

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  06/12/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's status for 2 of 8 residents reviewed for oxygen therapy (Resident #19 and #99).</p> <p>Findings include:</p> <p>1) Review of Resident #19's admission record showed an admission date of 6/27/2024 with the diagnoses including chronic systolic (congestive) heart failure, acute pulmonary edema, dyspnea, dependence on supplemental oxygen, and anxiety disorder.</p> <p>Review of Resident #19's physician order dated 2/20/2025 read, Oxygen at 2 LPM [Liters Per Minute] via N/C [Nasal Cannula] PRN [as needed] as needed for Shortness of Breath, No Humidity.</p> <p>Review of Resident #19's quarterly MDS assessment dated [DATE] showed no entries documented for receiving oxygen therapy under Section O- Special Treatments, Procedures and Programs.</p> <p>2) Review of Resident #99's admission record showed an admission date of 8/30/2024 with the diagnoses including chronic obstructive pulmonary disease with (acute) exacerbation, pneumonia, adult failure to thrive, chronic kidney disease, stage 3b, heart failure, atrial fibrillation, essential (primary) hypertension, and emphysema.</p> <p>Review of Resident #99's physician order dated 2/27/2025 read, Oxygen at 2 liters PRN via NC as needed for Shortness of Breath.</p> <p>Review of Resident #99's quarterly MDS assessment dated [DATE] showed no entries documented for receiving oxygen therapy under Section O- Special Treatments, Procedures and Programs.</p> <p>During an interview on 6/12/2025 at 6:43 AM, the Director of Nursing stated, I expect that all MDS information should be coded accurately. They [Residents #19 and #99] each have oxygen orders.</p> <p>During an interview on 6/12/2025, the MDS Coordinator stated, These [Residents #19 and #99's] MDSs are not accurate. They [Residents #19 and #99] do have oxygen. We do not have a policy that we use.</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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 2 residents reviewed for accidents (Resident #70), 2 of 5 residents reviewed for insulin administration (Residents #82 and #167), and 1 of 8 residents reviewed for oxygen therapy (Resident #166).</p> <p>Findings include:</p> <p>1) During an observation on 6/10/2025 at 8:07 AM, Resident #70 was lying in bed. The bed was in a low position. There was one fall mat on the right side of the bed. There was a fall mat stored behind a chair in the resident room (Photographic evidence obtained).</p> <p>During an observation on 6/11/2025 at 7:54 AM, Resident #70 was lying in bed. The bed was in a low position. There was one fall mat on the right side of the bed. There was a fall mat stored behind a chair in the resident room.</p> <p>Review of Resident #70's care plan initiated on 4/21/2025 read, Focus: At risk for falls related to general weakness, impaired mobility, advanced age, poor safety awareness, right sided hemi [hemiplegia], dm [diabetes mellitus], gout, g-tube [gastrostomy tube], incontinence of bowel and bladder . Interventions . Floor mats at bedside while in bed.</p> <p>During an interview on 6/11/2025 at 12:09 PM, Staff B, Licensed Practical Nurse (LPN), stated, [Resident #70's name] should always have bilateral floor mats while she is in bed.</p> <p>During an interview on 6/11/2025 at 1:34 PM, the Director of Nursing (DON) stated, [Resident #70's name] is care planned for fall mats, which means there should be a fall mat placed on each side of bed while the resident is lying in the bed. Staff should be making sure fall mats are put down when she is in bed.</p> <p>2) Review of Resident #82's physician order dated 4/12/2025 read, ACCU-CHECK BID [twice a day], Call MD [Medical Doctor] for further orders if BS [Blood Sugar] over 200 two times a day for DM.</p> <p>Review of Resident #82's electronic Medication Administration Record (eMAR) progress note dated 4/28/2025 read, ACCU-CHECK BID, Call MD for further orders if BS over 200 two times a day for DM, pt [patient] refused despite education on importance of BS check.</p> <p>Review of Resident #82's eMAR progress note dated 4/29/2025 read, ACCU-CHECK BID, Call MD for further orders if BS over 200 two times a day for DM, refused, education provided by nurse, continues to refuse, says she is fine. No pt. ate dinner, no signs of hyper/hypoglycemia noted at this time.</p> <p>Review of Resident #82's eMAR progress note dated 5/5/2025 read, ACCU-CHECK BID, Call MD for further orders if BS over 200 two times a day for DM, Resident states, I don't do that.