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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105581	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Clearwater	3480 McMullen Booth Rd Clearwater, FL 33761

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on interview and record review, the facility failed to report an event that led to transfer to a higher level of care within the specified timeframe of the allegation for one of one sampled residents (#1). Findings included: Review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation, revised September 2023 showed the center recognizes each resident's right to be free from abuse, neglect, and exploitation (ANE), misappropriation of resident property. 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. 6. Reporting: All team members are required to report suspected maltreatment to their immediate Supervisor or Director of Quality Assurance / designee or Executive Director. Notifications can take place in person or via telephone. The employee must report to department manager or supervisor in the center so that the resident may immediately be protected from further maltreatment. The Executive Director or The Director of Quality Assurance are to be informed immediately of the situation. In the absence of the Executive Director and the Director of Quality Assurance the Director of Clinical Services and / or the Social Service Director are to be informed of the situation immediately. The center also must report all alleged violations of any type of abuse or any event that led to significant bodily injury immediately but no later than 2 hours from the time of the allegation. The center must report all alleged violations of neglect, exploitation, or misappropriation immediately but no later than 24 hours from the time of the allegation. If any of these resulted in serious bodily injury, then you must report within 2 hours of the time of the allegation. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Incidents of ANE or Misappropriation requires notification to outside agencies. These include the State Survey Agency (Agency for Healthcare Administration), Adult Protective Services / Department of Children and Families and if there is suspicion that a crime is involved then notification to local law enforcement. The Director of Clinical Services / designee shall notify the physician and the resident's representative concerning the suspected maltreatment and the findings of the assessment. The Director of Clinical Services / designee shall reassure the resident's representative that an investigation has been initiated, that the resident is being protected and that appropriate action has been taken. All verbal contact with the resident's representative shall be documented accordingly. The Director of Quality Assurance / designee will file the Immediate Federal report with AHCA, and then submit the summary and findings of the investigation with the 5-Day Federal Report. Resident #1 was admitted on [DATE] and discharged on [DATE] to the hospital according to the face sheet. Review of the Admissions Report showed diagnoses included but were not limited to pneumonia, Urinary Tract Infection, severe protein-calorie malnutrition, hemiplegia following a Cerebral Vascular Accident, hypotension, polyneuropathy, muscle weakness, history of falls, dysphagia, neuromuscular dysfunction of bladder, gastrostomy, spinal stenosis, anemia, recurrent severe depressive disorder, stage 3 chronic kidney disease, other specified interstitial pulmonary diseases, and bronchiectasis. Review of the 5-day Minimum Data Set (MDS) dated [DATE] showed Section C Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section GG showed the ability to eat was not applicable, he required partial to moderate assistance for toileting and bathing. The resident used a wheelchair. Section K, Swallowing Disorder showed the resident used a feeding tube for nutrition. Review of the physician orders showed a full code and revealed; NPO diet. Enteral Feeding of Boost Very High Calorie, 237 ml [milliliter] bolus four times a day, family to provide as of 03/29/2024. Enteral feeding at bedtime, Jevity 1.5 237 ml every evening, flush with 120 ml water before and after as of 3/29/2024. Flush feeding tube with 120 ml of water before and after each feeding 5 times a day and four times a day for hydration as of 3/29/2024. Send to ER [emergency room] on 