STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105978	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Shore Care Center	6767 86th Ave N Pinellas Park, FL 33782

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to ensure Pre admission Screening and Resident Review (PASARRs) were accurate for five residents (#78, #5, #77, #2, #8) out of six residents sampled.Findings Included: 1. Review of Resident #78's admission record revealed an admission date of 02/20/2026. Resident #78 was admitted to the facility with diagnosis to include post-traumatic stress disorder, unspecified, major, depressive disorder, recurrent, moderate, alcohol abuse, and generalized anxiety disorder. Review of Resident #78's PASARR dated 02/20/2026 revealed section A. MI (Mental illness) was blank. Section II. Questions 1-7 were marked no. Section III revealed it was marked: no to provisional admission. IV. No diagnosis or suspicion or Serious MI or ID indicated. Level II PASARR eval not required was marked. 2. Review of Resident #5's admission record revealed an admission date of 02/21/2026. Resident #5 was admitted to the facility with diagnosis to include epilepsy, unspecified, intractable, with status epilepticus, generalized anxiety disorder, brief psychotic disorder, Parkinson's disease without dyskinesia, without mention of fluctuations, Parkinson's disease without dyskinesia, without mention of fluctuations, other specified persistent mood disorders, and major depressive disorder, recurrent, moderate. Review of Resident #5's PASARR dated 02/20/2026 revealed section A. MI (Mental illness) was blank. Section II. Questions 1-7 were marked no. Section III revealed it was marked: no to provisional admission. IV. No diagnosis or suspicion or Serious MI or ID indicated. Level II PASARR eval not required was marked. During an interview on 03/25/2026 at 9:44 a.m. the Director of Nursing (DON) and Social Services Director (SSD) stated when residents are admitted to the facility, the SSD reviews the PASARR and confirms the diagnosis that are listed in the chart. Psych sees the resident and confirms the diagnosis. If they add diagnosis or there are changes to the PASARR, the SSD tells the DON so she can update the PASARR. They stated Resident #78 and Resident #5 should have updated PASARR's to reflect their current diagnoses. 3. Review of Resident #77's admission record dated 02/25/2026 revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to major depressive disorder, recurrent, moderate, generalized anxiety disorder, brief psychotic disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety Review of Resident #77's Preadmission Screening and Resident Review dated 02/25/2026 revealed the psychotic disorder was not listed on the Level I PASARR. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Minimum Data Set (MDS) dated [DATE] revealed the resident had diagnoses of anxiety disorder, depression, and psychotic disorder. On 03/25/2026 at 2:41 p.m., an interview was conducted with the DON) and the SSD. They stated Resident #77's PASARR should have had a new level I completed to show he had psychotic disorder. 4. A record review of Resident #2's admission record revealed an initial admission date of 11/07/2023 and readmission date of 11/08/2025. Resident #2 was admitted to the facility with diagnoses to include brief psychotic disorder (10/02/2025), bipolar disorder (3/21/2025), major depressive disorder (3/21/2025), and generalized anxiety disorder (11/07/2023). A review of Resident #2's Level I PASRR, dated 10/6/2025, revealed: Section I: Mental Illness (MI) or suspected MI (check all that apply): bipolar disorder was marked. Findings based on documented history, behavioral observations, medications was marked. Section II: Other Indications for PASRR Screen Decision-Making question 3: A: psychiatric treatment more intensive than outpatient care was marked No. 4: Has the individual exhibited actions or behaviors that may make them a danger to themselves or others was marked No. An observation and interview on 3/22/2026 at 12:34 p.m. with Resident #2 was conducted. During the interview Resident #2 was speaking very loudly and using aggressive language toward staff members. Staff F, Certified Nursing Assistant (CNA) assisted Resident #2 with her wheelchair; Resident #2 slapped and pushed Staff F, CNA, on the left arm. An interview on 3/22/2026 at 12:42 p.m. with Staff F, CNA, was conducted. Staff F, CNA said Resident #2 often pushed, slapped, and yelled at staff. Staff F, CNA said Resident #2 had aggressive behaviors toward the staff. A review of Resident #2's progress notes revealed she had a change in condition on 3/22/2026 at 2:02 p.m. of, Behavioral symptoms (e.g. agitation, psychosis). The Primary Care Provider responded with the following feedback: A. Recommendations: Psych- BA52 (voluntary/involuntary psychiatric treatment). The police and emergency medical technician (EMT) transported Resident #2 to the hospital. A review of Resident #2's progress notes revealed a nurses note dated 3/8/2026 at 3:32 p.m. showing on 7a.m. to 3 p.m. shift patient was changed four times. She was put in bed. Writer assisted with care. She keeps throwing things at staff and yelling at staff. She is pulling her brief to the side and urinating on the floor several times. Writer has encourage patient to use call light. Resident #2's psychiatry notes were requested on 3/24/2026 at 3:00 p.m. and not provided. 5. A record review of Resident #8's admission Record revealed an initial admission date of 8/6/2024 and readmission date of 12/2/2025. Resident #8 was admitted to the facility with diagnoses to include suicidal ideations (12/2/2025), bipolar disorder (5/21/2025), major depressive disorder (5/21/2025), anxiety disorder (5/21/2025) primary insomnia (5/21/2025), and unspecified dementia (8/6/2024). A review of Resident #8's Level I PASRR, dated 8/29/2025, revealed: Section I: Mental Illness (MI) or suspected MI (check all that apply): anxiety disorder, bipolar disorder, depressive disorder, other: dementia and insomnia was marked. Findings based on documented history and medications was marked. Section II: Other Indications for PASRR Screen Decision-Making question 3: A: psychiatric treatment more intensive than outpatient care was marked No. 4: Has the individual exhibited actions or behaviors that may make them a danger to themselves or others was marked No. A record review of Resident #8's progress notes revealed an activity/recreation note dated 12/3/2025 at 12:32 p.m. Note Text: (Readmit) Resident had and interruption of stay; a brief hospitalization for suicidal ideations. Resident #8's psychiatry notes were requested on 3/24/2026 at 3:00 p.m. and not provided. An interview was conducted on 3/24/2026 at 10:45 a.m. with Staff A, (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse (RN) was conducted. Staff A, RN said she thinks Resident #8 received (voluntary/involuntary psychiatric treatment) in December 2025 for suicidal