</p> <p>Review of Resident #82's care plan did not show a focus for refusal of accuchecks due to diabetic diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2025 at 12:02 PM, the MDS (Minimum Data Set)/Care Plan Coordinator stated, [Resident #82's name] should have been care planned for refusal of accu-check. She frequently refuses her accu-checks for her diabetes. I look at progress notes daily and nurses are supposed to let us know if there is anything we have missed we can go ahead and care plan it.</p> <p>During an interview on 6/11/2025 at 1:32 PM, the DON stated, [Resident #82's name] care plan should have had a focus of refusals. If nursing knows something they can let the coordinator know. The care plan coordinator can also look and add any focus herself.</p> <p>3) Review of Resident #167's physician order dated 3/7/2025 read, ACCU-CHECK two times a day for DM.</p> <p>Review of Resident #167's physician order dated 3/11/2025 read, Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML [milliliter] (Insulin Lispro), Inject as per sliding scale: if 160-199= 4 units, 200-239= 5 units, 240-279= 6 units, 280-319= 8 units, 320-359= 9 units, 360-399= 11 units, less than 70 or greater than 400 call MD [Medical Doctor], subcutaneously before meals and at bedtime for DM Type 2.</p> <p>Review of Resident #167's eMAR progress note dated 4/4/2025 read, ACCU-CHECK two times a day for DM, refused her accucheck, educated by nurse, aox4 [alert and oriented].</p> <p>Review of Resident #167's eMAR progress note dated 4/20/2025 read, ACCU-CHECK two times a day for DM, states don't worry about taking that tonight MD aware, education provided.</p> <p>Review of Resident #167's care plan did not show a focus for refusal of accuchecks due to diabetic diagnosis.</p> <p>During an interview on 6/11/2025 at 12:05 PM, the MDS/Care Plan Coordinator stated, [Resident #167's name] should have been care planned for refusal of accucheck. The staff have not told me about it. Unit Manager job is to review the progress notes. My system is not set up to look at eMAR. I have to click the special button to view eMAR notes.</p> <p>4) During an observation on 6/9/2025 at 9:34 AM, Resident #166 was lying in bed, receiving oxygen via nasal cannula at 3 liters per minute.</p> <p>During an observation on 6/10/2025 at 8:16 AM, Resident #166 was lying in bed, receiving oxygen via nasal cannula at 3 liters per minute.</p> <p>Review of Resident #166's physician order dated 4/16/2025 read, Oxygen at 2 LPM [Liters Per Minute] Via N/C [Nasal Cannula] PRN [as needed] every shift.</p> <p>Review of Resident #166's care plan dated 4/16/2025 showed no focus for oxygen therapy.</p> <p>During an interview on 6/11/2025 at 12:07 PM, the MDS/Care Plan Coordinator stated, I do not see a focus for oxygen for [Resident #166's name]. I will need to add it to the care plan. The focus should have been added on his admission.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2025 at 1:30 PM, the DON stated, I would expect [Resident #166's name] have a care plan focus for oxygen.</p> <p>Review of the facility policy and procedure titled Person-centered Comprehensive Care Plan with the last review date of 5/31/2025 read, Guideline: It is the practice of the center to develop and implement a person-centered comprehensive care plan that includes measurable objectives and timeframes to meet their preferences and goals, and address the guest/resident's nursing, medical, physical, mental and psychosocial needs. The comprehensive care plan will be developed within 7 days after completion of the comprehensive assessment and no more than 21 days after admission. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both comprehensive and quarterly review assessment and with significant changes in the guest/resident's condition.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of accident hazards for 1 of 5 residents reviewed for dining (Resident #70).</p> <p>Findings include:</p> <p>During an observation on 6/10/2025 at 11:05 AM, Resident #70 was sitting in a wheelchair in the hallway with a gait belt and walker. Staff A, Physical Therapist (PT), was in front of Resident #70 with a clear plastic cup containing water. Staff A gave the cup to Resident #70. Resident #70 started drinking water from the cup. Staff B, Licensed Practical Nurse (LPN), asked Staff A if Resident #70 was supposed to be given regular thin liquids because she believed Resident #70 was on a thickened liquid diet. Staff A, PT, stated, She [Resident #70] is doing well with it. Staff B, LPN, stated she would need clarification after checking the order in the computer and reading out loud Resident #70 had a thickened liquid diet order. Staff B stated she would go get clarification from the speech therapist and walked away from the medication cart. Staff A tried to remove the cup from Resident #70's hand and the resident took a large drink from the water cup. Staff A removed the cup from Resident #70's hands. Resident #70 coughed twice after drinking the regular thin water.