STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105817	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Harbor Incorporated	700 John Ringling Blvd Sarasota, FL 34236

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 - Minimal harm or potential for 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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, review of facility's policies and procedures and staff interviews, the facility failed to protect the resident's right to be free from physical abuse by staff for 1 (Resident #1) of 3 residents reviewed. The findings included:Review of the facility's Abuse Prevention Policy effective 8/18/10, last revised December 2022 revealed Policy: 1. Plymouth Harbor will exercise all possible efforts to reduce the risk to residents from harm or mistreatment and to prevent incidents of Abuse, Neglect, Sexual Misconduct or Exploitation. 2. All allegations of abuse, neglect, sexual misconduct or exploitation of a resident will be thoroughly investigated and the resident protected during the course of the investigation. Purpose: To ensure residents are free from verbal, sexual, physical, and mental abuse, corporal punishment and/or involuntary seclusion. Procedures/Responsibilities: The definitions used in this document are based on federal regulations and guidelines as well as state law. A. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical Abuse includes hitting, punching, kicking, slapping, pinching, etc. It also includes controlling behavior through corporal punishment.Review of the clinical record for Resident #1 revealed an admission date of 11/21/25. Diagnoses included neurocognitive disorder with Lewy bodies (progressive brain disease causing fluctuating cognition, Parkinson's like movement issues).Review of the admission Minimum Data Set (MDS) assessment with an assessment reference date of 11/24/25 revealed Resident #1 scored 07 on the Brief Interview for Mental Status, indicating severe cognitive impairment, significant problems with memory, orientation and recall.The care plan initiated on 11/27/25 revealed the resident had impaired cognitive function or impaired thought processes related to the diagnosis of Lewy Body disease with rapid deterioration in cognitive status, and diagnosis of Parkinsonism. The interventions included to cue, reorient and supervise the resident as needed. Review of the facility provided incident investigations revealed on 12/8/25 the facility initiated a staff to resident physical abuse investigation for Resident #1.The allegation noted on 12/8/25 the Director of Nursing (DON) received an anonymous text message alleging that Licensed Practical Nurse (LPN) Staff A struck Resident #1.The details of the investigation noted the Administrator and the DON reviewed the facility's camera footage from the alleged incident. Resident #1 was seen attempting to bite LPN Staff A on the wrist. During the incident, two security officers assisted LPN Staff to put Resident #1 back in his wheelchair. The facility's investigation noted, The cameras showed no altercation involving abuse.On 12/9/25 the Administrator concluded the investigation and noted the allegation of physical abuse was not verified. The detailed description of the conclusion of the investigation noted, The camera footage review showed that the allegation of abuse is not verified. [Resident #1] attempted to get out of his wheelchair and he was assisted by the Nurse and two security guards back into his wheelchair. He was then wheeled back to his room by another staff member. The nurse nor the security guards struck the resident during this incident. The Administrator documented, Due to the investigation being unsubstantiated, there is no corrective action needed at this time.Review of the witness statements provided by the facility as part of the investigation revealed:On 12/8/25 LPN Staff A emailed a statement that on 12/7/25 at 10:30 p.m., Resident #1 was observed with increased agitation and restlessness. Resident #1 became verbally aggressive and combative, escalating to biting nursing staff during care interaction. Staff attempted verbal redirection and reassurance, but resident was not receptive. For safety, the nurse removed herself from the immediate area and notified additional staff for support. Resident continued to display exit seeking behavior and attempted to leave the premises. Resident eventually calmed with intervention of reapproach.On 12/8/25 Certified Nursing Assistant (CNA) Staff B wrote in a witness statement that she saw Resident #1 at the entry door trying to get out. Multiple staff tried to move him away from the door. He was just getting more agitated after multiple staff tried to redirect him. LPN Staff A came by and saw what was going on. She tried to help. Resident #1 tried to bite her on the arm. Multiple staff intervened.On 12/7/25 CNA Staff C wrote in a witness statement she witnessed Resident #1 beating the door with his wheelchair screaming to get out. LPN Staff A came, moved the resident and shut the alarms off. Resident #1 then went back to the doors. This time, the alarms did not lock the door so Resident #1 was able to get out. He was heading to the elevator. The resident's nurse was sitting at the nurse's station charting. LPN Staff A ran and grabbed the resident and placed him back in the wheelchair. Security then stepped in and peeled his hands off LPN Staff A.On 12/7/25 Security Guard Staff D wrote in a witness statement that he was called to the building because a resident was banging on the door and trying to leave the facility. Another nurse arrived to try to move him but when