3/30/2024. Review of the nursing progress notes showed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/30/2024 at 15:42 (3:42 p.m.) the patient was in the ice cream social and began to become hypoxia and de-sating. Brought back to his room and placed in his bed. O2 (oxygen) sats (saturation) in the 40s. Placed on portable oxygen. Put on 15 Liter rebreather mask which only improved to the 70s. Still pallor in color. Order to send out was made. 911 called. Pt [patient] sent out around 2 p.m. family aware. Staff C, Registered Nurse (RN) Review of SNF/NF [skilled nursing facility/nursing facility] to Hospital Transfer Form dated 03/30/2024 at 14:20 (12:20 p.m.) showed SOB [short of breath], oxygen saturation in the 60's. Enteral feeding via peg tube. Staff B, RN During an interview on 04/10/2024 at 1:47 p.m. with the Nursing Home Administrator (NHA), the Director of Nursing (DON) and the Director of Quality Assurance / Risk Manager (DOQA/RM), the DOQA / RM stated during the investigative process, Resident #1 was self-propelling in the facility. Resident #1 self-propelled from his room on the D wing to the C wing to the main dining room where a group activity was occurring. This was normal for him. Resident #1 was alert and oriented. Resident #1 performed his own transferring. Resident #1 socialized and was into mingling. DOQA / RM stated that Staff C, RN was his nurse and stated she last observed Resident #1 at 1 p.m. for his bolus feeding and medications. Resident #1's Certified Nursing Assistant (CNA) stated she observed him in his room at 1:30 p.m. for personal care. DOQA / RM stated he was independent at baseline. DOQA / RM stated Resident #1 has had the peg tube for greater than a year according to the family. Resident #1 managed the peg tube at home and gave his own bolus feedings at home. DOQA / RM stated that day (03/30/2024) at 3:30 p.m. he ate ice cream. The activity was an ice cream social. DOQA / RM stated, Originally, I was told he grabbed the ice cream. During the reenactment, Staff A, Activity Aide (AA) showed that she stands in front of the congregated group (20 residents), and she said she asks who wants ice cream and then she gives them ice cream. The NHA stated they have a rolling cart / cooler for activities only. It was scooped ice cream into cones. The DOQA / RM stated there were no other staff members in the ice cream social. There were other residents there but no staff. The DOQA / RM stated through the investigation it was determined Resident #1 had asked for the ice cream and Staff A, AA handed it to him. The NHA stated that the story changed a couple of times. The DOQA / RM stated the investigation was started on 04/01/2024, after DOQA / RM reenacted the scene with Staff A, AA. The DOQA / RM stated that Staff A, AA admitted she had the Dietary List. The Dietary List included all the residents and included all the residents' dietary types, NPO [nothing by mouth], thickened liquids, etc. The DOQA / RM stated the Dietary Tool was 11 pages long that day, it was a list of the whole house. The DOQA / RM stated Resident #1 was transferred to the hospital on 03/30/2024. The DOQA / RM stated Staff A. AA was removed from the schedule on 04/01/2024 after full knowledge of the incident. The DOQA / RM stated she was first informed he grabbed the ice cream. DOQA / RM found out it was given to him, and it was on a cone, not just a cup. On 04/04/2024, Staff A, AA was terminated from service with closure of the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DOQA / RM stated the Federal Report went in on 04/01/2024 for 1-day at 8:50 p.m., the 5-day on 04/05/2024 at 4:50 p.m. The DOQA / RM called DCF (Stated Agency: Department of Children and Families) on 04/01/2024 at 19:58 (7:58 p.m.) and Law Enforcement was called on 04/01/2024 at 18:56 (6:56 p.m.) The DOQA / RM stated she got the call of the incident on 03/30/2024 from the Staff B, RN, weekend supervisor, that Resident #1 had gotten ahold of ice cream and was being sent out to the hospital at 2:38 p.m. (on 03/30/2024). The DOQA / RM asked Staff A, AA to call her and with the initial call from Staff A, AA, and what was communicated to me, was he grabbed the ice cream, He got ice cream, he grabbed it. The DOQA / RM stated, Had I known the details I would have reported immediately. We did not follow MD [medical doctor] orders and a higher level of care was necessary. The NHA stated she was not notified