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	06/10/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to honor the Advanced Directive for one resident (#1) out of three residents sampled. On 05/14/2026, facility staff initiated Cardio-Pulmonary Resuscitation (CPR), including cardiac compressions (use of hands to push down hard and fast to manually pump blood through the heart), when Resident #1 was found unresponsive. The resident had a physician order for Do Not Resuscitate (DNR), dated 06/13/2025. Cardiopulmonary Resuscitation was provided to Resident #1 for approximately nine minutes. Failure to honor the resident's wishes caused unnecessary physical and psychosocial harm and denied Resident #1 a peaceful death. The survey team verified the facility's corrective actions to correct the noncompliance for F578 and found the facility to be in compliance as of 5/18/26, prior to the survey visitFindings included: Review of Resident #1's admission Record revealed an admission date of 05/02/2025, with medical diagnoses to include: Type II Diabetes Mellitus with hypoglycemia without coma, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #1's orders revealed an order for Do Not Resuscitate (DNR), dated 06/13/2025 with no end date.Review of Resident #1's medical record documents revealed a paper Do Not Resuscitate Order (Form DH 1896), signed by Resident #1 and the Physician on 06/13/2025.Review of Resident #1's quarterly Minimum Data Set (MDS), dated [DATE], showed Resident #1 had a Brief Interview Mental Status of 15, indicating intact cognition.Review of Resident #1's progress notes revealed:05/14/2026 at 11:25 AM: At 9:00am [Resident #1] was observed in bed absent of vital, no pulse, no respirations. Code blue called and initiated. EMT [Emergency Medical Technician] arrived at 9:13am and took over. Medical Director 5 [sic] pronounced him deceased at 9:20am.Review of Resident #1's Care Plan revealed the following:Focus: Resident #1 had chosen Do Not Resuscitate (DNR), initiated 06/13/2025.Goal: Resident #1's heart stopped beating or if the resident stopped breathing, Cardiopulmonary Resuscitation (CPR), was not to be initiated in honor with Resident #1's wishes, initiated 06/13/2025.Interventions included: verify presence of Physician's order for DNR, initiated 06/13/2025. During an interview on 06/08/2026 at 09:53 AM, Staff A, Certified Nursing Assistant (CNA), stated she saw Resident #1, on 05/14/2026 at around 08:00 AM. Staff A stated Resident #1 mentioned not feeling well. Staff A stated she told Staff C Licensed Practical Nurse (LPN), Resident #1 wasn't feeling well around 08:45 AM. Staff A explained having checked on Resident #1 again at approximately 09:00 AM, and stated the resident appeared asleep. Staff A stated she called out to Resident #1 three times, with no response, and she began looking for the rise and fall of Resident #1's belly and stated it was not there. Staff A explained having called out to Staff C, and the nurse went in to Resident #1's room to assist Resident #1. Staff A explained that Resident #1's assigned nurse asked her to get another nurse for assistance. During an interview on 06/08/2026 at 10:11 AM, Staff B Registered Nurse (RN), stated she was told by Staff A that Staff C Licensed Practical Nurse (LPN), needed assistance with Resident #1. Staff B stated that upon reaching the room of Resident #1, CPR was being performed by staff. Staff B stated everyone was asking about a code status and stated there was a lot of yelling that Resident #1 was a full code. Staff B stated someone said Resident #1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was a DNR. Staff B stated she saw a paper DNR for Resident #1. Staff B stated she did not check Resident #1's code status, prior to going to the room. During an interview on 06/08/2026 at 10:34 AM, Staff D RN, Unit Manager (UM), stated she heard a code blue (an emergency announcement used in healthcare facilities to signal that someone is experiencing a life-threatening medical emergency), through the facility intercom system, on 05/14/2026. Staff D stated upon entry into Resident #1's room we were told he was a CPR. Staff D stated she saw Staff C performing CPR on Resident #1. Staff D stated once it was determined that Resident #1 had a DNR, she and other staff members took over to assist with CPR. Staff D stated the DNR status was being checked when we got there. Staff D stated CPR was performed on Resident #1, before Resident #1's code status of DNR status was confirmed. Staff D stated a nurse attempted to not honor Resident #1's wishes. During an interview on 06/08/2026 at 11:48 AM, the Nurse Practitioner (NP), stated that upon entering