ideations. An interview on 3/24/2026 at 3:00 P.M. with the DON was conducted. The DON said Resident #2 was she's the worst resident we have and always causing us problems. The DON said Resident #2 was [NAME] Acted on 3/22/2026 due to her behaviors. The DON said Resident #2's PASRR was not correct and should have been updated when Resident #2 was readmitted to the facility on [DATE] and 3/23/2026. The DON said Resident #8 was [NAME] Acted for suicidal ideations. The DON said Resident #8's PASRR was not correct and should have been updated after her hospitalization. The facility did not provide a policy on the PASARRs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received care and treatment in accordance with professional standards of practice, the comprehensive care plan, and resident choice related to: 1) positioning of one (Resident #18), 2) communication with hospice for one (Resident #14), and 3) documentation of physician orders related to behavior monitoring, medications administration, wound care and tube feeding for three (Resident #5, Resident #11 and Resident #1) of six residents sampled. Findings Included: During an observation on 3/22/2026 at 12: 30 p.m., Resident #18 was observed in the dining room sitting in her wheelchair. Resident #18's torso was shifted off center towards the left of the wheelchair. During an observation on 03/23/2026 at 1:22 p.m., Resident #18 was observed sitting in a wheelchair near the nurse's station. Resident #18's torso shifted off center towards the right of the wheelchair. Review of Resident #18's admission record revealed an admission date of 01/17/2025. Resident #18 was admitted to the facility with diagnosis to include unspecified dementia with other behavioral disturbance, major depressive disorder, tachycardia, pseudobulbar affect and vitamin deficiency. Review of Resident #18 Minimum Data Set (MDS) dated [DATE] revealed, Resident #18 required substantial/maximal assistance (meaning helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort for mobility) with most activities of daily living (ADLs). Review of Resident #18's care plan dated 12/22/2021 revealed: Resident 18 has a functional abilities deficit related to cognitive deficits, generalized weakness, impaired mobility, requires queuing from staff. Interventions. turn and reposition as needed, shifting weight to enhance circulation. During an interview on 03/25/2026 at 9:40 a.m., Staff H, Certified Nursing Assistant (CNA) stated, Resident #18 requires assistance for most of her needs. Resident #18 likes to sit in her wheelchair and attend activities. She primarily enjoys feeding herself. She does not really like it when we try to assist her with meals, so we try to let her do it on her own. Resident #18 has a high back wheelchair with a neck pillow to help with her positioning. She likes to position herself in the chair where she is comfortable. I frequently reposition her when I see her needing to be adjusted. During an interview on 03/25/2026 at 2:41 p.m., the Director of Nursing (DON) stated I would expect staff to reposition the residents if they see they are leaning or not properly sitting in their wheelchair. They can look in the Kardex and check to see if they need repositioning or if there are any special cushions they should be using. CNAs should tell the nurse if the resident is slouching or leaning in their wheelchair is happening often, so we can get therapy to see them. Review of Resident #14's admission record revealed an admission date of 11/07/2023. Resident #14 was admitted to the facility with diagnosis to include unspecified dementia, major depressive disorder, anxiety disorders, cirrhosis cutis, and traumatic subarachnoid hemorrhage without loss of consciousness. Review of Resident #14's MDS dated [DATE], revealed skin conditions one stage four pressures (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ulcer. Review of Resident #14's orders revealed: 02/08/2026 Hospice to follow for treatment related to Cerebral Atherosclerosis . Review of resident #14's medication administration record (MAR) and treatment administration record (TAR) for February 2026 revealed: Collagenase ointment 250 unit/gram apply to right lateral foot topically everyday shift for wound care . no documentation was found on 02/19/2026, 02/23/2026 and 02/26/2026. Collagenase ointment 250 unit/gram apply to sacrum topically every day shift for wound care . no documentation was found on 02/05/2026, 02/09/2026, 02/12/2026, 02/19/2026, 02/23/2026 and 02/26/2026. Left lateral foot: skin prep every shift for wound care no documentation was found 02/07/2026 and day 02/22/2026. Offload bilateral heels, place pillow between legs, as tolerated by resident . no documentation was found on day 02/07/2026 and day 02/22/2026. Review of Resident #14's MAR and TAR for March 2026 revealed: Collagenase ointment 250 unit/gram Apply to left foot topically everyday shift for wound care . no documentation was found on 03/19/2026. Collagenase ointment 250 unit/gram apply to right lateral foot topically everyday shift for wound care . no documentation was found on 03/02/2026, 03/03/2026, 03/06/2026, 03/10/2026, 03/12/2026, and 03/17/2026. Collagenase ointment 250 unit/gram apply to sacrum topically everyday shift for wound care . no documentation was found on 03/02/2026, 03/03/2026, 03/06/2026, 03/10/2026, 03/12/2026, 03/17/2026, and 03/19/2026. Superior back-cleanse with normal saline pat dry, apply foam dressing . no documentation was found on 03/19/2026. Left lateral foot: skin prep every shift for wound care no documentation was found on 03/14/2026. Off load bilateral heels, place pillow between legs, as tolerated by resident . no documentation was found on 03/14/2026. Review of Resident #14's electronic medical record and paper medical record revealed no notes or documentation of communication with hospice. During an interview on 03/24/2026 at 5:23 p.m., Staff I, Licensed Practical Nurse (LPN), stated hospice comes in and sees the resident a few times a week. They are the primary for her care. If they change any orders they come to us, and we call the physician and confirm before we change it. They (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	come and talk with us after each visit. There is a binder at the nurses' station that we keep, as well. The hospice notes are scanned into her chart or located in the binder at the nurses' station. During an interview on 3/25/2026 at 1:00 p.m. with Staff J, Registered Nurse (RN), stated she is responsible for completing the MAR and TAR for wound care treatments. She said sometimes the nurses will sign off that the treatments have been completed. She said sometimes she does not go back into the TAR and click off that the treatments are completed. I completed the treatments, but if it's not documented it looks like it was not completed. I could go back into the TAR and mark completed if that would help. During an interview on 3/25/2026 at 2:10 p.m. the Director of Nursing (DON) stated the wound care nurse should not go back into the MAR/TAR and mark that treatments are completed, if she did not complete the dressing. If the MAR/TAR is not completed, then the treatment was not completed. My expectation is for the nurse who completes the treatment, to document on the MAR/TAR. During an interview on 03/25/2026 at 5:36 p.m., the Director of Nursing (DON) stated the only hospice note they have is from December. There are no further notes for Resident #14 in the chart. We are having them faxed over now. Review of Resident #5's admission record revealed an admission date of 02/21/2026. Resident #5 was admitted to the facility with diagnosis to include unspecified epilepsy, intractable with status epilepticus, generalized anxiety disorder, brief psychotic disorder, Parkinson's disease without dyskinesia without mention of fluctuations, other specified persistent mood disorders, and recurrent moderate major depressive disorder. Review of Resident #5's MDS dated [DATE] revealed resident is taking or has taken the following medications in the last 7 days and has a documented indication for the medication: antipsychotic, antidepressant, diuretic, opioid, antiplatelet, and anticonvulsant. Review of Resident #5's MAR/TAR for February 2026 revealed: Behavior monitoring was not documented on 02/22/2026 and 02/26/2026. Digoxin Oral Tablet 250 microgram (MCG) give one tablet via peg tube in the afternoon for heart failure.was not documented on 02/22/2026. Vital signs twice daily was not documented on 02/25/2026 at 0900. Glycopyrrolate oral tablet 1 milligram (MG), give 1 tablet via peg tube.was not documented on 02/22/2026. Valproate sodium oral solution 250 mg/5 milliliter (ml) give 10 ml via peg tube.was not documented on 02/22/2026 and 02/26/2026 at 1400. Enteral feed order . was not documented on 02/26/2026 at 2200. Flush feeding tube 180 ml of water every four hours was not documented on 02/22/2026 at 1000 and 1400. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's MAR/TAR for March 2026 revealed: Behavior monitoring was not documented on 03/17/2026 and 03/20/2026. Digoxin Oral Tablet 250 MCG Give 1 tablet via Percutaneous Endoscopic Gastrostomy (PEG) Tube was not documented on 03/01/2026. Mirtazapine Tablet 15 MG Give 1 tablet via PEG-Tube was not documented on 03/07/2026 and 03/14/2026. Vital signs twice daily was not documented on 03/01/2026 at 0900 and 03/14/2026 at 1700. Flush tube with 30 ML of water before and after.was not documented on 03/14/2026. Glycopyrrolate Oral Tablet 1 MG Give 1 tablet via PEG-Tube.was not documented on 03/01/2026 at 1400, 03/06/2026 and 03/14/2026 at 2200. Risperidone Tablet 0.5 MG Give 1 tablet via PEG-Tube.was not documented on 03/01/2026 at 0900 and 1300, 03/06/2026 and 03/14/2026 at 2100. Valproate Sodium Oral Solution 250 MG/5 ML Give 10 ml via PEG-Tube.was not documented on 03/01/2026 at 0600, 03/06/2026 at 1400, and 03/14/2026 at 2200. Enteral Feed Order.was not Percutaneous Endoscopic Gastrostomy on 03/01/2026 at 1000, 03/06/2026 at 2200, 03/14/2026 at 2200 and 03/14/2026 at 2200. During an interview on 03/24/2026 at 1:18 p.m., Staff K, RN stated Resident #5 is a bolus eternal feed. I keep the MAR/TAR pulled up here on the computer and once I have provided the eternal feed or the medication I mark it as completed. It shows a check mark if it has been completed. If it is not documented on the MAR/TAR, then it means the order or medication has not been completed. During an interview on 03/24/2026 at 5:50 p.m., the DON stated nurses are responsible for documenting behaviors. It is documented on MAR/TAR. If a medication is given it is documented on the MAR/TAR by the nurses as it is given. They should document if the resident is refused and add a note to the progress notes. She reviewed Resident #5's MAR/TAR and stated they did miss a few days during a certain shift. I would expect there to be documentation to show the medication or treatment has been completed. Review of the facility policy dated April 2019, titled Administering Medications, Policy: Medications are administered and is safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.22. The individual administering the medication initials the residents mar on the appropriate line after giving each medication and for administering the next ones.24. Topical medications used in treatments are recorded on the residence treatment record (TAR). Review of the facility policy dated July 2017, titled Charting and Documentation revealed, Policy: All services provided to the resident, progress toward the care plan goals, or any change in the residence medical, physical, functional or psychosocial condition, shall be documented in the residence medical record. The medical records that facilitate communication between the interdisciplinary team (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding the residents condition and response to care. Policy interpretation and implementation,.7. Documentation of procedures and treatments will include care specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual who provided the care; c. The assessment date and or any unusual findings obtained during the procedure/treatment. A review of the facility's Charting and Documentation policy revealed the following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: Medications administered; Treatments or services performed. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: The date and time the procedure/treatment was provided; How the resident tolerated the procedure/treatment; Whether the resident refused the procedure/treatment. A review of Resident #11's admission record revealed an initial admission date of 05/28/2025 and re-admission date of 01/22/2026. Further review of the admission record revealed diagnoses to include encephalopathy, unspecified, unspecified sequelae of cerebral infarction, aphasia following unspecified cerebrovascular disease, Parkinson's disease without dyskinesia, without mention of fluctuations, unspecified dementia, unspecified severity, with other behavioral disturbance, and major depressive disorder, recurrent, moderate. A review of Resident #11's active physician orders revealed the following: Pimavanserin Tartrate Oral Capsule 34 MG [milligrams] (Pimavanserin Tartrate) Give 1 capsule by mouth one time a day for parkinsons/dementia Monitor for Adverse Effects. Indicate- N [no] if not observed, Y [yes] if observed. If observed, notify physician, with a start date of 1/30/26. A review of Resident #11's care plan revealed the following: [Resident #11] is at risk for falls and/or fall related injury r/t [related to]: dx [diagnosis] of Parkinson's, generalized weakness, impaired balance, requires staff assist with transfers and ambulation, hx [history] of falls, uses w/c [wheelchair] as primary mode of locomotion, has a hx of falls, receives psychotropic meds [medications], use of medication that could increase risk for bruising and bleeding. Date Initiated: 