</p> <p>Review of Resident #70's physician order dated 6/3/2025 read, Regular diet, Mechanical Soft texture, Nectar Thickened Fluids consistency.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #70's Fiberoptic Endoscopic Evaluation of Swallowing dated 6/2/2025 read, Reason for Referral: to objectively assess swallow function . Laryngeal exam reveals no significant secretions. Right arytenoid partially prolapsed and sagging anteriorly. Mild arytenoid bilateral edema and erythema. Mild erythema along posterior aspect of true vocal fold. Complete mobility of arytenoids and true vocal folds. Patient had difficulty intermittently with volitional swallows and reduced ability to complete a breath hold on command. Patient presents with mild-moderate oropharyngeal dysphagia. Oral phase negatively impacted by reduced bolus containment resulting in spillage of liquids to the pyriform sinuses (L&amp;R). Slightly prolonged but adequate mastication and transport appreciated. Clear oral cavity following trails. Pharyngeal phase negatively impacted by mistimed laryngeal vestibule closure and suspected reduced hyolaryngeal excursion needed for epiglottic inversion resulting in bolus cascading over the epiglottic rim. Suspected adequate tongue base retraction and adequate pharyngeal constriction evidenced by trace diffuse residuals that independently clear with second swallow and/or liquid wash. Swallow initiated at the lateral channels for liquids promptly after spillage and the valleculae for solids. Trace penetration to the level of the vocal folds that ejects with throat clear response during the swallow on single straw sip thin liquid in isolation. Trace penetration over the interarytenoid space occurs during the swallow with immediate ejection on cup and straw sips thin liquids intermittently. Deep penetration to the level of the vocal folds occurs on cup sip thin liquids during the swallow following larger bite of mixed consistency peaches with immediate, throat clear response; however, further cued cough (patient produced throat clears) further assisted in ejection of penetration. Trace penetration to the level of vocal folds occurs on &amp;frac12; cup sips nectar thick liquids during swallow that ejects with spontaneous throat clear. Aspiration during the swallow occurs on cued, large, consecutive cup sips thin liquids with immediate, ineffective coughing. No other penetration nor aspiration observed including on solids, &amp;frac12; cup sips nectar thick liquids, or consecutive straw sip nectar thick liquids as well. Safety of the swallow is impacted by spillage and mistiming of the swallow on liquids. Additionally a fatigue factor appears to be a factor as well. Patient with numerous risk factors identified for risk of aspiration including prolonged NPO [nothing by mouth] status, reliance on peg tube feeds, reduced mobility, and dysphagia. Efficiency of the swallow is mostly compensated with independent swallows and extra time for the oral phase time. Consideration for mechanical soft solids and nectar thick liquids per SLP [Speech Language Pathologist] discretion. Patient may benefit from a meal [not legible] prior to full oral advancement per SLP discretion as well. Therapeutic trails of thin liquids and regular solids could be considered per SLP discretion given relatively preserved sensation of airway invasion. Recommendations . Liquid consistency: IDDSI [International Dysphagia Diet Standardization Initiative] 2 Mildly Thick/Nectar.</p> <p>Review of Resident #70's nutrition risk progress note dated 6/4/2025 read, Diet Order and Intake: Regular, mechanical soft, nectar thick liquids . Nutrition Summary and Recommendations: Resident was upgraded by SLP from NPO to Mechanical soft, nectar thick liquids.</p> <p>Review of Resident #70's Speech Therapy Treatment Encounter Note dated 6/5/2025 read, Session focused on trails of thing liquids (water) via open cup. Pt [patient] observed with . intermittent throat clearing, requiring max verbal cueing to achieve functional cough . A: Pt continues with s/s [signs/symptoms] of dysphagia with thin liquids and known aspiration of thin fluids on recent FEES [Fiberoptic Endoscopic Evaluation of Swallowing] (6/2).