's refusal. He said that he expects documentation related to the use of the hearing aids when the hearing aids are replaced. The Facility assessment dated and revised 9/23/25 showed the facility may accept/admit residents with a category of hearing loss and maintains contracts for service providers including audiology. On 6/11/26 at 5:15PM, the Regional Nurse Consultant, stated the facility had no hearing aid policy or assistive device policy. The facility's policy and procedure for Comprehensive Person-Centered Care Plans revised August 2023 revealed the policy was for the center to develop a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. The policy specified the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments and as changes in the resident's care and treatment occur. The policy indicated any interdisciplinary team member could enter the updates under the guidance of a registered nurse responsible for the resident. The policy further detailed the care plan should be re-evaluated and modified as needed to reflect changes in care, service and treatment. The document indicated the care plan evaluations would occur in response to changes in residents' physical, emotional, functional, psychosocial, or communicative status as they occurred.		

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 06/11/2026
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.			
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice that took account of the resident's experiences and preferences in order to eliminate or mitigate triggers which could cause re-traumatization of the resident, for 1 of 2 residents reviewed for diagnosis of Post Traumatic Disorder (PTSD), of a total sample of 41 residents, (#11). Findings: Resident # 11 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of T11-T12 vertebra, subsequent encounter for fracture with routine healing, Type 2 diabetes mellitus, major depressive disorder, unspecified dementia and PTSD. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of [DATE] showed the resident had a Brief Interview for Mental Status Score of 8 out of 15, which indicated her cognition was moderately impaired. The assessment listed PTSD as one of the active diagnoses listed under Psychiatric/Mood Disorders. A review of a psychiatrist progress notes on [DATE] revealed, Trauma: Patient reported a history of a physical altercation many years ago with one of her brothers, who is now deceased, which resulted in trauma to her right hand. Patient denied any current triggers. She reported disliking aggressively yelling types of environments but denied current concerns at this time. A review of resident #11's Comprehensive Care Plan revealed no specific care plan addressing PTSD nor the resident's dislike of aggressively loud environments. The Kardex did not indicate special instructions for Trauma Informed Care. A review of the Assessments/ Evaluations showed no Trauma Informed assessment was completed even though PTSD was listed on the admission assessment. On [DATE] at 1:45 PM, the Social Services Director acknowledged trauma informed care was not part of the resident #11's assessments nor did the comprehensive care plan address the resident's diagnosis of PTSD. She said the facility process was the Social Services Department was responsible to complete the evaluation and would gather the history of a resident. If triggers were identified, they would initiate a care plan and an automatic psychiatrist referral. She explained that the care plan and Kardex were important to complete so that all staff were aware of how to avoid triggers to not cause the resident any unneeded distress. The Social Services Director continued to explain she was on medical leave at the time the initial assessment was done for resident #11, but acknowledged the assessment was incomplete and that someone from the team should have addressed it. On [DATE] at 2:02 PM, the assigned Licensed Practical Nurse (LPN) A explained that resident #11 had PTSD as one of her diagnoses but could not find anything on the care plan. She stated nothing was listed regarding care or triggers as identified on another resident with PTSD on her assignment. On [DATE] at 2:10 PM, the North Wing Unit Manager said for Trauma Informed Plan of Care, it is a team effort to discuss the care plan and acknowledged resident # 11 did not have the Trauma Informed Care Plan. She explained she would address this with the team because it was important for the resident to have one. The MDS Coordinator who was at the nurse's station at that time, said she assisted with care plans, but the Social Services Department was primarily responsible for trauma informed care plans and assessments. On [DATE] at 2:14 PM, the assigned Certified Nursing Assistant (CNA) B said resident #11 was fine and she was not aware of any special instructions regarding her care. She then retrieved the Kardex for resident #11 which did not identify any special care instructions. On [DATE] at 2:35 PM, the Director of Nursing (DON) acknowledged resident #11 had no care plan for Trauma Informed Care and confirmed one should have been done. The DON explained that the Trauma Informed Care plan is important for staff to know how to care for residents with PTSD so that they could avoid any re-traumatization. The facility did not have a policy on Trauma Informed Care.