Resident #1's room, chest compressions were being performed on Resident #1, by Staff C LPN. The NP explained having assisted with chest compressions for Resident #1 and stated she found out later that Resident #1 had a code status of DNR. During an interview on 06/08/2026 at 01:00 PM with the Social Services Director (SSD), she stated that if a resident comes in with a DNR, Social Services will upload to the electronic health record (EHR) and nursing staff will put in a request for an order to the provider. She stated she updates the DNR book on a monthly basis and on an as needed basis if the resident is brought in before or after the audit period. If a resident is brought in during the weekend, it's the nursing staffs responsibility to obtain and upload to the EHR. During an interview on 06/08/2026 at 02:17 PM, Staff F Licensed Practical Nurse (LPN), stated she heard a code blue over the intercom to Resident #1's room. Staff F stated she went to check Resident #1's code status and saw that the resident had a DNR. Staff F stated she yelled down the hall that Resident #1 had a DNR.Staff F explained having checked Resident #1's code status, because that was the facility's process. During an interview on 06/08/2026 at 02:32 PM, Resident #1's Primary Care Physician (PCP) stated Resident #1's medical record included a DNR and stated the nurse didn't go back to the computer or chart before starting CPR. The PCP stated, if there was a DNR on the chart, then it should have been followed. During an interview on 06/08/2026 at 02:49 PM, the Medical Director (MD), stated the first action the staff should have taken for an unresponsive resident was to identify the resident's advanced directives. The MD stated should have known Resident #1's code status and how to honor it. The MD stated, they did not actually honor the resident's wishes. During an interview on 06/09/2026 at 12:32 PM, with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Director of Quality Assurance (DQA), they stated if a resident was found unresponsive, the staff was supposed to (if not a nurse), notify a nurse. They stated the nurse would then check the resident's vitals, breath sounds, pulse, and heart sounds. They stated another nurse would be delegated to check the resident's code status. They stated CPR would not be started until the code status of a resident was confirmed as full code. They stated CPR would continue until EMS arrived and took over. They stated if the resident had a DNR, once confirmed by a nurse or higher, the staff would contact the provider. During an interview on 06/09/2026 at 01:00 PM, with the NHA, DON, and the DQA, they stated between 08:00 AM and 09:00 AM, Staff A set up and left a food tray for Resident #1. They stated prior to 09:05 AM, Staff A went into Resident #1's room and spoke to the resident and tapped Resident #1's leg and received no response. They stated Staff A then left the room to notify the nurse. They stated Staff A and Resident #1's assigned nurse entered Resident #1's room at 09:03 AM. They stated Staff C, LPN, checked Resident #1's pulse and began CPR. They stated at 09:04 AM, Staff E NP, entered Resident #1's room. They stated the NP, said she saw Resident #1's assigned nurse performing chest compressions, and switched out with her to continue CPR. They stated after 09:05 AM, Staff D RN UM, began performing rescue breaths on Resident #1. They stated at 09:07 AM, EMS was contacted. They stated at 09:09 AM, Staff F confirmed Resident #1's code status as DNR. They stated EMS arrived at 09:11 AM. They stated EMS told the staff to stop CPR and respect Resident #1's wishes at 09:13 AM. They stated from 09:04 AM to 09:13 AM, CPR was being performed (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on Resident #1. They stated EMS confirmed Resident #1's DNR was valid. They stated upon admission to the facility, resident code statuses are confirmed. They stated facility staff did not follow the facility policy and stated no, Resident #1's wishes were not honored. Review of a policy titled: Advance Directives & Code Status, and revised 10/10/2024, revealed: 3. The code status order will be documented in the {Electronic Medical record (EMR)}and will serve as the primary source of validation of code status by a licensed nurse should a resident be found unresponsive. a. A licensed nurse will only initiate CPR once the code status has been verified in by a licensed nurse indicating the resident wants CPR. b. If has an order for DNR then CPR will not be initiated. c. If is down (internet outage, power failure) the code status must be verified by a licensed nurse using the back-up code status notebook. 