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. 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 (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: 105817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Plymouth Harbor Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE 700 John Ringling Blvd Sarasota, FL 34236	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 she tried to move him, the resident tried to bite the nurse. There was a bit of a struggle.On 12/7/25 Security Guard Staff E wrote in a witness statement that when he arrived at the facility Resident #1 was holding onto the door handle and refused to let go. At around 10:30 p.m., a nurse came by and attempted to remove his hand off the handle. The resident then went to bite her which is when she pushed the resident's head away with an open hand.On 12/11/25 at 1:46 p.m., in an interview Security Guard Staff D said on 12/7/25 he was called to the facility to help with a resident who was trying to leave through the front door. He said they were trying to redirect the resident when the resident bit the nurse.Security Guard Staff D said the nurse hit the resident in the face.On 12/11/25 at 3:45 p.m., in an interview, LPN Staff A said that on 12/7/25 around 10:30 p.m., Resident #1 was at the doors to the facility. She said the doors were locked because of his security bracelet that prevents him from eloping. She said she tried to get between him and the door so that staff could get in. She said he leaned over to bite her and he did not break the skin. She said as a reaction she guided his head back. She said she used her other hand to push more forcefully, then security came to help. She said after she pushed his head away, he thought she punched him, so he started yelling, Call the police, I want her picture taken. She said in hindsight, she probably shouldn't have approached him to block him from exit in that way. She probably should have tried talking to him more.On 12/11/25 at 4:25 p.m., in an interview, the DON said the expectations for handling a resident with dementia vary based on the resident. She said staff must be able to identify the sensory issues at hand and be able to pick up on cues. She said if Resident #1 was sitting at the door calmly, we would want to keep eyes on him. She said Resident #1 started becoming more agitated Friday afternoon (12/5/25). She said one to one supervision was not provided on Saturday (12/6/25) or Sunday (12/7/25).On 12/11/25 at 5:10 p.m., in an interview, Security Guard Staff E said that basically everything he wrote in his witness statement was true. He said that Staff A went over to the resident to try to get his hands off the door handles. He said the resident tried to bite her. Security Guard Staff E said he saw Staff A's hand hit Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1's face. He thought her hand was open.Review of the surveillance video of 12/7/25 from 10:25 p.m., through 10:30 p.m., provided by the facility as part of the investigation revealed:Resident #1 was sitting in a wheelchair facing a double door with glass panes. The resident's left hand was on the door handle. An unidentified person was seen speaking with the resident through the glass panes. Two security guards were observed walking towards the resident. They spoke with him and walked back to the nurse's desk about seven feet from the resident. At 10:27 p.m., a nurse wearing pink scrubs was observed approaching Resident #1rapidly from behind. The Administrator identified the nurse as LPN Staff A. The nurse was observed grabbing the resident's left arm to forcibly remove his hand from the door handle. Resident #1 appeared to resist and stood up from the wheelchair. LPN Staff A was observed striking the resident's face with her right hand. She held onto the resident's left arm and bent it at the elbow while a security guard was observed grabbing the resident's right arm. The other security guard was observed holding onto the resident's right arm while they placed him back in the wheelchair. They moved the resident's wheelchair away from the door. LPN Staff A opened the double doors and let an unidentified staff member in. Resident #1 attempted to stand up. A security guard wrapped his arm around the resident's torso and sat him back in the wheelchair. An unknown staff member was seen repositioning the resident from behind in the wheelchair. Resident #1 wheeled himself to the door, opened the door, stood up and attempted to go through the double doors. A security guard and LPN Staff A were observed holding onto the resident and place him back in the wheelchair.