STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105117	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Heritage Health & Rehabilitation Center	718 Lakeview Ave S Saint Petersburg, FL 33705

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for one resident (#1) out of seven sampled residents. Resident #1 sustained an unwitnessed fall on 08/21/25 and was not assessed after the fall. Resident #1 complained of hip pain on 08/23/25, an X-ray was obtained on 08/24/25 and Resident #1 was transferred to a higher level of care due to a right hip fracture on 08/24/25 and required surgical intervention.Findings included: An interview was conducted with Resident #2 on 09/02/2025 at 10:08a.m. Resident #2 was the roommate of Resident #1 and recalled the events of 08/21/2025 when Resident #1 had a fall. She stated the night of her roommate's fall; she was starting to fall asleep when she heard a loud sound and heard her roommate grunting ouch. Resident #2 said she remembered seeing her roommate in her wheelchair near the door shortly before the fall, but she was unsure as to what she was doing when the actual fall occurred. After she heard her roommate grunting ouch she immediately pushed her call light to get help and began yelling out for help. Resident #2 said it took ten minutes for staff to respond. Resident #2 stated she heard someone come into the room and then call for a second person to assist. She assumed the facility was following their protocol and taking care of the roommate until two days later when other staff members asked her if Resident #1 had fallen. Resident #2 said after the fall she had mentioned to staff, more than once, that her roommate seemed to be in pain and then she later found out she had broken her hip.An interview was attempted with Resident #1 on 09/02/25 at 9:25 AM, 1:30 PM, and 2:45 PM. Resident #1 was in bed with eyes closed for all three interview attempts.Review of Resident #1's admission Record revealed an admission date of 01/14/25 and readmitted on [DATE]. Resident #1's diagnoses included fracture of unspecified part of the neck of right femur with an onset date of 08/27/25. Other diagnoses included muscle weakness, reactive arthropathies, unspecified site., dementia without behavioral disturbances, osteoarthritis, anxiety disorder, arthritis, abnormalities of gait and mobility, lack of coordination, and metabolic encephalopathy. Review of Resident #1's Minimum Data Set (MDS), dated [DATE], Section C Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating moderate cognitive impairment. Review of Resident #1's medical record did not reveal any documentation or assessments related to a fall on 08/21/25.Review of Resident #1's progress notes revealed the following:On 08/23/25 at 10:10 AM a late entry note revealed, Resident's [family] was called at 10:07AM. I informed [family] that [Resident #1's] hip was broken and asked him what hospital he wanted her sent out to, .said [Hospital].On 08/23/25 at 5:00 PM revealed The Change In Condition/s reported on this CIC [change in condition] are/were: Falls.On 08/23/25 at 5:12 PM revealed Resident has a fall in room according to roommate. Resident is c/o [complaint of] Right hip/pelvis pain when leg is moved. MD [Medical Doctor] called and X-Ray ordered.On 08/23/25 at 5:20 PM a late entry note revealed Resident's [family] was called also and made aware that X-ray was being done due to possible fall with injuries. Pain medication was given Tylenol 500mg [milligrams] two tabs for pain with effective results. Resident stopped crying out and was lying in bed quietly.On 08/24/25 at 10:17 AM revealed Resident is being sent out to [Hospital] due to fracture of right hip.On 8/27/25 at 7:15 PM revealed patient returned from hospital via stretcher accompanied by EMS [Emergency medical Service] team.On 8/28/25 at 3:38 AM revealed, Resident status post right hip hemiarthroplasty with multiple sutures on right hip clean dry dressing intact. Abdominal binder in place due to replacement of peg tube that was dislodged while in hospital. Resident in bed at this time wither periods of moaning. PRN [as needed] medication administered for pain. Will continue to monitor.A review of Resident #1's hospital records revealed the following Assessment/Plan: Patient presented to hospital initially after sustaining a hip fracture after ground-level fall, underwent repair on 8/25/2025. Indication for surgery: Right displaced femoral neck fracture. Scheduled Procedure: 8/25/25 12:30 PM right hip hemiarthroplasty. Fortunately her PEG tube has become dislodged.will plan for EGD [esophagogastroduodenoscopy] with PEG [percutaneous endoscopic gastrostomy] insertion today, 8/26/2025.Risks, benefits and alternatives of endoscopic procedure discussed.including but not limited to infection, bleeding, perforation and need for surgery or repeat procedures or blood transfusion or hospitalization. Other risks include complications related to sedation. Death is a rare event.An interview was conducted on 09/02/2025 at 1:20 PM with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Risk Manager. The NHA stated around 11:20 p.m. on Sunday 08/23/2025 she received a phone call notifying her that Resident #1 had fallen a few days prior and had been experiencing pain. Orders for an x-ray had been put in and the next morning