7. If a resident is found unresponsive the EMR must be accessed to determine the code status order by a licensed nurse. For any resident without a physician's order for DNR, or without documented wishes to withhold CPR, EMS (911) is called, the attending physician notified, and emergency basic life support (CPR) is initiated by a licensed nurse. Facility immediate actions to remove the Immediate Jeopardy included: Resident's family was immediately notified of events, investigation and corrective measures implemented on 5/14/26.An immediate self-report was filed 5/14/26.The nurse who initiated compressions was questioned and verbally and in writing admitted she was aware of the P&P (Policy and Procedure) but did not follow it.All staff involved in the incident received immediate education regarding P&P and honoring resident wishes.An immediate audit was completed by medical records, and social services on 5/14/26 for all other residents that included code status order verification, care plan audit including advanced directive review, Do Not Resuscitate Order (DNRO) if applicable, and emergency code status back up binders, there were no concerns identified.The Human Resources (HR) director audited all licensed nurses CPR certification cards and all were in compliance on 5/14/26.The Director of quality assurance, director of education, and all Unit managers were present and initiated immediate re-education will licensed nurses to include the following; attestation of Advanced Directive Acknowledgement, Clinical Competency for CPR which included nurse to verify code status order before initiating CPR, and if a DNRO was identified CPR would be halted to honor resident wishes,Advanced Directive Code Status Quiz for competency, Abuse Neglect Exploitation(ANE) policy, and Resident Rights including honoring wishes all of these action items were completed by 5/18/26. Any new licensed nurses will be provided with the same re-education during orientation. The Director of Quality Assurance/designee immediately initiated on 5/14 Code Blue Drills to include after action review for opportunities with on-the-spot re-education this was done 3x daily for the first 15 days, on all three shifts with weekly ad hoc Quality Assurance and Performance Improvement (QAPI). All licensed nurses had completed a drill by 5/18/26. Verification of the facility's removal plan was conducted by the survey team on 06/08/2026: Ad Hoc meetings were performed on 05/14/2026, 05/21/2026, 05/28/2026, and 06/04/2026 with the Interdisciplinary team. Review of facility education and competencies revealed all nursing staff signed that they received: Advance Directive Acknowledgement, Palm Garden Clinical Competency, Exam: Advanced Directive Code Status. Interviews were conducted with 41 staff members: 19 licensed nurses, 19 CNAs, and 3 ancillary staff across all shifts. The staff members were able to state that they had been trained and were knowledgeable about the new policies. The facilities corrective actions plan included: 1. Resident #1 expired in the center on 5/14/26. No corrective measures could be implemented for resident #1. Resident's family was immediately notified of events, investigation and corrective measures implemented on 5/14/26. The nurse who initiated compressions was removed on 5/14/26 and subsequently terminated and reported to the Board of Nursing. An immediate self-report was filed 5/14/26. The nurse who initiated compressions was questioned and verbally and in writing admitted she was aware of the P&P but did not follow it.2. An immediate audit was completed by medical records, and social services on 5/14/26 for all other residents that included code status order verification, care plan audit including advanced directive review, DNRO if applicable, and emergency code status back up binders, there were no concerns (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	identified. The HR director audited all licensed nurses CPR certification cards and all were in compliance on 5/14/26. 3. The Director of quality assurance, director of education, and all Unit managers were present and initiated immediate re-education will licensed nurses to include the following; attestation of Advanced Directive Acknowledgement, Clinical Competency for CPR which included nurse to verify code status order before initiating CPR, and if a DNRO was identified CPR would be halted to honor resident wishes, Advanced Directive Code Status Quiz for competency, ANE policy, and Resident Rights including honoring wishes all of these action items were completed by 5/18/26. Any new licensed nurses will be provided with the same re-education during orientation. The Director of Quality Assurance/designee immediately initiated on 5/14 Code Blue Drills to include after action review for opportunities with on-the-spot re-education this was done 3x daily for the first 15 days, on all three shifts with weekly ad hoc QAPI. All licensed nurses had completed a drill by 5/18/26. 