STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105562	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Ocala	2700 SW 34th St Ocala, FL 34474

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 15234 Based on interview and record review the facility failed to ensure adequate supervision during toileting to prevent an accident resulting in head injury and transferred to a higher level of care for 1 of 3 residents reviewed for accident prevention (Resident #1). Findings include: Review of Resident #1's admission record documented diagnosis to include wedge compression fracture of first and fifth lumbar vertebra, Huntington's Disease, and ataxia (poor muscle control that affects balance and coordination). Review of the fall risk assessment for Resident #1 dated 12/14/2024, revealed a score of 13. A Score 10 or higher indicated the resident is at high risk of falls. Review of Resident #1's progress note dated 12/18/2024 documented, Late entry. Staff A, CNA [Certified Nursing Assistant] reports toileting resident and allowed her privacy and upon return to bathroom resident on left side appearing to bleeding {sic} from head. Resident states 'I fell .' Review of Resident #1's progress note dated 12/19/2024 documented, Resident returned from ER visit, skin assessment was completed. Resident with skin tear/abrasion to her left lateral leg .bruising to her left eye and a small, raised area to the left lateral forehead. There was a raised area/protrusion to the right shoulder with bruising to the area. Review of Resident #1's care plan, date initiated 10/19/2024 and revised 12/19/2024, documented Resident at risk for falls related to general weakness, impaired mobility, ataxia, Huntington's Disease, 1st lumbar vertebra fracture, 5th lumbar vertebra fracture, failure to thrive, poor safety awareness, impulsiveness, incontinent of bowel and bladder and opioid/psychotropic medication use. Resident #1's care plan documented fall precaution interventions that included Guest is not to be in bathroom without staff present. Date added to care plan: 12/16/2024. (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
	105562	A. Building B. Wing	12/19/2024

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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 - Actual harm Residents Affected - Few	During interview on 12/18/2024 at 2:02 PM, the Director of Nursing stated Staff A, CNA found the resident [Resident #1] bleeding on the bathroom floor has been suspended. He had been suspended pending investigation because he had not followed Resident #1's care plan related to supervision in the bathroom. The certified nursing assistant should have known to check the Kardex [a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan] for any care plan intervention updates. The Director of Nursing added the resident's [Resident #1] care plan had been updated to include not leaving her alone in the bathroom following a previous fall. During an interview on 12/19/2024 at 9:35 AM, the Director of Quality Assurance stated an aide told me the patient was in the dining room. She [Resident #1] asked to go to bathroom. He [Staff A] told me he asked staff how much assistance she [Resident #1] needed and was told one. I also interviewed the Unit Manager who verified she saw the aide answer the call light. The person that told him [Staff A] that [Resident #1] required assistance of one staff member should have also told him don't leave her alone. Review of Resident #1's hospital records titled Emergency Department Note dated 12/18/2024 documented, General/Constitutional: MS [Medical Status] Head: 2 superficial lacerations to the left frontal scalp with surrounding edema. EM-MDM [Evaluation and Management-Medical Decision Making]: Traumatic Injury. Physical exam significant for 2 superficial lacerations to the left frontal scalp with surrounding edema, A&Ox2 [alert and oriented times 2, is someone who knows who they are and where they are, but not what time it is or what is happening to them] baseline for the patient, cervical, thoracic, and lumbar spine tenderness. ED [emergency department] Discharge Plan. Clinical Impression: Closed head injury.