01/25/2026. Revision on: 01/25/2026, with interventions to include, . Administer medications as ordered; observe for effectiveness and for SEs [side effects]. Review of medications effecting fall risk as needed. [Resident #11] has a potential for alteration in thought process r/t: dx of dementia, psych [psychiatry] dx: depression, insomnia Date Initiated: 01/12/2026 Revision on: 01/12/2026, with interventions to include, Administer medications as ordered; observe for effectiveness and for SEs . A review of Resident #11's medication administration record (MAR) for February 2026 showed the following for the pimavanserin oral capsule 34 mg order and adverse effects monitoring: Adverse effect monitoring was not documented on 2/3/26, 2/4/26, 2/8/26, 2/18/26, 2/19/26, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/21/26, and 2/26/26. On 2/1/26 to 2/9/26, 2/11/26, 2/13/26 to 2/17/26, 2/19/26 to 2/28/26, the code of 9 was documented. A review of the chart codes showed the following, 9=Other/See Nurse's notes. A review of Resident #11's MAR for March 2026 showed the following for the pimavanserin oral capsule 34 mg order and adverse effects monitoring: Adverse effect monitoring was not documented on 3/1/26 to 3/4/26, 3/8/26, 3/21/26, and 3/24/26. On 3/2/26 to 3/10/26, 3/12/26 to 3/21/26, and 3/23/26 to 3/25/26, the code of 9 was documented. A review of Resident #11's progress notes revealed the following: 2/2/26, 2/4/26, 2/6/26, 2/9/26, 2/13/26, 2/20/26, 2/23/26, 2/25/26, 3/13/26, 3/16/26, 3/18/26, 3/23/26, and 3/25/26, Note Text: Pimavanserin Tartrate Oral Capsule 34 MG Give 1 capsule by mouth one time a day for parkinsons/dementia Monitor for Adverse Effects. Indicate- N if not observed, Y if observed. If observed, notify physician. med [medication] on order. 2/3/26, 2/5/26, 2/17/26, 2/19/26, 2/24/26, 2/26/26, 3/2/26, 3/3/26, 3/10/26, 3/12/26, 3/17/26, 3/19/26, and 3/24/26, Note Text: Pimavanserin Tartrate Oral Capsule 34 MG Give 1 capsule by mouth one time a day for parkinsons/dementia Monitor for Adverse Effects. Indicate- N if not observed, Y if observed. If observed, notify physician. Unavailable. 2/27/26, 3/4/26, 3/5/26, 3/6/26, and 3/9/26, Note Text: Pimavanserin Tartrate Oral Capsule 34 MG Give 1 capsule by mouth one time a day for parkinsons/dementia Monitor for Adverse Effects. Indicate- N if not observed, Y if observed. If observed, notify physician. on order. 3/21/26, Note Text: Pimavanserin Tartrate Oral Capsule 34 MG Give 1 capsule by mouth one time a day for parkinsons/dementia Monitor for Adverse Effects. Indicate- N if not observed, Y if observed. If observed, notify physician. spoke to family regarding medication. On 03/25/2026 at 3:48 p.m., an interview was conducted with the DON. She reviewed the February 2026 and March 2026 MAR for the pimavanserin medication administration and adverse effect monitoring. The DON said she understood the concern and confusion about the chart codes and the medication administration. She said she did not have an explanation and would find out. On 3/25/26 at 5:12 p.m., a follow up interview was conducted with the DON. She said she spoke with the unit manager and was told the order for pimavanserin was supposed to be discontinued. She said she would check if there was documentation about the medication being discontinued. A record review of Resident #1's admission record showed he was readmitted to the facility on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, type 2 diabetes mellitus, pulmonary fibrosis, dependence on renal dialysis, heart failure, cardiomyopathy, and hypertension. A review of Resident #1's MDS, 02/19/2026 revealed a brief interview for mental status (BIMS) score of 14 indicating cognitively intact. (continued on next page)

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	105978	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Shore Care Center	6767 86th Ave N Pinellas Park, FL 33782

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 03/22/2026 at 9:15 a.m. with Resident #1 was conducted. Resident #1 said he receives dialysis on Monday, Wednesday, and Fridays. Resident #1 said he is not sure he receives all his medications due to him being at dialysis. A record review of Resident #1's care plan revealed a focus: has a potential for complications related to hemodialysis for treatment of ESRD (end stage renal disease) with inventions including but not limited to: adjust medication schedule as required to accommodate for dialysis treatments. A record review of Resident #1 orders revealed the following orders: Stiolto Respimat Inhalation Aerosol Solution 2.5-2.5 MCG/(airway clearance techniques) ACT 2 puff inhale orally one time a day related to acute and chronic respiratory failure Sevelamer Carbonate Oral Tablet 800 MG Give 2 tablet by mouth with meals for hyperphosphatemia Sacubitril-Valsartan Oral Tablet 97-103 MG Give 1 tablet by mouth two times a day for HTN (hypertension) Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT\ML Inject as per sliding scale: if 151 - 199 = 2 units; 200 - 249 = 3units; 250 - 299 = 4units; 300 - 349 = 6 units; 350 - 425 = 8 units, subcutaneously before meals and at bedtime for DM (diabetes mellites) Incruse Ellipta 62.5 MCG\ACT Aerosol Powder, breath activated 1 inhalation inhale orally one time a day related to chronic obstructive pulmonary disease hydralazine HCl Oral Tablet 25 MG Give 1 tablet by mouth three times a day for HTN (hypertension) Carvedilol Tablet 25 MG Give 1 tablet by mouth two times a day for Hypertension Buprenorphine HCl-Naloxone HCl Sublingual Film 4-1 MG Give 1 tablet sublingually three times a day for pain Artificial Tears Ophthalmic Solution Instill 1 drop in both eyes four times a day for dry eyes A record review of Resident #1's medication administration record for February and March 2026 revealed no documentation for the medications as ordered by the physician on the following days: 3/2/2026 3/4/2026 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/6/2026 3/9/2026 3/11/2026 3/13/2026 3/16/2026 3/18/2026 3/20/2026 3/23/2026 An interview on 03/24/2026 at 10:43 a.m. with Staff A, Registered Nurse (RN) was conducted. Staff A, RN said Resident #1 should receive his medications before he leaves for dialysis and after he returns. Staff A, RN said Resident #1 did not receive some of his medications on dialysis days. Staff A, RN said the administration time of the medications should be changed to accommodate dialysis. An interview on 03/25/2026 at 10:10 a.m. with the DON was conducted. The DON said the process should be to reconcile medications around the dialysis time frame. The DON said Resident #1 did not receive his medications as ordered. A record review of a policy issued 4/1/2022 titled, Policy and Procedure Hemodialysis, revealed the policy is .to provide the necessary care and services to those residents receiving hemodialysis. The procedure is: 3. Recommendations will be verified with the physician and medications administered according to the times ordered by the physician or recommended by the dialysis center. Review of the facility policy needed July 2017 titled Hospice program revealed, Policy: Hospice services are available to residents at the end of life.10. In general it is the responsibility of the facility to meet the residents personal care and nursing needs and coordination with the Hospice representative, and ensure that the level of care provided is appropriately based on the individual residents needs these include.d. Communicating with the Hospice provider and documenting such communication to ensure that needs of the residents are addressed.12. Nursing services will coordinate care provided to the resident and the Hospice staff to include.b. Communicating with Hospice representatives and other health care providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident my family.d. obtaining the following information from the Hospice the most recent Hospice plan of care specific to each resident Hospice election form .e. Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forums, and record keeping requirements, to Hospice staff furnishing care to the residents.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, the facility failed to ensure the resident's right to be treated with dignity was honored, related to untimely incontinence care, resulting in anxiety for one resident (#13) out of one resident sampled.Findings included: On 3/22/26 at 11:53 AM an interview was conducted with Resident #13. Resident #13 revealed for at least the past two weeks they have had to sit in their own bowel movement for over an hour waiting for care on Thursdays and Fridays. The resident stated it is the same aides on both shifts that continue to lack timeliness in providing incontinence care. Resident #13 stated it upsets her when she has to wait so long. The resident said they never use their call light unless they have a bowel movement. Resident #13 said they were not a high-maintenance resident and only call for an aide when they needed assistance with bowel incontinence care. Resident #13 stated the aide will come and turn off the call light, tell them they will be right back and then take over an hour to come and perform incontinence care.On 3/25/26 at 2:02 PM an interview was conducted with Resident #13. Resident #13 stated she was nervous about tomorrow because it will be Thursday and then Friday and the aides taking care of her will be on duty. Resident #13 said she had anxiety and was worried about not being cared for timely if she has to go to the bathroom. The resident stated she hoped with the State being at the facility things would get better.A review of Resident #13's admission record revealed an initial admission date of 7/21/21 and a readmission date of 11/25/23 with diagnoses to include progressive multiple sclerosis, major depressive disorder, insomnia, gastroparesis, and constipation.A review of Resident #13's quarterly Minimum Data Set (MDS) assessment, dated 12/23/25 section C - cognitive patterns revealed a Brief Interview Mental Status (BIMS) score of 15 out of 15, meaning the resident was cognitively intact. Section E- Behavior revealed a score of 0, meaning the behavior for rejection of care was not exhibited.A review of Resident #13's progress notes revealed there was no documentation of Resident #13's refusals for incontinent care or expressing any behaviors noted in the resident's care plan. A review of Resident #13's care plan dated 11/25/23 revealed the resident has potential for or actual psychosocial wellbeing. Resident is to remain free of issues with psychosocial well-being by being encouraged to voice concerns/feelings; and be provided with reassurance as needed. The resident has a potential for traumatization. Provide the resident with a calming and reassuring environment. The resident has an alteration or potential for alteration in mood and displays the following: Feeling down, depressed, or hopeless. Encourage the resident to voice feelings, and provide reassurance as needed.Provide 1:1 visits as needed. A review of Resident #13's Bowel Task from December 1,2025-March 24,2026 revealed Resident #13 did not have care documented for the following Thursday and Friday shifts:7 AM-3 PM: 12/5/25, 12/11/25, 12/12/25, 12/19/25, 12/26/25, 1/2/26, 1/8/26, 1/9/26, 1/15/26, 1/16/26, 1/22/26, 1/23/26, 1/29/26, 2/5/26, 2/12/26, 2/20/26, 2/27/26, 3/5/26, 3/6/26, 3/12/26, 3/13/26.3 PM-11 PM: 1/8/26, 1/15/26, 1/23/26, 2/12/26, 3/13/26.11 PM-7 AM: 3/19/26.On 3/25/26 at 2:12 PM an interview was conducted with Staff H, Lead CNA (LCNA). Staff H, LCNA stated residents should be checked on or changed at least every 2 hours and as needed/requested by the resident. Staff H, LCNA stated there should be documentation on whether or not care was provided for each shift, including refusals and if the resident did not need to be changed. Staff H, LCNA stated if there is no documentation then it is hard to prove if care was provided during a shift for a resident.On 3/25/26 at 2:12 PM an interview was conducted with Staff G, Registered Nurse (RN). Staff G, RN stated every time incontinence care is provided there should be documentation that follows. Even if the resident refused or if care did not need to be provided, documentation should still be input per shift.On 3/25/26 at 4:14 PM an interview was conducted with the Director of Nursing (DON). The DON stated the residents care plan and Kardex (a specialized nursing reference care documentation worksheet) should be followed, and all documentation related to bowel and bladder should be documented on the residents' profile. The standard is for incontinence (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	car to be provided every two hours or as needed, and if a resident has more than one bowel movement (BM) a day, then at least just one documentation per shift is required. The DON stated if a resident does not have a BM for the shift, then 0 should be documented. If there is no documentation for the shift, it is audited the next morning during the clinical meeting to see what percentages are being complete and to see where there might be forgotten documentation. The DON stated the expectation for care staff is to document as their job description describes, and they are unable to verify a completed task if there is no documentation. The DON stated the circumstance for Resident #13 was not the expectation of the facility, and the staff will need to be educated. The DON stated it is not okay for Resident #13 to be feeling nervous and have anxiety about the Thursday and Friday shift coming on. The DON stated Resident #13 has the right to be provided with incontinent care when the resident needs it. The DON stated she must get with the staff coming on the next day shifts and educate them on documentation and providing timely incontinence care to residents in order to prevent feelings of anxiety or not being cared for properly.A review of the facility's Certified Nursing Assistant Job Description revealed the following: The primary purpose of your position is provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan, and any other duties that may be directed by your supervisor. As Certified Nursing Assistant you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Record all entries on flow sheets, notes, charts, and computer programs in an informative and descriptive manner. Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors. Follow work assignments, and/or work schedules in completing and performing your assigned tasks. Keep residents dry (i.e. change gown, clothing, linen etc., when it becomes wet or soiled). Assist resident with bowel and bladder functions (i.e. take to bathroom, offer bedpan or urinal. Portable commode, etc.). Maintain intake and output records, as instructed. Keep incontinent residents clean and dry. Check and report bowel movements and character of stools, as instructed.A review of the facility's Quality of Life-Dignity Policy, revised February 2020, revealed the following: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times. The facility culture is one that supports and encourages humanization and individualization of residents, and honors resident choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example: Promptly responding to a resident's request for toileting assistance.A review of the undated facility policy and procedure titled, Bladder and Bowel Incontinence Policy, revealed the following: It will be the policy of this facility to ensure that residents that are incontinent will receive appropriate care and services based on the resident's comprehensive assessment. Residents that are incontinent or bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure a call light was within reach for one (Resident #127) out of one residents sampled. Findings Included: During an observation on 3/23/2026 at 2:36 PM Resident #127 was observed seated in a wheelchair on the right side of the bed, facing east, a table in front of him with an open styrofoam container with spaghetti and meatballs. Resident #127 raised his left wrist and pointed saying pain. Resident #127 pointed to his neck with his right hand and said pain. I have told many people, and they have not done anything. I cannot walk or move and my pants are dirty. Resident #127's call light was observed to be hanging on the left side of his bed, out of his reach. During an observation on 3/24/2026 at 8:49 AM Resident #127 was observed wearing a hospital gown, sitting on the right side of the bed facing the door. Resident #127 pointed to his neck and stated pain, can you help me. Resident #127's call light was observed on the floor underneath the left side of his bed, out of his reach. (photographic evidence obtained) During an observation on 3/25/2026 at 9:44 AM Resident #127 was observed lying on his right side dressed in a hospital gown. Resident #127 stated I want to sit up, I cannot sit up, can you help me sit up? Resident #127 pointed to his neck and stated Pain. Resident #127's call light was observed hanging behind him on the left side of the bed from the bed rail. Resident #127 could not reach the call light. Review of Resident #127's admission record revealed an initial admission date of 7/21/2025 and a re-entry date of 3/11/2026. Resident #127 was admitted to the facility with diagnosis to include encephalopathy, acute respiratory failure with hypoxia, unspecified dementia with other behavioral disturbance, brief psychotic disorder, other specified persistent mood disorders, aphasia, repeated falls, primary osteoarthritis, and other seizures. Review of Resident #127's admission minimum data set (MDS) dated [DATE] revealed a brief interview mental status (BIMS) of 6 out of 15 showing severe cognitive impairment. The Functional Abilities section revealed for self-care, toileting hygiene and lower body dressing Resident #127 is dependent, meaning helper does all of the effort. Resident does none of the effort to complete the activity. For mobility, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer Resident #127 needs partial/moderate assistance where helper does less than half the effort, Helper lifts, holds, and supports trunk or limbs, but provides less than half the effort. During an interview on 3/25/2026 at 3:30 p.m., Staff B, Certified Nursing Assistant (CNA), stated she checks on residents every two hours. I am checking to see if they need to be changed or need a drink. I also look to see if the call light is within reach. The call light should be clipped to the resident or near them. Resident #127 needs assistance with getting in and out of bed and moving around he cannot do a lot for himself. During an interview and observation on 3/25/2026 at 9:50 AM the Assistant Director of Nursing (ADON) stated, she spoke with the physician yesterday and the physician will be seeing Resident #127 for pain. The ADON stated no the call light is not within reach of Resident #127. She moved the call light from the left side of the bed and placed it on the right side of the bed. During an interview on 3/25/2026 at 2:38 PM the Director of Nursing (DON) stated call lights should be within reach of the resident so they can call for assistance if needed. Staff should check on residents at least every two hours. When checking on the resident they should ensure the call light is able to be reached by the resident. Review of the facility policy dated 4/1/2022, titled Call Lights, revealed Policy: It will be the policy of this facility to respond to the residents request and needs via notification with the call light system. Procedure: . 4. Twitter, the call light should be within easy reach of the resident. 5. Some residents may not be able to use their call light or may have visitors that may move belongings, including the call light. Staff should check on these residents regularly.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the comprehensive Minimum Data Set (MDS) was accurately coded for two (2) out of six sampled residents (Resident #6 # 77). Findings included: Review of Resident # 6 admission record dated 03/25/2026 revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to recurrent moderate major depressive disorder, unspecified post- traumatic stress disorder, and unspecified personality disorder. Review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/2026 revealed Section A Identification information A1500 Preadmission Screening and Resident Review (PASRR) revealed no for answer to is the resident currently considered by the state Level II PASRR process to have a serious mental illness and/ or intellectual disability or a related condition. Further review of the MDS revealed Resident # 6 should have been considered for a level II PASRR due to his mental illness for depression and post-traumatic stress disorder. Review of Resident # 77 admission record dated 02/25/2026 revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to recurrent moderate major depressive disorder, generalized