4. The Director of Quality Assurance/designee will conduct ongoing competency audits utilizing code blue drills with after action reviews and questionnaires, a minimum of 3 x weekly on all shifts, including weekends and holidays a minimum of 30 days, then 3 x monthly ongoing with any concerns corrected on the spot. These drill audits will be presented weekly to the QAPI committee for a minimum of 30 days and then monthly ongoing for plan review and revision.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure nursing staff were competent in the identification of code status for one resident (#1) out of three residents sampled. On 05/14/2026, facility staff initiated Cardio-Pulmonary Resuscitation (CPR), including cardiac compressions (use of hands to push down hard and fast to manually pump blood through the heart), when Resident #1 was found unresponsive. The resident had a physician order for Do Not Resuscitate (DNR), dated 06/13/2025. Cardiopulmonary Resuscitation was provided to Resident #1 for approximately nine minutes. Failure to honor the resident's wishes caused unnecessary physical and psychosocial harm and denied Resident #1 a peaceful death. The survey team verified the facility's corrective actions to correct the noncompliance for F726 and found the facility to be in compliance as of 5/18/26, prior to the survey visitFindings Included: Review of Resident #1's admission Record revealed an admission date of 05/02/2025, with medical diagnoses to include: Type II Diabetes Mellitus with hypoglycemia without coma, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #1's orders revealed an order for Do Not Resuscitate (DNR), dated 06/13/2025 with no end date.Review of Resident #1's medical record documents revealed a paper Do Not Resuscitate Order (Form DH 1896), signed by Resident #1 and the Physician on 06/13/2025.Review of Resident #1's quarterly [NAME] Data Set (MDS), dated [DATE], showed Resident #1 had a Brief Interview Mental Status of 15, indicating intact cognition.Review of Resident #1's progress notes revealed:05/14/2026 at 11:25 AM: At 9:00am [Resident #1] was observed in bed absent of vital, no pulse, no respirations. Code blue called and initiated. EMT [Emergency Medical Technician] arrived at 9:13am and took over. Medical Director 5 [sic] pronounced him deceased at 9:20am.Review of Resident #1's Care Plan revealed the following:Focus: Resident #1 had chosen Do Not Resuscitate (DNR), initiated 06/13/2025.Goal: Resident #1's heart stopped beating or if the resident stopped breathing, Cardiopulmonary Resuscitation (CPR), was not to be initiated in honor with Resident #1's wishes, initiated 06/13/2025.Interventions included: verify presence of Physician's order for DNR, initiated 06/13/2025. During an interview on 06/08/2026 at 09:53 AM, Staff A, Certified Nursing Assistant (CNA) stated she saw Resident #1, on 05/14/2026 at around 08:00 AM. Staff A stated Resident #1 mentioned not feeling well. Staff A stated she saw Resident #1 again around breakfast time. Staff A stated Resident #1 said he did not feel well and did not feel like eating, and Staff A could leave the food tray. Staff A stated she told Staff C, Licensed Practical Nurse (LPN), Resident #1 was not feeling well around 08:45 AM. Staff A explained having checked on Resident #1 again at approximately 09:00 AM, and stated the resident appeared asleep. Staff A stated she called out to Resident #1 three times, with no response, and she began looking for the rise and fall of Resident #1's belly and stated it was not there. Staff A explained having called out to Staff C, and the nurse went into Resident #1's room to assist Resident #1. Staff A stated Staff C asked Staff G, CNA and herself, to get another nurse for assistance and to call a code blue (an emergency announcement used in healthcare facilities to signal that someone is experiencing a life-threatening medical emergency), over the intercom. Staff A stated she did not call a code blue, because she did not know how to call a code on the intercom. During an interview on 06/08/2026 at 10:11 AM, Staff B Registered Nurse (RN), stated she was told by Staff A that Staff C, LPN needed assistance with Resident #1. Staff B stated upon reaching the room of Resident #1, CPR was already being performed by staff. Staff B stated she observed CPR being performed on Resident #1's bed, without a backboard. Staff B stated she did not check Resident #1's code