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely review pharmacy consultant recommendations and implement the physician's revised medication order for 1 of 5 residents reviewed for unnecessary medications, of a total sample of 41 residents, (#5). Findings: Review of the medical record revealed resident #5, an [AGE] year-old male was admitted to the facility from an acute care hospital on 5/25/24. The resident's diagnoses included type 2 diabetes mellitus, hypertension, hyperlipidemia, history of pulmonary embolism, and dementia with psychotic disturbance. The most recent Comprehensive Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date of 4/28/26 indicated during the look-back period, resident #5 had severely impaired cognitive daily decision making skills, short term and long term memory problems, was dependent on staff to complete activities of daily living/functioning, able to propel himself in a wheelchair up to 150 feet, and sustained one fall with minor injury prior to the previous MDS assessment. The resident received high-risk anti-psychotic, anti-depressant, anti-coagulant (blood thinner), diuretic (fluid removing), opioid (narcotic pain), hypoglycemic (blood sugar lowering), and anti-convulsant (anti-seizure) medications. Review of the Care Plan Report included risk for skin impairment with an intervention (6/19/24) to use caution during transfers/bed mobility to prevent striking arms, legs, and hands against sharp/hard surfaces, (revised 2/02/26) impaired cognitive/communication function/impaired thought process related to dementia with behaviors, (revised 6/03/26) risk for falls as evidenced by dementia, decreased mobility, psychotropic medication use, impulsivity, behaviors, crawls out of bed, and poor safety awareness, (revised 4/29/26) impaired vision functioning, (revised 4/22/26) leaning to right side of wheelchair, and (6/19/24) anticoagulant therapy with a goal for decreased risk of adverse reaction from use and interventions to monitor for multiple abnormal bleeding signs and symptoms. Adverse effects of Eliquis may cause increased excess/abnormal bleeding complications including spinal clots leading to paralysis. It is highly advised to be extra careful to avoid injuries, (retrieved from mayoclinic.org on 6/12/26). The Pharmacy Consultation Report dated 4/06/26 recommended discontinuing Eliquis because of long term use since 6/18/24. The physician signed the form on 5/14/26 to discontinue the medication. The April, May, and June 2026 Medication Administration Records (MARs) documented resident #5 received Eliquis (blood thinner) 5 Milligrams twice daily for blood clot prevention until it was discontinued on 6/04/26. On 6/11/26 at 1:29 PM, the North Unit Manager said she received the Pharmacy Consultation recommendations from the Director of Nursing (DON). She explained she placed them in a binder on the nursing unit for the physician to review and she also called to get verbal/telephone orders. She said she checked every day to make sure the recommendations were addressed, and the Medical Records Coordinator also checked daily to monitor any missing items. On 6/11/26 at 1:45 PM, the Medical Records Coordinator said she was in her role for three years. She explained that she checked both units a minimum of two times per week, usually more for the signed pharmacy recommendation forms and she also called the physician when she noticed anything was missing or not reviewed yet. She said she provided the signed forms to the DON or Unit Managers to enter orders, and they returned them to her for uploading them to the Electronic Health Record. In a joint interview with the DON and Regional Nurse Consultant (RNC) on 6/11/26 at 1:57 PM, the DON explained she received the pharmacy recommendations via email and then she gave them to the Unit Managers to follow up with the physicians. She stated, we have 30 days to act on the recommendations; some things are more urgent than others. The DON conveyed it was important to review use of high-risk anticoagulants due to the risk of bleeding, especially with head injuries. She checked the pharmacy recommendation form earlier provided to surveyors dated 4/06/26 signed by the physician on 5/14/26 to discontinue resident #5's Eliquis and said she was not aware it wasn't (continued on next page)		

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued until 6/04/26 however, she would check the records. On 6/08/26 at 2:43 PM, resident #5 was observed in the North Unit common area propelling himself in his wheelchair. On 6/11/26 at approximately 3:30 PM, the RNC provided another copy of the same Pharmacy Consultation Report dated 4/06/26 and signed as M . on 6/04/26 by a different provider whom she stated was the Nurse Practitioner, which was why it was delayed. The form included a handwritten note, pt (patient) does not get out of bed and marked to decline the recommendation to discontinue Eliquis. The RNC did not explain why the note showed the resident didn't get out of bed after the surveyor stated the resident was previously observed in his wheelchair during the survey. Review of the facility's standards and guidelines titled Medication Regimen Review (MRR) dated 6/01/24 outlined the facility was responsible for timely alerting physicians of pharmacy recommendations and notifying the Medical Director of untimely responses. Non-time sensitive issues are expected to be addressed by the physician before the Pharmacy Consultants next monthly MRR.		