

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/21/2025
NAME OF PROVIDER OR SUPPLIER  Palm Garden of Largo		STREET ADDRESS, CITY, STATE, ZIP CODE  10500 Starkey Rd Largo, FL 33777	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from neglect related to: 1) providing timely care and services to prevent physical/emotional discomfort for toileting assistance for one resident (#4) out of five residents sampled, and 2) protecting residents from unsympathetic/negative attitudes from staff for three residents (#6, #7, and #5) out of three residents sampled. These failures resulted in emotional/psychological distress and a fear of retaliation among residents.</p> <p>Findings included:</p> <p>1. During a facility tour on 6/21/25 at 9:32 a.m., an observation was made of a call light signal on in Resident #4's room. There were no staff observed in the hallway responding the call light.</p> <p>On 6/21/25 at 9:40 a.m., an observation was made of a staff member at the nurse's station while the call light was displaying on above the nurse's station. The staff member, Staff H, Certified Nursing Assistant (CNA), said she was looking for something and could not answer a question on staffing assignments. She said, I don't mean to ignore you; I'm looking for something. Staff H walked away. Staff H did not respond to Resident #4's call light.</p> <p>On 6/21/25 at 9:44 a.m., the call light was still on in Resident #4's room. An interview was conducted with Resident #4 who was in her room, sitting in her wheelchair by her bedside. She stated she was waiting to be assisted with toileting. She said, I have been waiting to go to the bathroom. I need help. The resident stated the CNA (Certified Nursing Assistant) already came a half hour earlier and stated she was passing trays and would come and assist her later. The resident said, Don't call anyone else, she already said to wait . Please do not say anything . She will be mad if you ask her. The resident stated she waits for assistance all the time. When a surveyor suggested again going to get her help, the resident stated a third time, No, do not ask them. They get mad at me. I know they are busy. The CNA said to wait.</p> <p>Review of Resident #4's admission record revealed the resident was admitted to the facility on [DATE] with diagnoses to include: acute respiratory failure with hypoxia, colostomy status, Bipolar Disorder, and depression.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Minimum Data Set (MDS) for Resident #4, dated 5/30/2025, showed the resident had a Brief Interview of Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Section GG: Functional abilities showed, for lower body dressing: The ability to dress and undress below the waist, including fasteners, the resident needs substantial to maximal assistance (meaning helper does more than half the effort). Helper lifts or holds trunk or limbs and provides more than half the effort). C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy include wiping the opening but not managing equipment, the resident required supervision or touching assistance (meaning helper provides verbal cues and or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>Review of the comprehensive care plan for Resident #4, initiated on 4/1/2025, showed a focus area of ADL (Activities of Daily Living) self-care and/or mobility deficit - at risk for developing complications associated with decreased ADL's self-performance related to disease process condition. The goal indicated the resident will have all ADLs completed by staff as needed. Interventions included toileting assistance - Total assist x1. A second focus area revealed Resident #4 was at risk for alteration in skin integrity related to fragile skin, impaired mobility, use of blood thinning medication and morbid obesity with interventions to assist with toileting and peri-care as needed.</p> <p>Review of Resident #4's Kardex report (a document used by staff with specific instructions to a resident's care needs) showed for bladder/bowel: - Assist with toileting and peri-care as needed. - Provide ostomy care as ordered and prn (as needed). The report showed for transfers the resident required extensive assistance x1, for toileting - Total assist x1, for dressing, UB (upper body) limited assistance and LB (lower body) extensive assistance x1.</p> <p>On 6/21/25 at 9:56 a.m., an observation was made of the call light still on in Resident #4's room. Staff D, Registered Nurse (RN)/Weekend Supervisor (WS), was observed going to a storage closet in the same hallway, picking up some supplies, and speaking to Staff E, CNA, asking, Who has room [number]? The resident wants to go the bathroom. I can't do it myself. Staff E, CNA, stated another CNA [Staff B] had the room. Staff D, RN/WS, was observed walking to the resident's room and leaving immediately. She did not assist the resident. The call light remained on.</p> <p>On 6/21/25 at 10:19 a.m. Resident #4's call light was still on. Staff B, CNA, was observed in the hallway, not providing care at the time.</p> <p>On 6/21/25 at 10:23 a.m., Resident #4's call light was still on. An interview was conducted with the resident. She confirmed staff had not assisted her to the bathroom yet. She stated it had been a very long time, since breakfast time. The resident became teary-eyed and said, I need to be changed. Resident #4 said, You can get me help now. I can't wait anymore. I can't wait anymore. The resident stated her colostomy bag needed to be changed as well. She said, The smell is embarrassing.</p> <p>An interview was conducted on 6/21/25 at 10:27 a.m. with Staff E, CNA. She stated she was not assigned the room. She stated another CNA has her [Resident #4]. Staff E, CNA, said, I saw the call light. The supervisor told me. It has been on, probably an hour. I told her CNA the resident was waiting. Staff E, CNA, stated the resident's assigned CNA [Staff B] was helping another resident. Staff E said, Anyone can assist the resident. I could have. Staff E stated they were expected to help each other. She stated the residents should not wait that long to receive assistance. She said, I will go and help her now.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/21/25 at 10:33 a.m., an interview was conducted with Staff B, CNA. She stated she dropped off the breakfast trays around 8 a.m. She said, I saw her around 8 a.m.; she asked for ice and a shake. She did not ask to go to the bathroom at the time. When I picked up the tray, around 8:30 a.m., she asked to go to the bathroom, and I told her I would be back. Staff B stated another CNA had turned off the light and told her [the resident] I would be back. She said, I told her 'let me finish your roommate.' I finished her roommate and then went to care for other residents. Staff B stated she had asked the resident to wait maybe about an hour ago. She stated, I will help her now. Staff B stated the resident was dependent on staff for toileting.</p> <p>Resident #4 waited to be assisted with toileting for over 1.5 hours.</p> <p>An interview with Staff D, RN/WS, on 6/21/25 at 11:59 a.m. revealed she was filling in for the weekend supervisor. She said, I went there (Resident #4's room) and answered the light. I spoke to the resident; she said she wanted help to go to the bathroom. It was after breakfast. I said I would be back with help. I told her I could not do it myself. Staff D, RN/WS, stated she went looking for help and notified a CNA [Staff E]. Staff D stated Staff E, CNA, reported they would assist her. Staff D, RN/WS said, I should have confirmed. I don't know when it went on or how long it was on. I should have gone to help. Staff D stated she was helping with discharges. She stated she tries to get the lights herself and encourages the CNAs to follow her example. Staff D confirmed waiting over an hour and half to be toileted is too long. She said, I should have gone to help her. I was aware. An hour and half or an hour is too long to wait. Other CNAs should have stepped in. It is not acceptable. I am sorry for the resident. She stated no resident should feel like it was a bother to ask for help.</p> <p>2. During a facility tour on 6/21/25 at 9:20 a.m., an interview was conducted with Resident #5 in her room. She stated she had a problem with a staff member, a CNA. The resident was hesitant to talk about the problem. She said, I would rather not say anything and I don't want to upset her. The resident stated recently about a week ago, a CNA [Staff C] was providing her care. She stated the CNA was on the phone. She was ordering food during care. The resident stated she asked the CNA why she was ordering food during care. The resident reported the CNA got snappy with me. She stated, Since the incident she has been rude. The resident said, I saw her today. I pray to God I don't have her today. She stated she had not reported the incident to anyone. She said, I don't want any trouble with the CNA. The resident stated when the staff member comes to her room, She is rushed, she makes you feel bad about yourself. She stated, That sort of behavior cannot be right.</p> <p>Review of the admission record revealed Resident #5 was admitted to the facility on [DATE].</p> <p>Review of a quarterly MDS, dated [DATE], showed the resident had a BIMS score of 14, meaning intact cognition.</p> <p>Review of a Kardex for Resident #5 showed the resident required an assist of x2 for toileting and an assist of x1 for grooming. The resident required an extensive assistance x2 for bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/21/25 at 11:35 a.m. an interview was conducted with Staff C, CNA. She stated this was her first real job. She stated she was learning from the environment. Staff C stated a resident had a care issue with her, [Resident #11]. Staff C said, She does not want me to care for her related to something someone did to her when she was 14. I don't know what I had to do with it. I was advised not to go there by myself. She will claim I did not give her water, or she was stating I was neglecting her, like not changing her and stuff. They investigated, they spoke with her to get her side of the story. The end result they advised me not to go in there. Staff C stated she had not received customer service education. She said, Not that I know of. I did online training when I was hired, but not anything to do with that. Staff C stated she had received Abuse and Neglect training, most recently two weeks ago. She stated the SDC/LPN did it. She stated, She came and said, 'sign this paper about what not to do and how to care for the residents.' Staff C stated there was no reason why the residents would express concerns about her caring for them. She said, If they tell me they have a problem with me, I tell them I'm new and I'm still learning. Staff C said, No, I have not reported anything. Yes, some residents say stuff. I can't name them now.</p> <p>On 6/21/25 at 2:54 p.m. an interview with the Risk Manager revealed the way she investigates a grievance. She said, First, when I receive the grievance, I go to the resident and ask them if they had been abused. If they say 'no,' then I do not pursue it further. She stated she did not interview the staff members named in the complaints because the residents did not explicitly say they were abused. She said, I see what you are saying, the resident does not have to use the word abuse. She agreed if the use words like rough or mean, she should look into it. She stated she did not consider the residents might have been fearful of staff when they say they were not abused or neglected. She stated she did not consider the psychological impact on the residents. She said, I did not consider the fear of retaliation.