status, before going into the room. Staff B stated there was a lot of yelling in Resident #1's room with some staff members stating Resident #1's code status was full code. During an interview on 06/08/2026 at 10:28 AM, Staff G, CNA stated on 05/14/2026 Staff A, CNA ran down the hall and said there was an emergency in Resident #1's room. Staff G explained being asked (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by Staff C, LPN to call a code blue. Staff G stated she did not know how to page a code blue over the intercom. Staff G stated two or three minutes later, there was a code blue to a different room than Resident #1's room. During an interview on 06/08/2026 at 10:34 AM, Staff D, RN Unit Manager (UM) stated she heard a code blue through the facility intercom system, on 05/14/2026. Staff D stated upon entry into Resident #1's room We were told he was a CPR. Staff D stated she saw Staff C, LPN performing CPR on Resident #1. Staff D stated when residents are found unresponsive the process for staff call a code blue, grab a laptop, check the resident's code status, or use a binder at any nursing station for residents with DNRs. Staff D stated, I don't feel like she followed our process, checking the code status before starting CPR. Staff D stated, If she had checked the code status, she would not have started CPR. Staff D stated Staff C had received advanced directives training prior to 05/14/2026. During an interview on 06/08/2026 at 11:48 AM, the Nurse Practitioner (NP), explained chest compressions had been started by Staff C LPN, when she entered Resident #1's room on 05/14/2026. The NP stated she assisted with Resident #1's CPR and performed chest compressions. The NP stated, after she started CPR, she learned Resident #1 had a DNR. During an interview on 06/08/2026 at 12:28 PM, the Director of Quality Assurance (DQA), stated Staff C LPN told leadership staff she had checked Resident #1's code status prior to performing CPR. The DQA stated Staff C did not explain how she saw a different code status than DNR in Resident #1's Electronic Medical Record. During an interview on 06/08/2026 at 02:17 PM, Staff F Licensed Practical Nurse (LPN), stated she was responsible for education of staff at the facility. Staff F stated she responded to a code blue call on 05/14/2026. Staff F stated she first went to a med-cart to identify Resident #1's code status. Staff F stated, That's our procedure to check code status before we do anything. Staff F stated she yelled down the hall, that Resident #1 was a DNR. Staff F stated upon arrival to Resident #1's room, EMS was in the room. During an interview on 06/08/2026 at 02:32 PM, Resident #1's Primary Care Physician (PCP), stated Resident #1's had a DNR. The PCP stated, The nurse didn't go back to the computer or chart before starting CPR. The PCP stated, If there was a DNR on the chart, then it should have been followed. The PCP stated, It's on her unfortunately. During an interview on 06/08/2026 at 02:49 PM, the Medical Director (MD), stated the first action the staff should have taken for an unresponsive resident was to identify the residents' advanced directives. The MD stated the staff should have known Resident #1's code status and how to honor it. The MD stated for Resident #1's DNR, Unfortunately that was not handled properly. During an interview on 06/09/2026 at 12:32 PM, with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Director of Quality Assurance (DQA), they stated if a resident was found unresponsive, the staff was supposed to (if not a nurse), notify a nurse. They stated the nurse would then check the resident's vitals, breath sounds, pulse, and heart sounds. They stated another nurse would be delegated to check the resident's code status. They stated CPR would not be started until the code status of a resident was confirmed as full code. They stated CPR would continue until EMS arrived and took over. They stated if the resident had a DNR, once confirmed by a nurse or higher, the staff would contact the provider. During an interview on 06/09/2026 at 01:00 PM, with the NHA, DON, and the DQA, they stated for a resident who had a DNR, once the DNR was verified, someone was supposed to contact the provider, and then the staff was supposed to receive orders. They stated the NP, said she saw Resident #1's assigned nurse performing chest compressions, and switched out with her to continue CPR. They stated Staff D, RN UM, gave rescue breaths to Resident #1, during CPR. They stated no staff member stopped CPR until EMS arrived and told them to stop. They stated the facility had a policy in effect for over a year: if CPR was started on a resident who had a DNR, once the