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #70's Speech Therapy Treatment Encounter Note dated 6/10/2025 read, Session focused on trails of thin liquids and completion of swallow strengthening exercises. Pt observed to take single cup sips of thin liquid with . occasional impulsivity with increase rate of intake, improved with verbal cueing, reflexive cough following sequential or large sips.</p> <p>Review of Resident #70's eInteract SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers dated 6/10/2025 read, Signs and Symptoms Identified: other change in condition. 1a. List the other change: patient given liquids outside of recommended diet order. Started on: 6/10/2025 . B2. Respiratory Status Evaluation: 2a. Describe respiratory changes: 4. Cough . Review Findings and Provider Notifications: 4. Summarize your observations, evaluation and recommendations: patient was observed being given thin liquids by other staff member. patient was observed drinking the thin liquids. staff member informed that patient is on a nectar thick consistency. cup of water thrown away. made contact with speech therapy to clarify. ARNP, all upper management and daughter made aware of situation. new orders given for chest xay [sic]. Provider Notification and Feedback: Recommendation: chest x ray, 72 hour monitoring.</p> <p>Review of Resident #70's progress note dated 6/10/2025 at 11:30 AM read, As this Nurse was preparing medications at med cart, therapist approached med cart and retrieved plastic cup and poured water from the pitcher in the cup. This Nurse observed therapist giving the water cup to patient in the hallway that is on Nectar thick consistency liquids. Therapist was told patient is on thickened liquids, where she stated that patient is doing good and been upgraded. Therapist was asked to throw cup of water away so I could clarify with speech therapy. Before cup could be taken from patient, she began to drink the water quickly and coughed afterwards. Water cup was thrown into garbage, made contact with speech therapist who notified me that patient is still currently on nectar thick liquids. ARNP notified with new orders for chest xray and 72 hour monitoring. All upper management and Daughter made aware of situation.</p> <p>Review of Resident #70's progress note dated 6/10/2025 at 12:32 PM read, Note Text: patient given fluids outside of recommended diet orders, cough noted. ARNP [Advance Registered Nurse Practitioner] new order for chest xray.</p> <p>Review of Resident #70's physician order dated 6/10/2025 read, Chest xray related to cough, portable due to fall risk one time only for cough for 1 Day.</p> <p>Review of the written statement authored by Staff A, PT, dated 6/10/2025 read, I, [Staff A's name], had been gait training [Resident #70's name]. [Resident #70's name] requested water as she sat in her w/c [wheelchair]. I obtained water, reminded pt to sip a small sip and the swallow. [Resident #70's name] did so with no problems. Her nurse said that pt [patient] gets nectar thick liquid. I recalled, apparently in error, that at last week's staff meeting, pt was upgraded to thin liquids. I took the water from the patient, and in the process pt tried to take another sip after I had asked her to stop. I immediately asked DOR [Director of Rehabilitation] &amp; SLP to clarify pt's status with liquids. I had not checked [name of electronic medical record software] because I thought I knew already.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the written statement authored by Staff B, LPN, dated 6/10/2025 read, As I was standing at my med cart preparing medication, the therapist [Staff A's name] approaches my cart and retrieved a small plastic cup off my cart and poured water from the pitcher in the cup. I observed [Staff A's name] handing the water cup to [Resident #70's name]. I explained that the patient is on thickened liquids. The therapist stated to me that she's doing fine and has been upgraded. I told therapist I am not aware of patient being upgraded and I needed to clarify with the speech therapist. I asked [Staff A's name] to please take the cup from the patient. Patient then started to drink water faster before the cup was taken from her hand. Water cup was thrown in the garbage and I made contact with speech therapist who states she has not been upgrade and remains on nectar thick liquids.</p> <p>During an interview on 6/10/2025 at 11:15 AM, Staff B, LPN, stated, I went to speak with the speech therapist and she stated she has been working with [Resident #70's name] while drinking thin fluids but for nursing she [Resident #70] is still on thickened liquids and is not supposed to be given thin fluids. The physical therapist [Staff A] came to my cart and poured water out of the pitcher and gave it to [Resident #70's name]. The resident was not supposed to get thin liquids. I did not know she was pouring the water to give it to the resident only after I saw her drinking from the cup and that's when I told her I needed to get clarification. Normally staff will always ask the nurse before giving anything to drink or eat to the resident even if they are sitting in the hallway and the resident request water to drink they have to first ask the nurse. [Staff A's name] did not ask me what was [Resident #70's name] fluid consistency order before giving her the water. The water that was given to [Resident #70's name] was not thickened.</p> <p>During an interview on 6/10/2025 at 11:42 AM, the Speech Therapist stated, She [Resident #70] had a TIA [Transient Ischemic Attack] and we are working on dysphagia therapy. She [Resident #70] was NPO with peg tube and her and her daughter had a goal to be po [by mouth] and we did a swallow study two Fridays ago and decided a mechanical with thickened liquids was more appropriate. Since the swallow study we have been working with [Resident #70's name] to transition her to thin liquid. She is doing pretty well on the swallow study. She has impulsivity that she is drinking more at once when drinking. We are working on the use of swallow strategies. I think in small quantities no, within the next two weeks she should transition to thin liquids. Nectar thick is definitely safe. If she [Resident #70] was to be drinking thin liquids daily and with that lack of strategy, it would definitely be unsafe. We should just keep the thin liquids just to be given by speech therapy for now. I think because what we are looking for is the consistency with the strategies to see how independent she. The risk for aspiration pneumonia is low but aspiration itself is deficiently a risk. I believe staff should check diet order in [name of electronic medical record software] that is the most up to date diet recommendation. This has not happened before when a resident is given the wrong diet consistency that I am aware of.</p> <p>During an interview on 6/10/2025 at 12:21 PM, the Director of Nursing stated, [Staff A's name] was removed from schedule and gave a statement. We are reporting the incident. The staff are supposed to check the diet orders before giving anything to the residents. Non nursing staff should ask nursing to look in [name of electronic medical record software] and everyone should verify orders before giving the residents anything to eat or drink. There is potential for aspiration. The staff should have stop immediately when the nurse verbalized the concern of the diet consistency.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/2025 at 12:39 PM, Staff B, PT, stated, I have worked with [Resident #70's name] since she was admitted . I was doing gait training in the hallway with the resident. I said do you need water and she [Resident #70] said no and then she said yes. Two weeks ago in the rehab meeting, speech therapist said she had upgraded her [Resident #70] diet and was changing the resident from peg tube to regular diet and they were evaluating the resident to see if she could get enough calories with eating food. I recalled that as she had been upgraded to thin liquids, so I did not check [name of electronic medical record software] to check her status I thought I knew it. I gave her water in a cup. I told her to take a sip and swallow and take her time. The nurse told me she [Resident #70] is nectar and at that point I thought there was some kind of mix up I told her to stop and she grab the cup even harder to take another drink. Two weeks ago she was not taking anything by mouth. If I had understood that it was nectar I would not have attempted to give her water at all. We are to look at [name of electronic medical record software] and verify the diet but like I said I thought I knew and I did not do that [check system to verify diet]. I never made a mistake like that before. Obviously having swallowing issue and giving them the wrong consistency they can choke. She did cough but at the end when she took the big drink. It should not have happened. I did not remove it [water cup] immediately because I had confusion and was surprised that she [Resident #70] was not on thin liquids. Once I understood I did removed the cup. She had half of the water in the cup still when I took the water cup away.