about the incident until 04/01/2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on interview and record review, the facility failed to ensure the Comprehensive Patient-Centered Care Plan was developed and accurate related to NPO (nothing by mouth) status and behaviors for one of three sampled residents (#1). Findings included: Resident #1 was admitted on [DATE] and discharged on [DATE] to the hospital. Review of the Admissions Report showed diagnoses included but were not limited to pneumonia, Urinary Tract Infection, severe protein-calorie malnutrition, hemiplegia following a Cerebral Vascular Accident, hypotension, polyneuropathy, muscle weakness, history of falls, dysphagia, neuromuscular dysfunction of bladder, gastrostomy, spinal stenosis, anemia, recurrent severe depressive disorder, stage 3 chronic kidney disease, other specified interstitial pulmonary diseases, and bronchiectasis. Review of the 5-day Minimum Data Set (MDS) dated [DATE] showed Section C Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section GG showed the ability to eat was not applicable, he required partial to moderate assistance for toileting and bathing. The resident used a wheelchair. Section K, Swallowing Disorder showed the resident used a feeding tube for nutrition. Review of the physician orders showed a full code and revealed: -NPO diet; -Enteral Feeding of Boost Very High Calorie, 237 ml (milliliters) bolus four times a day, family to provide as of 03/29/2024; -Enteral feeding at bedtime, Jevity 1.5 237 ml every evening, flush with 120 ml water before and after as of 3/29/2024; -Flush feeding tube with 120 ml of water before and after each feeding 5 times a day and four times a day for hydration as of 3/29/2024. Review of the Baseline Care Pla) showed admitted from hospital with pneumonia, community acquired, with aspiration; acute hypoxia, respiratory failure, UTI [urinary tract infection], CVA [cerbral vascular accident] with right hemiparesis dysphagia g-tube. Nutrition / Hydration: diet order. Review of Resident #1's care plans showed: The resident was dependent on GT [gastric tube] for nutrition and hydration as of 03/29/2024. Interventions included but not limited to administer tube feeding as ordered, family to provide product as of 3/29/2024; advance to oral intake per ST [speech therapy] as of 3/29/2024; flush tube with water as ordered as of 3/29/2024; keep head of bed elevated during feed tubing administration as of 3/29/2024; monitor as as available as of 3/29/2024; monitor tolerance of tube feeding via nursing documentation and / or discussion with resident; verify tube placement prior to administering feeding; weight per protocol all as of 3/29/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 has behavior problems related to non-compliance with diet. He has chronic dysphagia, g-tube dependent, and is aware of risk involved, as evidenced by (drinking tap water from the bathroom sink, eating cookies, cheese found in room that he grabs off tray at nurses' station). As of 03/20/2024. Interventions included to explain care in advance, in terms resident understands as of 3/20/2024; observe behavior episodes and attempt to determine underlying cause as of 3/20/2024; re-approach later if becomes agitated as of 3/20/2024; report changes in behavior status to physician / nurse as of 3/20/2024; and strive to anticipate care needs and provide them before resident becomes overly stressed as of 3/20/2024. During an interview on 04/11/2024 at 10:04 a.m. the MDS coordinator confirmed the behavior care plan focus area did not indicate the resident was NPO (nothing by mouth). She stated the interventions were a checked box area, but she did have the option to personalize the interventions for the resident. During an interview on 04/11/2024 at 10:57 a.m. the Director of Quality Assurance / Risk Manager (DOQA / RM) stated, I became aware of the behaviors during the investigation, not before. She stated she found an unopened package of cheez-its snacks in the resident's room; however, no-one saw him eating or drinking. During an interview on 04/11/2024 at 11:33 a.m. the Director of Nursing (DON) stated that at morning meeting, DOQA / RM stated she had spoken with the significant other the significant other had stated he tried to get cookies from her. The DON stated she spoke with the MDS Director and reviewed Resident #1's behavior care plan with the DOQA / RM. The DON stated we