STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105409	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golfview Nursing Center	3636 10th Ave N Saint Petersburg, FL 33713

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to permit a resident to return to the facility after a hospital stay for one resident (#1) of three sampled residents reviewed for discharge process. Resident #1 was eligible for discharge from the hospital on [DATE] and as of 06/27/2025, the facility notified the hospital Resident #1 was not accepted back at the facility. Findings included:A review of Resident #1's admission Record revealed he was admitted to the facility on [DATE] and was discharged on 05/17/2025 to an acute care hospital. His medical diagnoses included, but not limited to schizoaffective disorder, bipolar type; unspecified diastolic (congestive) heart failure and atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, and morbid obesity due to excessive calories.A review of a Brief Interview for Mental Status (BIMS), dated 03/26/2025, documented a score of 15, which meant the resident was cognitively intact.A review of Resident #1's care plan, initiated 04/20/2023, reflected a focus area: [Resident #1] wishes to Stay[sic] at this facility under long term care. The goal of the plan: The resident's discharge goals are LTC (Long Term Care). The interventions included: Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress, initiated on 04/20/2023.A review of Resident #1's progress notes revealed the following: 05/17/2025 at 6:00 p.m.: Nurse reported to this writer that resident had a change in condition. This writer went to resident room. Resident noted to have vitals as followed . HR [heart rate] 117, O2 [oxygen] Sats [saturation] Fluctuating between 74-76% on 3 liters Via N/C [nasal cannula]. Temp [temperature] 99.4 Tympanic. Patient presented with altered mental status, noted to be confused and unable to follow simple commands due to concerning vitals and neurological presentation, 911 activated .05/17/2025 at 6:42 p.m.: hospitalized [DATE] at 6:51 p.m.: Call place to [Hospital], Admitting DX [diagnosis] Acute Hypoxic Respiratory Failure.Review of the facility's Midnight Census Report dated 7/1/25 and 7/2/25 revealed Resident #1 was not admitted back to the facility.Review of Resident #1's medical record did not reveal a 30-day notice of discharge was provided to Resident #1.An interview was conducted on 06/18/2025 at 11:26 a.m., with Staff E, Director of Nursing (DON). Regarding Resident #1, she stated the reason the resident was transferred to the hospital was respiratory distress. She confirmed the resident had been at the facility for three to four years. She confirmed the Nursing Home Transfer and Discharge Notice, dated 05/17/25, was the notice provided on 05/17/25 for the transfer to the hospital. She stated the resident had not come back. When asked if Resident #1 could come back, Staff E, DON said, Yes. When asked if there was any reason the facility would not take him back, Staff E, DON said, There was a discussion about safety due to his size. His weight is (### pounds). It took over an hour to complete his transfer to the hospital. It took three different transports to be able to transfer the resident due to his size and the type of equipment necessary. Staff E, DON stated, I just received paperwork today, (06/18/2025), the hospital is requesting the resident to come back. She stated this was the first paperwork from the hospital asking for a return. When asked if anyone had received any phone calls requesting the return of the resident, she stated she would have to talk to the Nursing Home Administrator (NHA). Most of the time, the case managers will talk with the NHA about a returning resident. An interview was conducted on 06/18/2025 at 1:44 p.m. with the NHA and Staff E, DON regarding Resident #1. The NHA stated the hospital had not called him, but the hospital had called Representative A, Hospital/Facility Liaison. The NHA stated he did not know when Representative A, Hospital/Facility admission Liaison was called or what the discussion was. The NHA stated, probably one week after the resident was admitted to the hospital, we had a discussion that the resident should come back. The NHA said he had not decided whether or not to take the resident back at the time. He said he did not know if Resident #1 was ready to come back. The NHA said, if the resident wanted to come back, he could come back. Staff E, DON stated she had received clinical paperwork that morning (06/18/2025).On 06/18/2025 at 10:12 a.m., Representative B, Local Hospital Supervising Care Coordinator, was interviewed by phone. He stated when an attempt to return Resident #1 back to the facility was made, the admissions coordinator flat out refused to take the resident back. Representative B, Local Hospital Supervising Care Coordinator stated Resident #1 was still in the hospital, he is alert and oriented. The hospital has been having a difficult time placing the resident. When asked if the facility had requested any additional information from the hospital about the resident's condition to make their determination on whether or not to take the resident back, he said no. The resident had no additional conditions.On 06/18/2025 at 2:10 p.m. Representative B, Local Hospital Supervising Care Coordinator, was interviewed again by phone. He