</p> <p>During an interview on 6/10/2025 at 1:13 PM, the Registered Dietician stated, The standard is to check on [name of electronic medical record software] the eMAR [electronic medication administration record] system and verify the diet there. The consistency may varied it is ordered by speech therapy due to swallow difficulties determine by the speech therapy. [Resident #70's name] first was admitted she was NPO and continuous tube feeding. Speech upgraded her on 6/3 to a mechanical soft nectar thickened diet. I saw her on 6/4 to adjust her feeding tube since her diet was upgraded. [Resident #70's name] should not be given regular thin fluids unless directed by a speech therapist. Consistencies are important due to the risk of aspiration. To my knowledge this has never happened before.</p> <p>During an interview on 6/10/2025 at 12:49 PM, the Director of Rehabilitation Services stated, The first thing staff have to do is go to [name of electronic medical record software] and look at the diet. This is the only way to really know what is the correct diet for the patient. I do not recall resident diet we talk about the upgrade and goals what needs to be done to move forward. I cannot recall if the speech therapist specifically mention the diet during the weekly meeting. We don't talk about the in-depth details just a brief overview. The protocol and guideline would be to check the diet. The best practice is not to assume, the best practice is to check [name of electronic medical record software]. This has never happen before in my department. We do not want them to choke and it is standards of practice to follow the plan of care of the patient and diet is part of the plan of care of a patient. Cough is the very first thing that would happen. The key is consistency if someone is given all day long all the time the wrong consistency then there is a risks of aspiration pneumonia. This resident is beginning trained with speech therapy. The notes shows they are on their way to being progress to upgrade the resident. They did a swallowing study and they felt it was the time to start with the progression of the diet.</p> <p>During an interview on 6/10/2025 at 12:58 PM, the Speech Therapist stated, Last Tuesday we had a weekly meeting and whomever is working with the resident they speak and I announce the result of the swallow study. The therapist could ask me any questions at that point if they have any questions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Palm Garden of Ocala		STREET ADDRESS, CITY, STATE, ZIP CODE  2700 SW 34th St Ocala, FL 34474	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/2025 at 2:29 PM, the Medical Director stated, [Resident #70's name] has history of CVA [cerebrovascular accident], pharyngeal dysphagia. If given the wrong consistency there is always a risk for a potential aspiration pneumonia. [Resident #70's name] was NPO and now upgraded thicken nectar. In theory, staff should have verified diet and safeguard the residents. It's the resident's rights to drink but it is also their resident rights to drink the proper consistency.</p> <p>Review of the facility policy and procedure titled Thickened Liquid Policy with the last review date of 5/31/2025 read, Purpose: The center provides commercially-prepared thickened liquids, as prescribed, to residents/guest who require them. Definitions: Thickened liquids refers to liquids in which the consistency has been altered to facilitate safe, oral intake. They are ordered as part of treatment for disease or clinical condition, such as dysphagia due to a stroke, cancer, multiple sclerosis, or other neuromuscular disease. Policy Explanation and Compliance Guidelines: 1. Thickened liquids are provided only when ordered by a physician/practitioner or when ordered by a registered dietitian or speech-language pathologist who has been delegated to write diet order, to the extent allowed by state law. 2. The use of thickened liquids will be based on the resident's/guest's individual needs as determined by the resident's /guest's assessment . 9. Thickened liquid should be available between meals for additional hydration.</p> <p>Review of the facility policy and procedure titled Therapeutic Diet Orders-Policy with the last review date of 5/31/2025 read, Purpose: The center provides all residents/guest with food in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's/guest's treatment/plan of care in accordance with his/her goals and preferences. Definitions: Mechanically Altered Diet is one in which the texture or consistency for food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. Policy Explanation and Compliance Guidelines . 