were discussing the in the morning meeting. We wanted to make sure something was in the care plan that he may get something on his own based on the significant other's interview. The DON verified the behavior care plan looked like the facility knew about the non-compliant behaviors as of the admission and were occurring at the facility. The DON agreed the interventions were very basic for a behavior care plan and needed to be more focused on his behaviors and specific to him. The Regional Nurse stated on 04/11/2024 at 12:00 p.m. they use the MDS 3.0 RAI User's Manual as the care plan policy. Review of the facility's policy, Baseline Care Plan, effective October 2022 showed it is the practice of the center to develop and implement a baseline care plan for each guest/resident within 48 hours of the admission. The baseline care plan will include instructions needed to provide effective and person-centered care to the guest / resident that meet professional standards of quality care .will include specific health and safety concerns. The baseline care plan will address at a minimum: Dietary orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on interview and record review, the facility failed to ensure the documentation was accurate in the medical record for three of three sampled residents (#1, #2, #3). Findings included: Resident #1 was admitted on [DATE] and discharged on [DATE] to the hospital according to the face sheet. Review of the Admissions Report showed diagnoses included but were not limited to pneumonia, Urinary Tract Infection, severe protein-calorie malnutrition, hemiplegia following a Cerebral Vascular Accident, hypotension, polyneuropathy, muscle weakness, history of falls, dysphagia, neuromuscular dysfunction of bladder, gastrostomy, spinal stenosis, anemia, recurrent severe depressive disorder, stage 3 chronic kidney disease, other specified interstitial pulmonary diseases, and bronchiectasis. Review of the 5-day Minimum Data Set (MDS) dated [DATE] showed Section C Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Section GG showed the ability to eat was not applicable, he required partial to moderate assistance for toileting and bathing. The resident used a wheelchair. Section K, Swallowing Disorder showed the resident used a feeding tube for nutrition. Review of the physician orders showed a full code; NPO (nothing by mouth) diet Review of the Clinical Admission on 03/19/2024 showed under 11. Nutrition section 3. He was receiving nutrition orally. 4. Taking nutrition and hydration orally. No complaints of thirst. No signs and symptoms of swallowing disorder. Mucous membranes moist. 5. Intake, NPO was not checked. Education does not address Gastrostomy tube. Review of the nursing progress notes showed: -On 03/20/2024 at 1557, resident continues on antibiotic po (by mouth) for pneumonia with no adverse effect. Resident has a productive cough with moderate secretions, denies SOB (shortness of breath). No active fever, fluids encouraged. Staff E, Licensed Practical Nurse (LPN) -On 03/20/2024 at 19:02 (7:02 p.m.) showed no signs of difficulty breathing. No SOB noted. Head of bed elevated. Head elevated at 30 degrees. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Secretion clear. Cough with effective airway. Cough with retained secretions. No pain related to cough. Taking nutrition and hydration orally. No complaints of thirst. No signs / symptoms of swallowing disorder. Staff E, LPN -On 03/21/2024 at 15:52 (3:52 p.m.), HOB (Head of Bed) elevated at 30 degrees. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Secretions clear. cough with effective airway. Taking nutrition and hydration orally. No complaints of thirst. No signs / symptoms of a swallowing disorder. Currently on antibiotics (ABT) for pneumonia. Staff E, LPN (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/21/2024 at 15:59 (3:59 p.m.), resident continues on ABT po for pneumonia with no adverse effects presents with productive cough with moderate clear secretions. Resident denies SOB or pain with coughing. No current fever. Staff E, LPN -On 03/22/2024 at 15:34 (3:34 p.m.) no signs of difficulty breathing. No SOB noted. HOB elevated at 30 degrees. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Secretions clear. cough with effective airway. Taking nutrition and hydration orally. No complaints of thirst. No signs / symptoms of a swallowing disorder. Currently on antibiotics. Staff E, LPN -On 03/23/2024 at 17:46 (5:46 p.m.), pt (patient) had several opened back dated g-tube syringes on dresser in room, pt used an opened syringe and bolus self with Boost which was located in drawer. Old open g-tube syringes removed from room. Pt approached this writer and stated he bolus self with Boost for years and he wants g-tube syringes to remain at bedside for his own personal use. PCP (primary care physician) will follow up with pt. LPN -On 03/24/2024 at 15:09 (3:09 p.m.) HOB elevated at 30 degrees. No signs of difficulty breathing. No SOB noted. No cough. Nutrition was blank. Staff B, Registered Nurse, weekend supervisor (RN, WE supervisor) -On 03/25/2024 at 16:50 (4:50 p.m.) No signs of difficulty breathing. No SOB noted. HOB elevated 30 degrees. Cough present. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Secretions yellow. cough with effective airway. Taking nutrition and hydration orally. No complaint of thirst. No s/s of a swallowing disorder. Currently on Abt for pneumonia. Staff E, LPN -On 03/26/2024 at 20:31 (8:31 p.m.) No signs of difficulty breathing. No SOB noted. HOB elevated 30 degrees. Cough present. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Secretions clear. cough with effective airway. Taking nutrition and hydration orally. No complaint of thirst. No s/s of a swallowing disorder. Currently on Abt for pneumonia. Staff E, LPN -On 03/28/2024 at 15:22 (3:52 p.m.) No signs of difficulty breathing. No SOB noted. HOB elevated 30 degrees. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Cough with effective airway. Taking nutrition and hydration orally. No complaint of thirst. No s/s of a swallowing disorder. Currently on Abt for pneumonia. Staff E, LPN -On 03/29/2024 at 15:17 (3:17 p.m.) pulse ox at 94%. Alert and oriented x 3. No signs of difficulty breathing. No SOB noted. HOB elevated 30 degrees. Cough present. Moist/loose productive cough noted. Moderate amount of secretions. Secretions are moderate in consistency. Cough with effective airway. Taking nutrition and hydration orally. No complaint of thirst. No s/s of a swallowing disorder. Currently on Abt for pneumonia. Staff E, LPN Review of the Aide Tasks showed: What percentage of the meal was eaten? (continued on next page)

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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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/11/2024 at 11:33 a.m. the Director of Nursing (DON) stated the documentation was an error, referring to the nursing notes and aide task notes. The DON stated she would have to call these staff members and ask them about their documentation. She stated she did not look at the documentation in the ADL (activities of daily living) tasks after the incident. The DON stated, I truly feel they were just checking it off. We will look into that and start education today. It is very concerning to me. 22481 A review of Resident #2's clinical chart, the face sheet, documented an admission of 03/01/2024 with a readmission of 03/25/2024. His diagnoses information included Pneumonitis due to inhalation of food and vomit. A review of Resident #2's physician orders reflected he was ordered a NPO (Nothing by mouth) diet. A review of Resident #2's snack provision, as documented by the certified nursing assistants for the period of 03/28/2024 through 04/09/2024, reflected the resident had been documented to have been provided a snack on 03/28, 03/29, 03/30, 04/01, 04/02, 04/03, 04/04, 04/05, 04/06, 04/07,04/08, and 04/09. An observation was conducted on 04/10/2024 of Resident #2 in his room. Resident #2's eyes were open, alert, but he did not verbally answer questions. He nodded acknowledgment, and nodded when asked if he was comfortable. A review of Resident #3's clinical chart, the face sheet, documented an admission of 02/23/2021 with a readmission of 03/15/2024. His diagnoses information included Pleural effusion and dysphagia. A review of Resident #3's physician orders reflected he was ordered a NPO diet. A review of Resident #3's snack provision, as documented by the certified nursing assistants for the period of 03/28/2024 through 04/09/2024, reflected the resident had been documented to have been provided a snack on 04/05/2024. An observation was conducted on 04/10/2024 at 11:15 a.m. of Resident #3, in his room. He was observed in bed, the television was on. Resident #3 did not answer when spoken to.