STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105275	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Pines Nursing Center	6140 Congress St New Port Richey, FL 34653

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 - 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, interviews, and record review, the facility failed to provide supervision to a known wandering resident resulting in an incident of potential sexual abuse for two residents (#8 and #9) out of three residents sampled. On 05/30/2026, facility staff became aware that Resident #9, who was cognitively impaired, had entered Resident #8's bed while both residents were fully unclothed. The facility did not implement immediate protective measures consistent with their policy. Findings included: On 06/24/2026 at 02:36 PM, Resident #9 was observed self^propelling through D^Hall without staff present. Resident #9 did not answer questions, and continued past her own room, and approached the threshold of another resident's room. At 02:48 PM the same day, Resident #9 was observed self^propelling from the dining room toward the area between A^Hall and B^Hall, without staff supervision. During an interview on 06/24/2026 at 02:12 PM, Resident #8 stated that on 05/30/2026, Resident #9 came into his room, removed her clothing, and got into his bed. He reported that both he and Resident #9 were fully unclothed and lying together for approximately half an hour before staff entered the room and removed Resident #9. Resident #8 reported that a staff member then sat in a chair next to his bed and would not allow him to leave the bed for about 15 minutes. During an interview on 06/24/2026 at 02:28 PM, Staff A Certified Nursing Assistant (CNA) stated Resident #9 was ambulatory with minimal assistance and frequently self^propelled around the facility. Staff A stated Resident #9 entered any random room all the time, attempted to enter other rooms almost daily, and that she had received no direction regarding increased supervision since the incident on 05/30/2026. During an interview on 06/24/2026 at 02:43 PM, Staff B, CNA stated Resident #9 piddles around everywhere, had wandered into rooms on a different wing, and had attempted to get into another resident's bed previously. During an interview on 06/24/2026 at 02:47 PM, Staff C, CNA stated that Resident #9 wandered around the facility. During an interview on 06/24/2026 at 03:06 PM, Staff D Licensed Practical Nurse (LPN) stated Resident #9 was very confused, had dementia, frequently propelled herself up and down halls, entered other residents' rooms, and attempted to exit the building. Staff D stated redirection was sometimes ineffective. Staff D confirmed Resident #9 did end up in the bed with [Resident #8] and was not clothed. Staff D also stated staff were not allowed to enter certain information into the medical record and added, this place has a habit of sweeping things under the rug. An interview on 06/24/2026 at 03:54 PM, with Staff E, LPN revealed Resident #9 wandered frequently and on 05/30/2026 she got into [Resident #8's] bed. Staff E reported when Staff F called for assistance, she found Resident #9 lying on the right side of Resident #8's bed, unclothed from the waist down, with her head at the head of the bed and back toward Resident #8's roommates. Resident #8 was in the bed with a blanket wrapped around his genital area and no other clothing visible. Staff E reported she had been in the room [ROOM NUMBER] to 30 minutes prior and did not know how long Resident #9 had been in the bed. She stated Resident #9 frequently entered other residents' beds and rooms. Staff E stated Staff F had previously reported Resident #8 made sexually inappropriate comments. During an interview on 06/24/2026 at 05:23 PM, Staff F, CNA) stated that on 05/30/2026 at approximately 09:00 PM, she returned from a (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	30ˆminute break and observed Resident #8's curtain closed, which was unusual. Upon opening the curtain, she found Resident #8 and Resident #9 completely naked in Resident #8's bed. Resident #9 was lying flat on her back with all body parts exposed, and her clothing, including her adult briefs were placed on her wheelchair. Resident #8 was sitting at the foot of the bed with his back to Resident #9. Staff F stated she removed Resident #9 from the room and assisted Resident #8 with incontinence care. She reported that supervision of Resident #9 involved redirection, oneˆonˆone monitoring for short periods, and 15ˆminute checks, but stated that sometimes it could slip and she did not know who supervised her residents while she was on break. On 06/24/2026 at 05:52 PM, an interview was conducted with the Nurse Practitioner for both residents who stated she was informed by facility staff that the residents had been found together briefly and fully clothed. She stated that had she known they were unclothed and together for approximately 30 minutes, she would have conducted a more extensive assessment and obtained additional history. She stated a reasonable person could have experienced emotional harm, stress, anxiety, or confusion as a result of the incident. During an interview on 06/24/2026 at 09:37 PM, the Social Services Director (SSD) stated she contacted the NP and reported Resident #9 had briefly gotten into Resident #8's bed and admitted she did not provide additional details. During an interview on 06/24/2026 at 08:06 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) stated the DON was notified at 08:55 PM on 05/30/2026 that Resident #9 had been found in Resident #8's room. They confirmed Resident #9 was completely unclothed below the waist and Resident #8 had only a brief on. They stated they did not know how long they had been together, did not know who was supervising the residents while Staff F was on break. They stated they did not interview Resident #9's roommates. They confirmed the investigation did not begin until 06/02/2026. They stated they implemented interventions for 15ˆminute checks for Resident #9. They stated there was a possibility a reasonable person would have had a negative outcome. They stated supervision was performed through staff members but not directly assigned to specific residents. The NHA stated there was not adequate supervision. Record review revealed that Resident #8 had moderate cognitive impairment and a history of sexually inappropriate behaviors, while Resident #9 had severe cognitive impairment, dementiaˆrelated wandering, and required increased supervision as outlined in her care plan. Documentation from 05/30/2026 did not reflect monitoring consistent with the resident's needs or facility policy. Review of a facility policy titled, Abuse, Neglect, Exploitation, Misappropriation, Mistreatments, and Injury, revised 03/2025, revealed (2.) Neglect means the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.