STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105271	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Ciega Center	1414 59th St S Gulfport, FL 33707

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews, the facility failed to provide adequate supervision to prevent resident to resident altercation for two (#5 & #6) of thirteen sampled residents. Findings included: A review of Resident #6's admission record showed an admission in 02/2020. The diagnosis information included: chronic pain syndrome; neuromuscular dysfunction of bladder; muscle wasting and atrophy not elsewhere classified; idiopathic progressive neuropathy; generalized anxiety disorder; bipolar disorder; type 2 diabetes; atherosclerotic heart disease of native coronary artery without angina pectoris; . A review of Resident #6's BIMS, dated 02/03/2026, documented a score of 14, which indicated cognitively intact. A review of Resident #5's admission record showed an admission of 01/05/2026. The diagnosis included: cerebral infarction; dysarthria following cerebral infarction; encephalopathy; difficulty in walking; unspecified dementia without behavioral disturbance; psychotic disturbance, mood disturbance and anxiety; cognitive communication deficit; . A review of Resident #5's Brief Interview for Mental Status (BIMS), dated 01/06/2026, documented a score of 00, which indicated severe cognitive impairment. A review of Resident #5's progress note dated 03/05/2026 showed an Interdisciplinary team (IDT) meeting held to discuss Resident #5 for elopement risk. Resident #5 with diagnosis of Dementia, able to self-propel in wheelchair. BIMS 0. IDT agrees to continue with wanderguard. Wanderguard in place and functional. Care plan reviewed. A review of Resident #5's Progress notes, dated 03/18/2026 at 3:12 p.m., documented by the Social Service Director: Staff observed an altercation between two residents on 400 hall. The conflict began after resident was in another resident room touching their property. [sic] coming into room putting on the resident shoes. Verbal escalation occurred, followed by punches being thrown by both residents. Resident was crying stating he was punching and punching. [sic] . Evaluation completed, resident was observed with an injury in the area of their eye and side of their face. Resident appeared crying, shaken up following the incident. A review of Resident #5's nursing skin check dated 03/18/2026 at 4:12 p.m., revealed Resident #5 had three new skin impairments found: left eyebrow cut, left temple hematoma, and below left temple abrasion. A review of Resident #5's Progress notes, dated 03/20/2026 at 2:38 p.m., revealed a follow up with Resident #5 related to the incident. Resident #5 was asked if he was in pain and resident pointed to his face above eye and said ouch, something there. Resident observed in no emotional or psychological distress or anxiousness. Will continue to monitor. An interview conducted on 03/24/2026 at 11:21 a.m. with the Social Service Director (SSD), she stated she was familiar with Resident #5, prior to coming to this facility, he had been in another facility, he has a guardian. Yes, he goes into other peoples' rooms. He is not interviewable. He is in a wheelchair (w/c). On 03/24/2026 at 11:15 a.m., an observation of the location of Residents #5 and #6's rooms. Their rooms were separated by fifteen other resident rooms and the nurses' station. On 03/24/2026 at 11:24 a.m., an observation of Resident #5, in the dining room, sitting with a Speech Therapist. Resident #5 was observed dressed in seasonally appropriate clothing, bruising on the left outer eye area. On 03/24/2026 at 11:40 a.m., an interview was conducted with the Speech Therapist. The Speech Therapist stated currently working with Resident #5. She said, Resident #5 has documented to dementia prior to admission to this facility. He is oriented towards himself. He does (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 0689 Level of Harm - Actual harm Residents Affected - Few	not know where his room is. Resident #5 is a busy body. He will spend all day looking for his room. He likes reading. The speech therapist explained Resident #5 has aphasia, meaning he has difficulty in naming objects. The speech therapist stated, Resident #5 knows something happened to him. The speech therapist stated Resident #5 suffered from significant bruising right after the event, as the bruising was much worse than it is now. She said Resident #5 points to the bruise at sometimes. The speech therapist stated Resident #5 does wander although easily re-directed. On 03/24/2026 at 2:00 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She confirmed she had been working on the day of the altercation, 03/18/2026, between Resident #5 and #6. She stated she did not see it. I was at the nurses' station. The oncoming nurse (Staff B, LPN), came up the hall with (Resident #5). Staff A was observed to motion towards the end of the hall where Resident #6's room was located. She stated, (Resident #5) had blood on his face and eye. I asked him what happened. (Staff B) said Resident #6 hit Resident #5. I grabbed the Business Office Manager and went to Resident #6's room. I asked Resident #6 what happened. He said they were fighting. Staff A stated, Resident #5, he does not understand. I said to Resident #6, if he was doing something, why not just call? When Staff A was asked if she could recall the last time she had seen Resident #5 prior to the event on 03/18, she said, The last time. At this time, Staff A was observed to look down the hall, and she stopped what she was saying. An observation was conducted of Resident #5 in his (w/c), at the end of the hall next to the exit doors outside of Resident #6's room. Staff A was observed to run down the hall, observed to re-direct Resident #5, back towards the nursing station. He was observed to self-propel his w/c towards the nursing station. Staff A continued the interview, she stated, that day, she had seen Resident #5 after lunch. I don't think he knows what room is his. He needs to be re-directed. On 03/24/2026 at 2:18 p.m., an interview was conducted with The Minimum Data Set (MDS) Coordinator, Registered Nurse (RN). The MDS/RN stated being responsible for completing