5. Culinary and nursing team members are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received respiratory care as ordered by physician for 4 of 8 residents reviewed for respiratory services (Residents #19, #66, #166 and #51).</p> <p>Findings include:</p> <p>1) During an observation on 6/9/2025 at 9:27 AM, Resident #19 was in bed, receiving oxygen at 4 liters per minute via nasal cannula. The oxygen concentrator was on the left side of the bed outside of the resident's reach.</p> <p>During an interview on 6/9/2025 at 9:27 AM, Resident #19 stated, I don't touch the oxygen. The nurses do that. They take it off and put it on for me.</p> <p>Review of Resident #19's physician order dated 2/20/2025 read, Oxygen at 2 LPM [liters per minute] via N/C [nasal cannula] PRN [as needed] as needed for Shortness of Breath. No Humidity.</p> <p>During an interview on 6/10/2025 at 7:47 AM, Staff E, Licensed Practical Nurse (LPN), stated, The oxygen is not running at the right amount.</p> <p>2) During an observation on 6/9/2025 at 12:19 PM, Resident #66 was receiving oxygen at 5 liters per minute via nasal cannula from an oxygen concentrator. The oxygen concentrator was on the left side of the resident's bed, outside of the resident's reach.</p> <p>During an interview on 6/9/2025 at 12:19 PM, Resident #66 stated, I never touch my oxygen. They (the staff) do that.</p> <p>Review of Resident #66's physician order dated 2/27/2025 read, Oxygen at 3 LPM via n/c PRN every shift for Shortness of Breath.</p> <p>During an interview on 6/11/2025 at 11:48 AM, Staff E, LPN, stated, Her oxygen is supposed to be at 3 liters not at 5 liters. We should check on oxygen every day. I usually do that after I do meds (medications).</p> <p>3) During an observation on 6/9/2025 at 9:34 AM, Resident #166 was lying in bed, receiving oxygen via nasal cannula at 3 liters per minute.</p> <p>During an observation on 6/10/2025 at 8:16 AM, Resident #166 was lying in bed, receiving oxygen via nasal cannula at 3 liters per minute.</p> <p>Review of Resident #166's physician order dated 4/16/2025 read, Oxygen at 2 LPM via N/C PRN every shift.</p> <p>During an interview on 6/11/2025 at 12:10 PM, Staff B, LPN, stated, I have never known [Resident #166's name] to adjust the flow rate for his oxygen. I have never seen him touching it. The respiratory therapist comes twice a week and is the one who will adjust the oxygen rate. [Resident #166's name] has orders for oxygen to be at 2 liters via nasal cannula as needed.</p> <p>(continued on next page)</p>		

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

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2025 at 12:10 PM, Staff B, LPN, stated, [Resident #166's name] oxygen is running at 3 liters per minute and it should be set at 2 liters per minute. I will have to adjust the flow rate.</p> <p>During an interview on 6/11/2025 at 1:30 PM, the Director of Nursing (DON) stated, The staff should check the oxygen flow rate and make sure it is running at the rate that it is ordered.</p> <p>4) During an observation on 6/9/2025 at 10:00 AM, Resident #51 was lying in bed with her eyes closed, receiving oxygen via nasal cannula at 5 liters per minute.</p> <p>Review of Resident #51's physician order dated 3/20/2025 read, Oxygen at 3 LPM via N/C continuously every shift.</p> <p>During an interview on 6/11/2025 at 8:12 AM, Staff C, Registered Nurse, stated, I don't know how that happened. She [Resident #51] has COPD [Chronic Obstructive Pulmonary Disease] and shouldn't receive high levels of oxygen. I will go in and ensure it stays at the ordered 3 liters per minute.</p>

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure residents' medication regimens were free from unnecessary antibiotic use for 1 of 3 residents reviewed for active infections (Resident #165).</p> <p>Findings include:</p> <p>Review of Resident #165's admission record showed the resident was admitted on [DATE] with diagnoses including essential (primary) hypertension, fracture of right femur, history of falling, peripheral vascular disease, and non-infective gastroenteritis and colitis.</p> <p>Review of Resident #165's physician orders showed an order dated 6/7/2025 for stool test for Clostridium difficile (C. diff) one time only for loose stool for 1 day.</p> <p>Review of Resident #165's physician orders showed an order dated 6/7/2025 for administration of Vancomycin HCl (Hydrochloride) oral capsule 125 MG (milligram) 1 capsule by mouth four times a day for prophylaxis.</p> <p>Review of Resident #165's lab results dated 6/8/2025 for C. diff. showed a negative result.