

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105562	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Palm Garden of Ocala		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interview and record review, the facility failed to ensure physician ordered medication parameters were followed for adequate indications for use, resulting in the administration of unnecessary medications for 1 of 3 residents, Resident #1 reviewed for unnecessary pain medications. Findings include: Review of Resident #1's admission record documented diagnosis of fibromyalgia (a disorder of pain processing causing chronic widespread pain), low back pain, unspecified, unspecified dementia, unspecified severity without behavioral disturbance, psychotic, mood disturbance and anxiety, insomnia unspecified, essential (primary) hypertension (high blood pressure), hyperlipidemia unspecified (high cholesterol), migraine, long term use of opiate analgesic, fracture of one rib, left side, gastroesophageal reflux disease without esophagitis, anxiety disorder, major depressive disorder, recurrent, mild, unspecified glaucoma and presence of right artificial shoulder joint. Review of Resident #1's physician order dated 12/9/2025 read, Tramadol HCL tablet 50 mg (milligram) give 1 tablet by mouth every six hours as needed for moderate and severe pain level 6 to 10. Review of Resident #1's Medication Administration Record (MAR) for December 2025 documents Tramadol HCL tablet 50 mg tablet was administered on 12/10/2025 at 2107 (9:07 pm) for a pain level of 5, on 12/12/2025 at 2033 (8:33 pm) for a pain level of 5, on 12/13/2025 at 1937 (7:37 pm) for a pain level of 5, on 12/15/2025 at 2127 (9:27 pm) for a pain level of 5, and on 12/16/2025 at 2008 (8:08 pm) for a pain level of 4. During an interview on 12/17/2025 at 12:05 PM the Director of Nursing (DON) stated, I would expect all staff to follow orders for medications, that would include any parameters that the doctor orders. They should not administer medication outside the parameters written. During a telephone interview on 12/17/2025 at 2:00 PM the Medical Director stated, I believe that all physician orders should be followed as they are written. Pain medication parameters are tricky sometimes with patients insisting on getting a certain medication. During a telephone interview on 12/17/2025 at 3:35 PM Staff A, Licensed Practical Nurse (LPN) stated, I did give her pain medicine outside the parameters if I documented something less than the orders say. I should have followed the doctor's order. A request for the medication administration policy and procedure and the following physician order policy and procedure was requested of the Director of Nursing on 12/17/2025 at entrance and again at 12:05 PM, none were provided by the time of exit.</p>

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
---	-------	-----------