the care plan for Resident #5. The MDS/RN was asked about Resident #5's wandering behavior and stated knowing about the behavior. The MDS/RN stated a behavior care plan was developed for Resident #5's wandering into other residents' rooms. The MDS/RN stated, I do not believe he knows where his room is. A review of Resident #5's Care Plan was conducted with the MDS coordinator. The Care Plan documented a focus: Behavioral: The resident has a behavior problem r/t (related to) wandering into other residents' room, rummaging, initiated 03/17/2026. The goal of the plan: The resident will have few episodes. The interventions listed were:Document behaviors, and resident response to interventions, initiated 03/17/2026.Intervene as necessary to protect the rights and safety of others. Approach/ speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, initiated 03/17/2026.Praise the resident for appropriate behavior as indicated, initiated 03/17/2026.Consider location, time of day, persons involved, and situations. Document behavior and potential causes, initiated 03/24/2026.Anticipate and meet the resident needs, initiated 03/24/2026. On 03/24/2026 at 2:30 p.m., an interview with Staff C, Certified Nursing Assistant (CNA). She stated she was familiar with Resident #5, she had him on and off. She stated he was ambulatory with a w/c. Yes, he goes into other peoples' rooms, he has been doing it since he has been here. On 03/24/2026 at 2:37 p.m., an interview was conducted with Staff D, CNA. She stated she was assigned Resident #5 on a regular basis. She stated, since he has been here, he has self-propelled in the w/c; he will follow simple instructions. His room, he does not remember, he goes into every room; he has dementia. She confirmed she had worked on 03/18. She stated she normally changes her assigned residents after lunch, she had changed him and saw him wandering. She stated, when we see him going into other residents' rooms, I re-direct. I do not document going into rooms. On 03/24/2026 at 3:08 p.m., an interview was conducted with the Director of Nursing (DON). She stated a BIMS was conducted for Resident #5 on 01/06/2026, the score was 0, which indicated the resident was cognitively impaired'. She stated Resident #5 does have the behavior of wandering into rooms. He has only done it a couple of times per my knowledge, that was reported to me. Normally CNAs or nurses report to the unit manager and it is communicated to us in the clinical stand down meeting, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	daily at 3:15 p.m. On 03/25/2026 at 12:30 p.m., the 03/18 event between Resident #5 and #6 was reviewed with the Nursing Home Administrator (NHA) and the DON. The NHA stated the event occurred on 03/18/2026 at approximately 3:00 p.m. in Resident #6's room. It was unwitnessed. The NHA stated Resident #6 came back from a leave of absence to his room and saw Resident #5 in the room with Resident #6's shoe on. The NHA said, Resident #6 stated he went to take the shoe off of Resident #5 and their heads bumped, he said it was an accident. Resident #5 was unable to provide details. Resident #5 had redness and swelling to his left eye. When the NHA and the DON were asked if they had been aware of Resident #5's behavior of wandering into residents' rooms, both stated, they were unaware of Resident #5's behavior of entering other persons rooms until this event. They said, we should have been made aware of it. We were aware that (Resident #5) moved around the facility freely. On 03/25/2026 at 2:13 p.m., the NHA was asked if she had reviewed the camera footage for the date, 03/18/2026. The NHA confirmed video footage was available for the hall in front of Resident #6's room since it was near an exit door. The NHA stated, we are looking at it today. On 03/25/2026 at 2:45 p.m., the NHA provided the available video recording. She stated the time indicated on the video record was one hour and 3 minutes off, behind due to daylight savings time. i.e. 13:39 would mean 14:39 +3 min, =2:42 p.m. A review of the footage was conducted with the NHA. The view of the video footage, the camera was directed at the exit door, which Resident #6's bedroom door could be observed. The following was observed: 13:39 (2:42 p.m.), Resident #5 was observed in front of the exit doors in the hall, outside of Resident #6's room. Resident #5 was in a w/c, he was looking and touching the wall in the hall. 13:40 (2:43 p.m.), Resident #5 self-propelled into Resident #6's room. 13:50 (2:53 p.m.), Resident #6 was observed to come into view. He was on a motorized w/c. He entered the room; the door closed to leave an approximate one-foot opening. 13:52 (2:55 p.m.), Resident #5, was observed self-propelling out of the room, in his w/c, a stream of blood could be seen from his eye, down his cheek to his mouth. He had two different shoes on. The NHA confirmed she observed blood on Resident #5's face; she stated Resident #5 was headed towards the nursing station. 13:52.39 (2:55.39 p.m.), Staff B, LPN, was observed coming into view, walking towards Resident #6's room, he turned and entered the room across the hall from Resident #6's room. 13:52:55 (2:55.55 p.m.), Staff B, LPN, was observed coming out of the room from across the hall, leaving the view of the camera towards the nurses' station. 13:53:06 (2:56.06 p.m.), Resident #6 is observed exiting his room on his motorized w/c; no blood is observed on his person. Staff B, LPN was observed to come into view and interact with Resident #6. The NHA stated Staff B, LPN, was talking to Resident #6, keeping him at the one end of the hall. End observation. A review of the facility's Abuse Prevention Program policy and procedure, last revised 03/2022, documented the policy: The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment and misappropriation of resident's property. The Procedure: The facility has implemented the following processes in an effort to provide residents, visitors and staff with a safe and comfortable environment. Prevention .Facility leadership will identify situations in which abuse, neglect, mistreatment, exploitation, misappropriation may be more likely to occur, such as: Residents with needs/ behaviors which might lead to conflict or abuse/ neglect.