</p> <p>Review of Resident #165's physician orders showed an order dated 6/8/2025 for administration of Vancomycin HCl Oral Capsule 125 MG, 1 capsule by mouth four times a day for prophylaxis.</p> <p>Review of Resident #165's Medication Administration Record (MAR) for June 2025 showed the resident received Vancomycin HCl 125 mg oral capsule on 6/7/2025 at 6:00 PM, 6/8/2025 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM, 6/9/2025 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM, 6/10/2025 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM, 6/11/2025 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM, and 6/12/2025 at 12:00 AM and 6:00 AM.</p> <p>Review of Resident #165's progress note dated 6/11/2025 at 2:07 PM read Stool sample negative. Patient returned to [Room number]. patient notified of room change and agreeable.</p> <p>Review of Resident #165's physician order dated 6/11/2025 read, Vancomycin HCl Oral Capsule 125 MG (Vancomycin HCl), Give 1 capsule by mouth four times a day for Prophylaxis until 06/15/2025 23:59 [11:59 PM].</p> <p>During an interview on 6/12/2025 at 10:20 AM, the Infection Preventionist stated, The resident should have had Vancomycin discontinued after the results of the stool sample came back negative for C. diff on June 8, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy and procedure titled Infection Prevention and Control Manual Antibiotic Stewardship and MDROs [Multidrug Resistant Organisms] with an effective date of December 2020 and the last review date of 5/31/2025 read, Policy: It is the policy of this facility to provide systematic efforts to optimize the use of antibiotics in order to maximize their benefits to residents, while minimizing both the rise of antibiotic resistance as well as adverse effects to patients from unnecessary antibiotic therapy. Antibiotic stewardship will include an assessment process, use of evidence-based criteria, efforts to identify the microbe responsible for disease, selecting the appropriate antibiotic along with documentation indicating the rationale for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure foods were stored in a safe and sanitary manner in the main kitchen and in 1 of 3 nourishment rooms of the facility.</p> <p>Findings include:</p> <p>During an observation while conducting a tour of the main kitchen on 6/9/2025 at 9:08 AM with the Dietary Supervisor, there were one unwrapped peperoni pizza sitting on top of a cardboard box located on the third shelf with no opened date or expiration date, and one 5-pound plastic container of sour cream sitting on the second shelf with a date of 5/10/25 written in black marker in the walk-in cooler.</p> <p>During an interview on 6/9/2025 at 9:12 AM, the Dietary Supervisor acknowledged the unwrapped, undated pizza and stated, That should be wrapped up with a use by date on it. The Dietary Supervisor could not clarify if 5/10/25 was the opened date or the expiration date of the sour cream. The Dietary Supervisor stated, I think that is the opened date. It [the container of sour cream] should have been discarded.</p> <p>During an observation while conducting a tour of the nourishment rooms on 6/9/2025 at 9:40 AM with the Dietary Supervisor, in Nourishment room [ROOM NUMBER] on Hallway 400, there was one grey grocery bag with a clear plastic bowl of fruit containing strawberry and grapes sitting on the bottom shelf of the refrigerator, without an expiration date or a label identifying to whom the food belongs to.</p> <p>During an interview on 6/9/2025 at 9:40 AM, the Dietary Supervisor stated, All food brought in should be labeled with the resident's name, and the date it was brought in.</p> <p>Review of the facility policy and procedure titled Food Labeling &amp; Dating- Refrigeration with the last review date of 5/31/2025 read, 2. The food shall be stored covered, marked for contents, and dated when placed in the refrigerator or freezer . 6. The discard day or date may not exceed the manufacturer's use-by-date, or seven days, whichever is earliest. The date of opening or preparation counts as day 1.</p> <p>Review of the facility policy and procedure titled Nourishment and Life Enrichment Refrigerator and Freezer Storage with an effective date of November 1, 2024 and the last review date of 5/31/2025 read, 1. Foods in the nourishment and Life Enrichment Refrigerators can be kept for up to 3 days or per manufacture guidelines . 3. All food items that are prepared by the family members or visitors must be stored in the following manner: a. Stored in an air-tight container or Ziploc bag, b. labeled with the Resident/Guest name and room number, c. labeled with a date of storage.</p>