STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105537	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Boca Ciega Bay	1255 Pasadena Ave S, Suite C South Pasadena, 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an injury of unknown source-an acute right subcapital femoral neck fracture, was reported to the Agency for Healthcare Administration (AHCA), Adult Protective Services (APS), and local law enforcement within 24 hours of becoming aware of the X ray results, for one resident (#2) of six sampled residents. Findings included: Record review showed Resident #2 was admitted on [DATE] and readmitted on [DATE]. Diagnoses included cerebrovascular disease, prior intracerebral hemorrhage, hypertension, dysphagia, hemiplegia following cerebral infarction, and a need for extensive assistance with personal care.A Brief Interview for Mental Status (BIMS) dated 08/29/2025 documented a score of 6, indicating severe cognitive impairment.Review of the facility's event log (03/01/2026-05/16/2026) showed:04/08/2026: Unwitnessed fall with a skin tear to the left elbow; no additional injuries documented.04/28/2026: Unwitnessed fall; nursing assessment documented no injuries. On 06/15/2026 at 3:30 p.m., the Director of Nursing (DON) confirmed these assessments.On 06/15/2026 at 10:01 a.m., a phone interview with the resident's family member/POA revealed: On 05/03/2026, the resident had extreme pain. Hospice was contacted to assess the resident. The family insisted on an Xˆray. Hospice crisis care evaluated him, provided pain management, and ordered an Xˆray. Hospice later informed the family that the Xˆray revealed a fracture in the upper right thigh. The family member reported the nursing home's demeanor changed following this discovery, becoming cold.Record review showed an Xˆray procedure (Hip unilateral with or without pelvis, 2-3 views) completed on 05/06/2026 at 23:17 and reported on 05/07/2026 at 4:39 a.m.Final Radiology Report Findings showed an Acute right subcapital femoral neck fracture, 1/2 shaft-width superiorˆlateral displacement, Soft tissue swelling; no dislocation and Bony demineralization.On 06/15/2026 at approximately 3:30 p.m., interviews were conducted with the Nursing Home Administrator (NHA) and the DON. The DON stated the family reported the resident's pain on 05/04/2026, prompting hospice involvement on 05/04, 05/05, and 05/06/2026. The DON stated she physically assessed the resident on 05/06/2026 but did not document the assessment. The DON confirmed she reviewed the Xˆray results on 05/07/2026 in the morning. The physician reviewed the Xˆray at approximately 8:30 a.m. on 05/07/2026 and concluded the fracture was pathological. The NHA stated she became aware of the fracture on her way to work on 05/07/2026. She stated she did not report it because the physician believed the fracture was pathological and she had no indication of abuse or neglect.Record review and interviews showed despite the facility becoming aware of the acute fracture on 05/07/2026, there was no evidence the injury was reported to AHCA, APS, or law enforcement within 24 hours as required for injuries of unknown source.Review of the facility's undated Abuse, Neglect, Exploitation & Misappropriation policy showed: It is the policy of this facility to take appropriate steps to prevent abuse (be it verbal, sexual, physical or mental), neglect, exploitation and misappropriation and the occurrence of an injury of an unknown source, and to ensure that all alleged violations of Federal and / or State laws are reported immediately to the Administrator, the Risk Manager, the Social Service Director, and the Director of Nursing. The Abuse Coordinator/ designee shall report any alleged violations of abuse or (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	serious bodily injury immediately, but no later than 2 hours to the Agency for Health care Administration, the Adult Protective Services, and the local law enforcement if they feel a crime has occurred. If the alleged violation involves neglect, misappropriation of resident property, exploitation or injuries of an unknown source and involves no serious bodily injury, it must be reported no later than 24 hours.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement a careˆplanned intervention for the use of floor mats for one resident (Resident #2) of six sampled residents. Resident #2's care plan included the use of floor mats when the resident was in bed; however, the intervention was not in place at the time of the resident's fall on 04/08/2026.Findings included: Record review showed Resident #2 was admitted on [DATE] and readmitted on [DATE]. Diagnoses included, but were not limited to, cerebrovascular disease; urinary tract infection; nontraumatic intracerebral hemorrhage, unspecified; personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits; atherosclerotic heart disease of native coronary artery without angina pectoris; cervical spondylosis without myelopathy or radiculopathy; essential hypertension; dysphagia following cerebral infarction; hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side; need for assistance with personal care; and syncope and collapse.A review of the Brief Interview for Mental Status (BIMS) dated 08/29/2025 documented a score of 6, indicating severe cognitive impairment.The resident's care plan, initiated 08/29/2025, identified a problem of risk for falls or fallˆrelated injury related to deconditioning, gait and balance problems, dementia, and a history of falls. The goal, initiated 08/31/2025, stated the resident would not sustain serious injury through the review date. Interventions included the use of floor mats when the resident was in bed, initiated 09/29/2025.On 06/15/2026 at approximately 3:30 p.m., an interview was conducted with the Director of Nursing (DON), with the Nursing Home Administrator present. The DON reported Resident #2 had two falls in April 2026, on 04/08 and 04/28. During review of the 04/08/2026 fall event, the DON stated the fall occurred at 5:30 a.m., was unwitnessed, and occurred from the bed to the floor. The bed was in low position. The resident sustained a skin tear to the left elbow. The DON stated, He did not have mats.Review of the facility's Resident Assessment Instrument (RAI) Comprehensive Care Plan Policy, effective 09/2024, documented: The facility will utilize the RAI process to assess residents' needs, develop individualized care plans, and ensure the delivery of quality care. This process will involve interdisciplinary team members and be revised to reflect resident condition changes.

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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	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 observation, record review, and interviews, the facility failed to provide adequate supervision to reduce the risk of accidents for one resident (#3) of six sampled residents. Resident #3 experienced six falls between 05/13/2026 and 06/06/2026. Only four of the falls were recorded in the facility's fall log, and the required postˆfall investigations and careˆplan revisions were not consistently completed.Findings included: On 06/15/2026 at 1:23 p.m., Resident #3 was observed seated in a wheelchair as family members prepared to take the resident on a leave of absence. Record review showed Resident #3 was admitted on [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness, encephalopathy, paroxysmal atrial fibrillation, need for assistance with personal care, and a cognitive communication deficit. A Brief Interview for Mental Status (BIMS) dated 05/07/2026 documented a score of 1, indicating severe cognitive impairment.A review of the care plan revealed a problem area identifying the resident as being at risk for falls related to deconditioning, gait and balance problems, a history of falls, vertigo, and leftˆside weakness, initiated on 05/06/2026. The goal stated the resident would not sustain serious injury through the review period.Interventions included:Encourage resident to remain in common areas while awake (05/13/2026).Medication adjustments for restlessness (05/25/2026).Clinical workup/treatment for UTI (urinary tract infection) (06/08/2026).Encourage participation in exercises/activities to improve mobility (05/14/2026).Psych services for medication review (05/15/2026).Call light within reach and encourage use (05/06/2026).Safety education to resident/family (05/14/2026).Encourage keeping bed in low position (05/14/2026).Ensure appropriate footwear/nonˆskid socks (05/06/2026).Orientation to surroundings (05/06/2026).PT (physical therapy) evaluation/treatment as ordered (05/06/2026). A second care plan focus area identified an ADL(activity of daily living) selfˆcare deficit, including interventions for wheelchair locomotion, assistance with bed mobility, dressing, eating, hygiene, toileting assistance by one staff for toileting, transfer assistance by two staff, participation encouragement, and monitoring for changes in function; initiated on 05/06/2026.The facility's fall log dates (03/01/2026-06/15/2026) listed four falls for Resident #3: 05/13 at 3:31 p.m., unwitnessed 05/14 at 7:40 p.m., unwitnessed 05/15 at 3:06 p.m., witnessed 05/23 at 6:00 p.m., unwitnessedRecord review showed two additional falls, on 06/01/2026 and 06/06/2026, that were not recorded on the fall log.Record review of nursing documentation (05/01/2026-06/15/2026) revealed two documented falls:On 05/13/2026, 15:39: Resident found lying on left side on floor mat next to bed. Resident stated he was trying to get in bed. No injury. Provider and family notified.On 05/23/2026, 19:28: Resident found sitting on buttocks on floor mat next to bed with linens around legs. No injury. Provider and family notified.The record review revealed the following: No nursing note for 05/14/2026 at 7:40 p.m. fall. No nursing note for the 05/15/2026 fall at 3:00 p.m. No IDT (interdisciplinary) meeting note for the 05/23/2026 fall. No nursing notes for 06/01/2026 or 06/06/2026 falls. No IDT review documented for the 06/01/2026 or 06/06/2026 falls.Review of a progress note dated 05/15/2026, 9:04 a.m. entryshowed: IDT documented a review of a recent fall, but the note did not identify which fall (05/13 or the fall on 05/14). On 06/15/2026 at approximately 3:00 p.m., the Director of Nursing (DON), with the Nursing Home Administrator present, was interviewed regarding the fall investigations. The DON stated the 05/13/2026 fall occurred when the resident attempted to get into bed from his wheelchair, and the intervention added was encouraging the resident to remain in common areas when awake. The DON stated the 05/14/2026 fall occurred when the resident attempted to make his bed and sustained a skin tear. The DON stated the 05/15/2026 fall was witnessed by a nurse, but documentation did not indicate the bed height. The DON stated the 05/23/2026 fall had no documented bed height and that careˆplanned interventions were expected to be in place. The DON stated the 06/01/2026 fall occurred when family attempted to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer the resident without staff, and the intervention added was education for the family. The DON stated the 06/06/2026 fall occurred when the resident attempted to transfer from the wheelchair to the bed and stated the low bed height does not have anything to do with this fall, noting the only intervention implemented was treatment for a urinary tract infection.A review of the facility's Risk Management - Fall Risk Reduction Program policy, undated, documented that residents at risk for falls would be identified and individualized interventions implemented, underlying medical issues addressed, the effectiveness of interventions evaluated, and all resident falls reviewed by the interdisciplinary team. The procedure required documentation of circumstances of each fall, including resident position, environmental factors, condition prior to the fall, witness statements, and implementation of new strategies to prevent recurrence.