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He said he does not know why the facility didn't accept the resident back. He said he did not know where Resident #1 was at this time. A phone interview was conducted on 7/2/25 at 9:35AM with the NHA. He said Representative A, Facility/Hospital admission Liaison, is a third party contracted personnel who handles the admissions and the readmission back to the facility, the facility does not have an in-house admissions coordinator. The NHA said when a hospital requests a readmission the interdisciplinary team at the facility reviews the hospital documentation to see if the resident is safe for admission. He said Representative A, Facility/Hospital admission Liaison, is the person who informs the hospital of the decisions and the NHA said he includes Representative A, Facility/Hospital admission Liaison, as part of the interdisciplinary team who reviews the information provided. The NHA confirmed Resident #1 has not been re-admitted back to the facility because he has concerns about Resident #1's weight, although the resident has lost some weight while he's been in the hospital. The NHA said he has talked to the social worker at the hospital, and they said he still weighs over 600 pounds. The NHA said the facility still has not made the decision to accept Resident #1 back or not because of his weight. The NHA said he does not know if Resident #1 is ready for discharge from the hospital. The NHA said he started as the NHA on the day Resident #1 was sent out to the hospital, so he does not know how the facility was providing care to Resident #1 leading up to his discharge to the hospital. A phone interview was conducted on 7/2/25 at 12:11 p.m. with Resident #1. He said he was still at the hospital, but he is feeling better. Resident #1 was asked if he wanted to go back to the facility and he said, I can't go back to the facility because they won't take me back. He said he doesn't know why they won't take him back but it makes me feel bad. He said he never received a discharge notice from the facility. He said he has been ready for discharge for about a month now, but the hospital is having a problem finding a place for him because of his weight. He said the hospital is now looking for facilities outside of Florida. He said most of his family is in Florida. He said the staff at the facility were bringing him food from outside the facility, chicken, shrimp, oxtails, ice cream with caramel sauce. They were feeding my addiction, so I was getting bigger and bigger. Resident #1 said he has lost 65 pounds at the hospital because they put him on a concentrated carbohydrate diet. A phone interview was conducted on 7/2/25 at 12:25 PM with Representative C, Local Hospital's Case Manager. She said she was working on Resident #1's discharge back in May of 2025. She said she spoke to Representative A, Facility/Hospital admission Liaison. He was nasty to me. She said when she asked him if the facility was going to readmit Resident #1, he told me Yea well we're not. She asked what that meant and he told her No. She said her supervisor, Representative B, Local Hospital Supervising Care Coordinator, called Representative A, Facility/Hospital admission Liaison on 5/26/25 and wrote a note on 5/26/25 at 12:15 p.m. which said Consult to escalate. Patient is long term care of [Facility] since April of 2022. [Representative A, Facility/Hospital admission Liaison] is refusing, adamantly refusing, to accept the patient back. He said the patient was confused when he left the facility, so they called the POA [Power of Attorney] who refused to sign the bed hold so they do not have to take the patient back. [Representative A, Facility/Hospital admission Liaison] continues stating patient is bariatric, over 700 pounds, eats/orders whatever he wants, difficult to turn, has bed sores and no longer able to meet his needs. Since the POA refused to sign the bed hold he is under no obligation to take the patient back. [Representative A, Facility/Hospital admission Liaison] informed me no 30-day notice was provided but he is well within his right to refuse the patient because the bed hold was never signed. Representative C, Local Hospital's Case Manager said Resident #1 has lost a lot of weight since he has been at the hospital and as of today, he weighs 656 pounds and the day after he came into hospital, he was 709.5 pounds. She said Resident #1's discharge case has been escalated up to the complex discharge social worker at the hospital. A phone