STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106103	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulfport Nursing Center	1430 Pasadena Ave S 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure a comprehensive person-centered care plan was developed to include a discharge plan for one (#5) of five sampled residents. Resident #5 had no discharge plan documented in her care plan. Findings included:A review of Resident #5's admission record, documented an admission of 08/14/2025. Her diagnoses list included but not limited to: Sepsis, unspecified organism; pressure ulcer of sacral region, stage 4; chronic kidney disease stage 2; other bacterial agents of the cause of diseases classified elsewhere; muscle wasting; need for assistance with personal care and chronic embolism and thrombosis of unspecified deep vein of lower extremity bilateral.A review of Resident #5's Hospital Record, History and physical, dated 08/09/2025, documented, biba (brought in by ambulance) from home sepsis alert per ems (emergency medical services) patient has been confined to a chair dt (due to) generalized weakness x 1 week covered in urine and feces. Pt (patient) alert to self. History of present Illness: The patient is a [AGE] year-old female with a PMH (past medical history) of moderate major depression, type II DM (diabetes mellites), Diabetic nephropathy, dyslipidemia, hyperuricemia, osteoporosis, metabolic encephalopathy, and thoracic aortic atherosclerosis who presented with altered mental status and was found at home with generalized weakness over 1 week covered in urine and feces. Pt is alert to self and place, but not to time. On an examination today, pt is unable to provide a history. She recalls being in a comatose state. She seems aware of her surroundings but is unable to recall anything. She keeps talking to herself, referring to self in the third person. Lower extremity ultrasound was remarkable for bilateral lower extremity DVT (deep vein thrombosis), greater on the right than the left. Multiple occlusive and nonocclusive thrombi were noted. Patient was also found to have a decubitus ulcer in the sacral region, unstageable.On 12/15/2025 at 11:45 a.m., Resident #5 was observed in bed on a specialized mattress. Resident #5 was awake and alert. Upon interview Resident #5 was very specific on how to pronounce her first name. When asked about her call bell light, Resident #5 said she had not seen one, she did not know how to use it. She said, I say, you who to attract the attention of staff; she stated no concerns with care or staff responding to her. Her call light was observed to be next to her, a flat mechanism of sensitive touch call light button. During the interview, staff were observed to bring her lunch tray in, provide set up, converse with her, and offer assistance which she declined. She was observed to start to feed herself.An interview was conducted with the Rehabilitation Director (RD) on 12/15/2025 at 12:30 p.m. The RD stated being familiar with Resident #5. The RD stated Resident #5 is currently receiving speech therapy for swallowing concerns. Resident #5 had received physical and occupational therapy until benefits exhausted, around the end of November. Resident #5 was never ambulatory. Resident #5 requires 1-2-person assistance. Resident #5 was able to progress to standing in the stand frame for strengthening but could not ambulate. Resident #5 requires 24-hour care.A review of Resident #5's comprehensive care plan revealed no discharge plan.An interview conducted with the Minimum Data Set Coordinator (MDSC), Licensed Practical Nurse 12/15/205 at 12:41 p.m. The MDSC stated Resident #5 was short term resident and it was decided just the other day (12/09) that she was unsafe to go home. The MDSC confirmed Resident #5 did not have a discharge plan.An interview with the Director of Nursing (DON) on 12/15/2025 at 2:20 p.m. The DON stated Resident #5 has memory concerns and the physician wrote Resident #5 lacks capacity to understand what is going on and is unable to make informed decisions. An interview was conducted on 12/15/2025 at 4:50 p.m. with the SSD. The SSD stated attending care plan meetings. When asked about discharge planning, the SSD stated, I know we do the discharge summary and the progress notes. When asked about Resident #5's discharge care plan, he was observed to review Resident #5's electronic clinical record, and he confirmed the care plan had no discharge care plan. A review of the facility's Comprehensive Care Plans policy and procedure, last revised 07/27/2022, documented the policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.The guidelines included:. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. 3. The comprehensive care plan will describe, at minimum, the following: . d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate.