| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105574 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Palm Garden of Largo | 10500 Starkey Rd<br>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.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the safety of one resident (#2) out of three residents sampled. This failure resulted in a fall with major injury for Resident #2 when the individual care plan for transfer was not followed during a shower. Findings included: On 05/18/2026 at 12:15 p.m. Resident #2 was observed lying down in bed. She stated she was still in pain from the fall she had a week ago during a shower. She stated a Certified Nursing Assistant (CNA) transferred her with the Hoyer Lift without assistance in the shower chair. She stated during her shower she kept telling the CNA she felt like she was going to fall out of the chair. She stated the chair felt like it was falling apart and she knew she was going to fall. She stated the CNA left her in the bathroom alone and that is when she fell out of the shower chair. Resident #2 stated she has never broken anything on her body before and she was in a lot of pain.Review of an admission record, dated 05/20/ 2026, revealed Resident #2 was admitted to the facility readmitted on [DATE] with diagnoses to include: active primary progressive multiple sclerosis, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, paraplegia, narcolepsy without cataplexy, contracture, left knee. Review of a Minimum Data Set (MDS) assessment, dated 02/10/2026, showed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #2 was cognitively intact. Review of a Situation Background Assessment Recommendation (SBAR) Communication Form, dated 04/21/2026, revealed a change in condition due to a fall. According to the documentation an 11-7 CNA had hollered out in the hallway for help. Resident #2 was observed lying on the bathroom floor, with the CNA bracing her neck and head. Shower seat grip noted on floor, resident verbalized severe pain during movement when she was transferred from the bathroom floor. The resident verbalized pain in her left hip noted as 9 out of 10. Medical Doctor gave orders to send {Resident #2} out to the hospital due to high probability of resident having sustained an acute fracture. Review of Hospital Record revealed Resident #2 was admitted to the hospital on [DATE] due to a fall and left hip pain. Review of an operative report, dated 4/22/2026, revealed Resident #2 operative diagnoses was Left hip displacement. She underwent treatment of left intertrochanteric fracture with intramedullary implant placement of gamma nail. Review of a Psychiatry progress note, dated 5/4/2026, revealed Resident #2 was seen due to staff reported concerns regarding a prior incident to a recent fall in the shower. Resident # 2 had expressed concerns that her chair felt unstable and may have been malfunctioning. Resident #2 subsequently experienced a fall, resulting in injury.Review of Resident #2's care plan, date initiated 09/09/2015 with a revision dated 04/27/2026, revealed the following:Focus: Activity of Daily Living (ADL) self-care deficit related to: Multiple Sclerosis with paraplegia, spasticity, right sided hemiplegia with contractures. She returned on 4/24/2026 status post left hip fracture status post open reduction and internal fixation with intramedullary nailing.Goal: Resident #2 will maintain ADL's self-performance levels as evidence by no decline in current level of functioning through review date, revision dated 11/14/2025, target date 08/06/2026.Interventions: Hoyer Lift, and 2 persons assist with transfers, and showers. During an interview on 05/18/2026 at 3:12 p.m. with Staff A, Registered Nurse (RN), (continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | stated she was Resident #2 assigned nurse. She stated Resident #2 had a recent fall on the morning shift. Staff A stated Staff B, CNA did not follow Resident #2's plan of care, which required her to have two people assistance during bathing because the resident has poor trunk ability. Staff A stated on the day of the fall she saw Staff B standing in the hallway asking for help with Resident #2. Staff A stated she went down to the resident room, and once she entered the bathroom, she saw resident #2 on the floor, with nothing underneath her. Staff A stated she immediately assessed Resident #2. The resident said her pain level was a 10. She stated she immediately contacted the doctor because she suspected Resident #2 had broken something by the way her leg was positioned on the floor. The doctor ordered a stat x-ray, but he decided to send the resident out to the hospital. Staff A stated Resident #2 told her that she had told Staff B she was slipping out of the shower chair before she fell, but the aide kept showering her. Staff A said the aide left the bathroom to get assistance, the resident fell out of the shower chair. Staff A stated they removed the resident shower chair from the room because the Risk Manager told her the chair was faulty and not safe for use. During an interview on 5/18/26 at 4:28 p.m. with Staff B, CNA stated, I got {Resident #2} in the shower chair and took her in the shower. {Resident #2} said she felt like she was falling. Someone was supposed to come to assist me, but they never came. Staff B stated they only worked with three CNA's that night and each aide had 18-19 residents each. I transferred {Resident #2} using the Hoyer to the shower chair with no issues. After five minutes in the shower {Resident #2} said she felt like she was going to fall out of the shower chair. When I went to get her out the shower, the resident said, ?You haven't washed my hair', and she wanted her hair washed. Staff B stated while she was washing Resident #2's hair the chair started to come apart. She stated, The whole half of the silicone came off the shower chair. Staff B stated, It was the piece of the chair that holds the resident in that came off. Her butt was on the floor but her back was still in the chair. I put the call light on and waited 5-6 minutes. I propped her up and yelled for help. No one came. Staff B stated after she propped Resident #2 in a sitting position she left the resident in the bathroom to get help. She stated she had to walk halfway down the hall toward the nurses station and saw the nurse. She said, The nurse came. She went and got another aide to assist us with getting the resident off the floor. Staff B stated she had to wait another 5-6 mins to help get Resident #2 off the floor. The nurse had moved her leg and the resident said ouch. The nurse asked if she was in pain. The resident said no but it hurt when the nurse moved her leg. Staff B stated the Risk Manager said the shower chair blue piece was old and dirty and the other half was hanging on by a string and she said the chair was not pushing properly. Staff B stated part of the cushion on the shower chair was attached to the chair and the other half of the cushion came off. She stated the chair did not recline and it was not working properly. Staff B stated. They fired me because I didn't use two people to transfer Resident # 2. She stated she was not trained properly; she had 19 residents assigned to her that night and three out of the 19 residents assigned to her had to have showers. Staff B stated she did not know the resident plan of care prior to assisting her. She only had one day of orientation then assigned to the floor to work.During an interview conducted on 5/19/2026 at 10:07 a.m. with the Risk Manager (RM), she stated when she looked at the chair the silicone nonslip pad looked like it was ripped. She stated it may have happened when the resident slipped off the chair and the nonslip silicone was dislodged from the chair. She stated the part was supposed to keep a resident from slipping out of the chair. The Risk Manager stated the resident should have had two people assisting her during her shower, it would have prevented her from falling; if the aide had followed the resident's care plan.During an interview conducted on 5/19/26 at 1:55 p.m. with Resident #2's Primary Care Provider he stated he sees Resident #2 every week. He stated, I've seen her for 15 years. Resident #2 is paraplegic with multiple sclerosis. She totally depends on the assistance of others for all of her care. I was told the shower chair broke down under her while she was in it and she fell on the floor. She was assisted by one person at the time of her shower which is a total violation due to safety. Her fall caused her a fracture of the left hip, and she had to undergo surgery while in the hospital. She will have agonizing pain for a long time as a result of her<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | injury. At this time her pain is controlled by medications. Prior to the fall she was not taking any pain medications. It is hard to tell if she is going to continue on opioids for a longer period of time or not. My main concern is to make sure she is comfortable, but she is not there at this time due to her consistent pain. This has impacted on her psychosocially as she normally goes to bingo, and likes to attend other activities at the facility, but obviously with her having to recover from the surgery she is confined to the four walls of her room. My recommendation is to make sure her pain is controlled, we are gradually coming to that point. It's going to take another 2 to 4 weeks to work on the pain where she is at a level where she could be placed in a chair to attend activities again. This sudden change has caused more difficulties for her. Review of the Certified Nursing Assistant Job Description, dated September 2019, revealed the following:Basic Function; Provide routine daily clinical care and services that support the care delivered to guests requiring long-term or rehabilitative care in accordance with the established with the established clinical care procedures and directed by your supervisor. Essential Functions; Provides care as directed by the professional nurse to guests requiring long-term rehabilitative care. Provide services that support the care delivered to the guests. Marginal Functions; All equipment is operated in a safe manner and the only equipment utilized that which previous training of use has occurred. Defective equipment is reported to the Charge/ Staff Nurse. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation, Revised September 2023, revealed the following:Neglect, Neglect as defined in statute 483.5 is the failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This occurs when the center was aware of or should have been aware of, goods or services that the resident (s) required but the center failed to provide them resulting in or may result in physical harm, pain, mental anguish, or emotional distress. The facility did not have any other policy related to this citation |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure proper infection control practices were utilized related to contact precautions on two resident units (100 and 200) out of three resident units in the facility.Findings included:An observation was conducted on 5/18/26 at 9:42 a.m. of a staff member entering room [ROOM NUMBER], which had a contact precaution sign on the door. The staff did not use personal protective equipment (PPE) while in the room.An observation as conducted on 5/18/26 at 9:53 a.m. of a staff member in room [ROOM NUMBER], which had a contact precaution sign on the door. The staff member did not have any PPE on while in the room. The staff member exited the room, spoke to the nurse in the hall, reentered the room, then exited again. No hand hygiene was observed. At 9:58 a.m. Staff C, LPN entered room [ROOM NUMBER] without donning PPE.An interview was conducted on 5/18/26 at 10:03 a.m. with Staff C, Licensed Practical Nurse (LPN). Staff C confirmed a resident in room [ROOM NUMBER] was on contact precautions. She said staff only wear PPE in the room if they are doing direct care or dressing changes. She said if staff are dropping off trays, passing medications, or talking to the resident they do not wear PPE in contact precaution rooms. The following observations were conducted on 5/18/26 between 10:19 a.m. and 11:43 p.m. on the 100 resident unit: -A Certified Nursing Assistant (CNA) entered room [ROOM NUMBER], which had a contact precaution sign. The staff member did not don PPE to enter the room. The staff member was then observed exiting the room without performing hand hygiene and entered another resident room.-A CNA entered room [ROOM NUMBER], which had a contact precaution sign, with only gloves on and no gown.-An unknown staff member was in room [ROOM NUMBER], which had a contact precaution sign, with no PPE on.-Staff D, CNA was in room [ROOM NUMBER], which had a contact precaution sign, with no PPE on.An interview was conducted on 5/18/26 at 11:50 a.m. with Staff D, CNA. She said for residents on contact precautions, staff only wear PPE when doing personal care for the resident. She said they do not have to wear PPE all the time in the room for resident on contact precautions.An observation and interview was conducted on 5/18/26 at 1:50 p.m. of Staff E, Housekeeper, in room [ROOM NUMBER], which had a contact precaution sign on the door. Staff E was cleaning the room with no PPE on. Upon exiting the room, Staff E was asked about the contact precaution sign and the use of PPE. She said she had training but forgot to put PPE on.An observation and interview was conducted on 5/18/26 at 1:56 p.m. with Staff F, Van Driver. room [ROOM NUMBER] had a contact precaution sign on the door. The Unit Manager, CNA, and van driver were all observed to be in the room with no PPE on. Staff F exited the room and stated he had training on the types of precautions and PPE use. He said he is a driver for the facility but also helps with small maintenance things when he is not busy. He said he would normally ask the nurse what the precautions are for and if it is for a wound or something like that or he is just walking in to fix something he would not wear PPE.An interview was conducted on 5/18/26 at 2:21 p.m. with the Director of Nursing (DON). The DON provided a list of residents on contact precautions and said there were a few additional residents they just removed from precautions that shift. She said they had so many residents on precautions due to a gastrointestinal (GI) outbreak the week before. The DON said if the residents had no diarrhea after 48 hours, they were taking them off precautions. The DON said they had not figured out what the bacteria was.At 2:26 p.m. the facility's Infection Preventionist (IP) joined the interview.She said she is the IP as well as the staff educator in the facility. The IP stated they had 14 residents and 3 staff members with the GI symptoms in the last week. She said some had nausea, vomiting, and diarrhea while others and just one or two of those symptoms. The IP said they did hand hygiene education for the whole house and were cleaning high touch surfaces every two hours. She said they put residents with symptoms on contact precautions and a few on special contact precautions due to those being tested for clostridium defile (C-Diff). The IP said for residents on contact precautions there is a sign W for window or D for door on the sign. She said staff know if<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the door bed is the one on precautions they should wear PPE when encountering that resident. The IP said staff did not have to wear PPE anytime they entered the room. The DON then said for contact precautions staff should wear a gown and gloves anytime they enter the residents' room if there is a sign on the door. She said it did not matter which resident was specifically on the precautions. The DON and IP both reiterated staff should read the signs and follow what it says.Review of a facility policy titled Transmission Based Precautions, effective September 2019, showed the following:Transmission based precautions are used when route of transmission is not completely interrupted using standard precautions alone and the pathogen may have multiple routes of transmission. Transmission based precautions are divided into: contact precautions, droplet precautions, and airborne precautions. Precautions in place when symptomatic infections are not deemed colonized by the resident physician or center infection preventionist.1. Contact precautions: wear PPE (personal protective equipment) gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas of the resident environment. |