anxiety disorder, unspecified brief psychotic disorder, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident #77's MDS with an ARD of 03/02/2026 revealed Section A Identification information A1500 Preadmission Screening and Resident Review (PASRR) revealed no for answer to is the resident currently considered by the state Level II PASRR process to have a serious mental illness and/ or intellectual disability or a related condition. Further review of the MDS revealed Resident # 77 should have been considered for a level II PASRR due to his serious mental illness. On 03/25/2026 at 2:16 PM, an interview was conducted with Staff D, Minimum Data Set Director (MDSD). Staff D stated she completed Resident # 6's MDS Initial assessment. When she reviewed his preadmission screening and resident review (PASRR) in January it showed he did not have a Mental illness noted that supported the need of a level II. So, she marked no in section A1500 to the answer should the resident be considered for a level II. Staff D stated when she conducted Resident #77 assessment and reviewed his PASRR it did not click that she should have selected yes to show he should have been considered for a level II PASRR based on his diagnoses. Staff D stated she will fix the assessment and put a plan of correction in place. On 3/25/2026 at 2:30 PM an interview was conducted with the Director of Nurses (DON). The DON stated her expectations are that residents' assessments are completed accurately.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure appropriate supervision during smoking time for one (Resident #77) out of four residents sampled. Findings included: On 03/22/2026 at 9:40 AM, and 1:45 pm, Resident # 77 was observed sitting outside smoking a cigarette with a smoke apron on. A staff member was observed sitting behind a table inside the facility with a cart observed next to the table. On 03/22/2026 at 9:40 AM. An interview was conducted with Staff B, Certified Nursing Assistant (CAN). Staff B, CNA stated she is the smoking aid for today. Staff B stated she always sits inside the facility when she provides supervision during smoking times. Review of Resident #77's admission record dated 02/25/2026 revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to major depressive disorder, recurrent, moderate, generalized anxiety disorder, brief psychotic disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety Review of Resident #77's physician order summary dated 03/25/2026 showed an electronic monitoring device, everyday shift check for function. Order date 3/12/2026. Review of an Elopement Risk Evaluation dated 3/12/2026 showed Resident #77 scored 14 indicating he is at risk for an elopement. Review of a Nursing Progress note dated 3/24/2025 showed Resident #77 exhibited exit seeking behaviors- Redirection was effective. Review of Resident #77's care plan showed a focus showing he has been assessed as able to smoke with supervision. Resident/responsible party have been informed of the facility smoking policy. Date initiated 03/12/2026, revised on 03/12/2026. Review of the care plan goals showed Resident #77 will adhere to the smoking policy daily. Resident will demonstrate safe smoking practices through the next review date. Target date 06/13/2026. Review of the care plan intervention showed accompany resident to designated smoking areas and provide supervision. On 03/25/2026 at 10:00 AM, Staff E, CNA was observed assisting Resident #77 with his cigarettes outside. Then Staff E returned to the facility to get something off the smoking cart while Resident #77 remained outside smoking. Later Staff E was observed back outside providing Resident #77 with supervision. Staff E stated she has to remain outside with Resident #77 while he is outside smoking because his hands shake while he smokes and he requires supervision. Staff E stated every resident that is marked to have supervision has to have staff outside with them during smoking times. They are not allowed to be left outside by themselves. On 03/25/2026 at 10:40 AM with the Director of Nurses (DON) and the Nursing Home Administrator (NHA). The DON stated if a resident needs supervision, then the aid could sit inside the facility and watch them from the window, even if the resident has dementia. If they require 1:1 then that's a different story. Then they would require staff to sit outside with them. The NHA stated her expectation is if a resident requires supervision, then that resident needs are met according to their care plan. The NHA stated supervision doesn't mean the aids have to sit outside with the residents because they can provide supervision while in the facility looking through the window. The NHA and DON both stated their definition of supervision is that staff monitor residents that require supervision from inside or outside the facility during smoking times. Review of the facility policy titled, Resident Smoking Policy, no date showed Policy Statement, it is the policy of this facility to establish and maintain safe smoking policies, in accordance with resident's rights and preferences, and in accordance with Life Safety Code requirements, and state and local laws governing safe practices for the facility. Direct Supervision of Residents, after residents has a smoking assessment performed by a licensed nurse and it is found that safety smoking equipment is necessary, smoking aides and residents must comply with the safety equipment is necessary, smoking aids and residents must comply with the safety equipment to ensure safety. The care plan must be reviewed to ascertain if any specific safety devices such as a non-flammable apron must be used during the smoking period. Residents must comply with any and all safety interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure a medication was obtained one (Resident #27) of seven residents sampled. Findings include: On 03/22/2026 at 9:20 AM, Resident # 27 was observed in bed with the bed at a 90-degree angle. A pillow was observed under his legs to keep his feet offloaded while in bed. Resident # 27 stated he has felt weak, so he has not been out of bed or participated in therapy. On 03/22/2026 at 12: 50 PM, Resident # 27 was observed sitting up in bed eating lunch and visiting with his wife. Review of an admission record dated 03/25/2026 revealed Resident # 27 was admitted to the facility originally on 01/20/2026 and readmitted on [DATE] with diagnoses to include but not limited to metabolic encephalopathy, generalized anxiety disorder, acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, obstructive sleep apnea (adult) (pediatric) Review of nursing progress note dated 3/11/2026 showed Modafinil Tablet 200 milligram (MG), give 1 tablet by mouth two times a day for obesity. Note showed order awaiting script medical doctor notified. Review of a nursing progress note dated 3/12/2026 showed Modafinil Tablet 200 milligram (mg), give 1 tablet by mouth two times a day for obesity. Note showed pharmacy to