

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/14/2025
NAME OF PROVIDER OR SUPPLIER  Palm Garden of Gainesville		STREET ADDRESS, CITY, STATE, ZIP CODE 227 SW 62nd Blvd Gainesville, FL 32607	

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 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45576</p> <p>Based on interview and record review, the facility failed to ensure resident records were complete and accurate for 1 of 3 residents, Resident #2, reviewed for wound care.</p> <p>Findings include:</p> <p>Review of Resident #2's clinical records documented Resident #2 had diagnoses to include pressure ulcer of left buttock, stage 3 (full-thickness skin loss, where the wound extends into the subcutaneous tissue).</p> <p>Review of Resident #2's physician's orders dated 4/1/25 read, Wound Care: left buttock, pressure; clean with soap &amp; water, pat dry, apply honey to calcium alginate and cover open area. Cover with optifoam dsg [dressing], T/Th/Sat [Tuesday/Thursday/Saturday] and PRN [as needed] every evening shift every Tue, Thu, Sat [Tuesday/Thursday/Saturday] for left buttock, pressure, S3 [Stage 3] and as needed for left buttock, pressure, S3 [Stage 3]; heel protectors to bilateral heels while in bed as tolerated every shift for wound prevention; Wound Care: right lateral heel, pressure; skin prep daily to lateral heel every evening shift for right lateral heel; pressure, S1 [Stage 1] and Wound Care: left heel, pressure; skin prep daily to lateral heel; every evening shift for left heel, pressure, S1 [Stage 1].</p> <p>Review of Resident #2's treatment administration record, dated 4/1/2025 - 4/30/2025, failed to provide documentaiton of Resident #2's ordered treatment for left buttock on 4/10/2025 and 4/12/2025, ordered treatment for the left heel was not documented on 4/4/2025, the ordered treatment for his right lateral heel was not documented on 4/4/2025, and his ordered intervention for bilateral heel protectors was not documented on 4/4/2025.</p> <p>During an interview on 4/14/2025 at 12:50 PM, the Director of Nursing stated audits had been completed and had been focused audits to ensure wound treatments were completed as ordered. The verification audits were not focused on determining whether wound treatments had been documented when completed. She confirmed Resident #2's wound care interventions had not been documented completed as ordered on the April, 2025 treatment administration record.</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
---	-------	-----------