</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on 6/21/25 at 2:21 p.m. The NHA stated they take abuse and neglect allegations very seriously. He stated in the last 11 days, they had 11 reportables. He stated they have a lot of grievances documented, which indicates they are following their policy. He said some are related to customer services. He stated sometimes they will go to the resident, and the residents will immediately say there were no concerns or they're happy with care. He said, There needs to be a more robust investigation. He said, We need to have accountability. We are trying to change a culture. We have started a Gem program - for staff to immediately reward a resident or get them a special treat if they like.</p> <p>Review of a facility policy titled, Grievance Policy and Procedure, Revised March 2024, showed:</p> <p>Purpose: The center recognizes the guest/resident/legal representative/family has the right to voice grievances to the center without discrimination and without fear of reprisal. The center team members are responsible for making prompt efforts to resolve a grievance and to keep the guest/resident appropriately updated on the progress being made toward resolution.</p> <p>Definitions: Prompt effort to resolve includes the center's acknowledgment of a grievance and to actively work toward a documented resolution of that grievance.</p> <p>Policy:</p> <p>The Grievance Official and Social Services personnel will serve as guest/resident liaisons/advocates in the concern grievance procedure.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. The center will support the right of the guests/residents to file a grievance anonymously.</li> <li>2. The center will make information available on how to file a grievance to the guest/resident/legal representative/family. This can be done by providing the information directly to the guest/resident and/or by posting the procedure in prominent locations throughout the center.</li> <li>3. The name and contact information (business address and email address and business phone number) for the Grievance Official will be posted in prominent locations throughout the center. The Grievance Official is the Social Service Director/designee of the center.</li> <li>4. The guest/resident has the right to file a grievance orally or in written format.</li> <li>5. The center will make a prompt effort to resolve any grievance received. Grievances will be reviewed, investigated, resolved and documented in five days.</li> <li>6. The center team members will immediately report all alleged violations involving neglect, abuse, injury of unknown origin, and/or misappropriation of guest/resident property following the center abuse prohibition policy.</li> <li>7. The center will review with the guest/resident/legal representative/family the final resolution of the grievance.</li> <li>8. The guest/resident/legal representative/family have the right to obtain a written decision regarding the grievance.</li> <li>9. The center will maintain the grievance and any supportive documentation for a period of not less than 3 years.</li> </ol> <p>Procedure:</p> <p>5. a. The Grievance Official is responsible for the following items: 1. Overseeing the grievance process to include receiving and tracking grievances through to their conclusions to include the investigation, documentation of the summary and the follow-up. 2. Leading any necessary investigations.</p> <p>Review of a facility policy titled, Abuse/Neglect prohibition policy and procedure, effective March 2015, showed:</p> <p>Policy: The center recognizes each resident's right to be free from abuse, neglect, and exploitation (ANE), misappropriation of resident property and maltreatment, including, but not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>This includes the center's identification of residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, observing for changes that would trigger abusive behavior, reassessment of the interventions on a regular basis. The center will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property or have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, misappropriation of property or mistreatment. This center reports suspicions of crimes committed against a resident of this center in accordance with section 1150B of the Social Security Act to at least one law enforcement agency and the State Survey Agency.</p> <p>Definitions:</p> <p>Psychological abuse is defined as: humiliation, harassment, malicious teasing, and threats of punishment or deprivation.</p> <p>Verbal abuse is defined as the use of oral, written, or gestured language. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to; threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.</p> <p>Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Mistreatment: Inappropriate treatment or exploitation of a resident.</p> <p>Procedure:</p> <p>3. Employee Obligation: all employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating the resident's rights. Any employee who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source of origin and misappropriation of resident property, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury to the immediate supervisor, or the Director of Quality Assurance, or the Executive Director of the center.</p> <p>5. Identification: Reporting of suspected maltreatment is required of all team members. All incidents will be reviewed by the center's QAPI Committee for detection of patterns and/or trends. Non-action, which results in emotional, psychological, or physical injury, is viewed in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and treatment of the resident.</p>		