deliver. Review of a nursing progress note dated 3/13/2026 showed Modafinil Tablet 200 milligram (mg), give 1 tablet by mouth two times a day related to obstructive sleep apnea. Observe for adverse effects. Note showed awaiting from pharmacy medical doctor aware noted. Review of a nursing progress note dated 3/14/2026 showed Modafinil Tablet 200 milligram (mg), give 1 tablet by mouth two times a day related to obstructive sleep apnea. Note showed awaiting on pharmacy. Review of a change in condition dated 03/14/2026 revealed Resident # 27 was noted lethargic and hard to arouse, altered level of consciousness Review of a care plan focus for Resident # 27 showed he has a potential for respiratory complications or respiratory distress related to (r/t) acute and chronic respiratory failure and obstructive sleep apnea, Resident # 27 becomes shortness of breath when lying flat. Date initiated 02/01/2026 and revised date 02/01/2026. Review of the care plan goals showed Resident # 27 will remain free from symptoms of respiratory distress. Resident # 27 will be able to maintain patent airway and will not exhibit signs of respiratory distress through next review date 03/11/2026, Target date 04/19/2026. Review of the care plan intervention showed administer medication as ordered; observe for effectiveness and side effects. On 03/24/2026 at 5:00 PM an interview was conducted with Staff C, Registered Nurse (RN)/Unit Manager (UM) and the Director of Nurses (DON). Staff C, RN/UM stated when Resident # 27 was admitted to the facility the hospital did not send a script for the Modafinil medication. He was admitted to the facility on the evening shift, so he would not receive his medication the same day he came to the facility due to his arrival time. They reached out to the Advanced Registered Nurse Practitioner (ARNP), to find out if she could fill the script or if they had to reach out to psych or pain management. Staff C, RN/UM stated the medication is used for his sleep apnea. Staff C stated Resident # 27 primary provider confirmed she would send over a script for the medication on the 12th, but they did not receive it. Staff C stated Resident # 27 missed a total of three days of his medication. During that time, they closely monitored his labs. Staff C stated they reached back out to the primary to inform them they did not receive the script to fill for the Modafinil, and she sent over another one on the 16th. Staff C stated it is not acceptable Resident # 27 had to go 5 days without his medication. On 3/25/2026 at 6:00 PM, an interview was conducted with the Medical Director. The Medical Director stated it was not acceptable that the resident did not receive his medication for the days he missed. If the facility could not get one of the resident's doctor, then they should have reached out to him, and he would have filled the script for the Modafinil. He stated he is always available and Resident # 27 should have never had to go without his medication for that amount of time. On 3/25/2026 at 6:11 PM, an interview was conducted with the pharmacy consultant. He stated he is not responsible for medication scripts at the facility. He only (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105978	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Shore Care Center	6767 86th Ave N Pinellas Park, FL 33782

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducts pharmacy reviews, and gradual dose reductions. He stated he can provide information on what would happen if a resident went without Modafinil for a few days. He stated a resident would be extremely weak and would not be able to participate in anything because they would be very lethargic. Review of the facility policy titled, Medication Ordering and Prescribing: New Orders, Revision date 9/2014 showed Purpose, to ensure that residents receive newly ordered medications in a timely manner. Policy, the facility will submit new orders to the pharmacy in a consistent manner.New admissions: Facility will send orders for new admission to the pharmacy using a blank Physician Order Sheet or the facility's preprinted admission Order Sheet. Orders will be submitted to the pharmacy via facsimile.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, interviews, and record review the facility did not ensure narcotics were double locked and stored safely, medications were labeled with an opened date and an expiration date, and thickened liquids requiring refrigeration were removed from one of two medication storage rooms and one of four medication carts.Findings included: An observation on 3/22/2026 at 9:50 A.M. of the East side medication storage room revealed several narcotics were stored in an unlocked box in the refrigerator labeled B Box. An observation on 3/22/2026 at 10:00 A.M. of East Hall 200 medication cart revealed a Symbicort inhaler was opened, used, and undated; an opened box of thicken liquids dated 2/22/2026 in third drawer of the medication cart. The directions on the thickened liquids box were: Refrigerate prior to serving.After opening, may be kept up to 7 days under refrigeration. An interview on 3/22/2026 at 10:02 A.M. with Staff K, Licensed Practical Nurse (LPN) was conducted. He said the narcotics should have been locked. He said he did not have a key for the lock. He said that narcotics in the box were for his residents, and he is responsible for keeping the narcotics locked. He said he did not know when the inhaler was opened, stating, I will date it for today. He said the thickened liquids should have been stored in the refrigerator and he did not know why it was stored in the medication cart. An interview on 3/22/2026 at 10:16 with Staff L, LPN/Unit Manager was conducted. She said the narcotics in the refrigerator should have been locked and she did not know why or how long the narcotics were unlocked. She said the inhaler should have been labeled with the opened date. She did not know when it was opened. She said the box of thickened liquids was expired and does not belong in the medication cart. An interview on 3/25/2026 at 9:51 A.M. with Director of Nursing (DON) was conducted. The DON said the narcotic box in the refrigerator should have been locked. The DON said the box of thickened liquids was not supposed to be stored in the medication cart and should have been discarded. The DON said the expectation was for all medications to be labeled with the date the medication was opened and the expiration date. A record review of an undated policy titled Medication Labeling and Storage interpretation for medication storage was 2: The nursing staff is responsible for maintaining medication storage and preparation areas; 6: Medications are stored separately from food and are labeled accordingly; 7: Controlled substances are separately locked in permanently affixed compartments. A record review of an undated policy titled Administering Medication interpretation was 12: When opening a multi-dose container, the date opened is recorded on the container.