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interviews, the facility failed to ensure a resident experiencing a new onset of significant pain was assessed, had pain characteristics documented, and the pain was reported to the physician and hospice in a timely manner for one resident (#2) of six sampled residents. Findings included:A review of Resident #2's clinical record showed a documented new onset of pain on 05/03/2026 at 5:57 p.m., rated 8/10, with no documented anatomical location and no documented physician notification. On 05/04/2026 at 5:01 p.m., pain was documented as 7/10, and on 05/05/2026 at 11:29 a.m., as 10/10, again with no anatomical location documented and no evidence of physician notification.Review of nursing documentation on 05/05/2026 at 11:29 a.m. showed communication with hospice. An X-ray was ordered on 05/06/2026, with results on 05/07/2026, identifying an acute right subcapital femoral neck fracture. A final Radiology Report Findings showed an Acute right subcapital femoral neck fracture, 1/2 shaft-width superior lateral displacement, Soft tissue swelling; no dislocation and Bony demineralization.A review of nursing notes from 04/01/2026 through 05/16/2026 revealed no nursing notes documented between: 04/01-04/09; 04/10-04/28 and 04/30-05/04.Additionally, there were no assessments documented in the Evaluation Record from 05/02/2026 through 05/14/2026.A review of the Medication Administration Record for May 2026 confirmed administration of as needed Oxycodone for documented pain levels ranging from 4-10 between 05/03/2026 and 05/13/2026. The pain levels were documented as follows:05/03 at 1957, with a pain level of 805/04 at 1701, with a pain level of 705/05 at 1615, with a pain level of 405/06 at 0021, with a pain level of 005/06 at 0431, with a pain level of 805/05 at 1129, with a pain level of 1005/06 at 1553, with a pain level of 6.05/07 at 0000, with a pain level of 805/07 at 0457, with a pain level of 805/08 at 0527, with a pain level of 1005/13 at 1542, with a pain level of 8The resident's Care Plan, initiated 08/31/2025 and 12/08/2025, directed staff to: Observe, document, and report pain characteristics (quality, severity, anatomical location, onset, duration, aggravating/relieving factors). Observe and report signs of non verbal pain. Notify the physician immediately for breakthrough pain.Record review showed these interventions were not followed, as documentation lacked to show the required pain characteristics were documented to include timely physician notifications.Review of progress notes dated 05/05/2026, 11:19 a.m. showed, met with resident's [family member], reports resident continues with pain. Requested Hospice visit to readdress chronic pain. Hospice notified will send nurse out. On 05/06/2026, 10:45 a.m. Resident with continued pain control, Hospice team making real time adjustments to around fluctuations in pain. A review of Resident #2's Evaluation record revealed there were no assessments documented for the reviewed periods of 04/30/2026 through 05/04/2026 and 05/02/2026 through 05/14/2026.During a phone interview on 06/15/2026 at 10:01 a.m., Resident #2's family member and health care power of attorney reported the resident was in extreme pain on 05/03/2026. The family contacted hospice and requested an X-ray. Hospice provided crisis care and pain management. The family reported the fracture was identified, and soon after, interactions with facility staff felt cold.On 06/15/2026 at approximately 3:30 p.m., the Director of Nursing (DON) reported the family informed her on 05/04/2026 of the resident's increased pain and requested hospice involvement. The DON stated hospice evaluated the resident on 05/04, 05/05, and 05/06, making adjustments to pain medication. She reported she completed a physical assessment on 05/06, though no documentation of this assessment was present in the record. The DON confirmed the physician did not see the resident until 05/07, when X-ray results were available.The facility did not provide a policy related to the stated concerns.