DNR was confirmed, CPR could be stopped without the need for a provider or EMS to give an order to stop. They stated on 05/14/2026 at 09:09 AM, Staff F LPN confirmed Resident #1's code status as DNR. They stated CPR was performed on Resident #1 on 05/14/2026 from 09:04 AM to 09:13 AM. They stated, They should have stopped and verified in [the Electronic Medical Record] the way she wastrained. They stated the competencies for the nurses who performed CPR were not demonstrated properly.Review of a document titled: Job (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Description revealed: Job title: Registered NurseEssential Function:-Works using the guidelines established from the Nurse Practice Act, company standards, policies and procedures and clinical judegement.-Implements the guest plan of care and evaluates the guest's response.Marginal Functions: Decisions are made that reflect knowledge and good judgment and demonstrate an awareness of guest/family/physician needs. Review of a document titled: Job Description revealed:Job Title: Licensed Practical NurseEssential Function:-Works under direct supervision using the Nurse Practice Act, policies and procedures and clinical judgement.-Implements the guest plan of care and evaluates the guest's response. A document titled: Clinical Competency and revised 08/2024, revealed standards to include:3. Delegates a licensed nurse to check {Electronic Medical record (EMR)}for code status order.9. Does not begin CPR if DNR order.12. Places resident on back, backboard or hard surface to begin CPR.16. Stop CPR if it was started and a DNR order was found/presented. Honor Resident wishes.Review of a policy titled: Advance Directives & Code Status, revised 10/10/2024, revealed:3. The code status order will be documented in the {Electronic Medical record (EMR)}and will serve as the primary source of validation of code status by a licensed nurse should a resident be found unresponsive.a. A licensed nurse will only initiate CPR once the code status has been verified in EMR by a licensed nurse indicating the resident wants CPR.b. If EMR has an order for DNR then CPR will not be initiated.c. If EMR is down (internet outage, power failure) the code status must be verified by a licensed nurse using the back-up code status notebook.7. If a resident is found unresponsive the EMR must be accessed to determine the code status order by a licensed nurse. For any resident without a physician's order for DNR, or without documented wishes to withhold CPR, EMS (911) is called, the attending physician notified, and emergency basic life support (CPR) is initiated by a licensed nurse.Facility immediate actions to remove the Immediate Jeopardy included: Resident's family was immediately notified of events, investigation and corrective measures implemented on 5/14/26.All staff involved in the incident received immediate education regarding Policies and Procedures (P&P) and honoring resident wishes.An immediate self-report was filed 5/14/26.The nurse who initiated compressions was questioned and verbally and in writing admitted she was aware of the P&P but did not follow it. An immediate audit was completed by medical records, and social services on 5/14/26 for all other residents that included code status order verification, care plan audit including advanced directive review, Do Not Resuscitate Order (DNRO) if applicable, and emergency code status back up binders, there were no concerns identified.The Human Resource (HR) director audited all licensed nurses CPR certification cards, and all were in compliance on 5/14/26.The Director of quality assurance, director of education, and all Unit managers were present and initiated immediate re-education will licensed nurses to include the following; attestation of Advanced Directive Acknowledgement, Clinical Competency for CPR which included nurse to verify code status order before initiating CPR, and if a DNRO was identified CPR would be halted to honor resident wishes,Advanced Directive Code Status Quiz for competency, ANE policy, and Resident Rights including honoring wishes all of these action items were completed by 5/18/26. Any new licensed nurses will be provided with the same re-education during orientation. The Director of Quality Assurance/designee immediately initiated on 5/14 Code Blue Drills to include after action review for opportunities with on-the-spot re-education this was done 3x daily for the first 15 days, on all three shifts with weekly ad hoc Quality Assurance and Performance Improvement (QAPI). All licensed nurses had completed a drill by 5/18/26. Verification of the facility's removal plan was conducted by the survey team on 06/08/2026:Ad Hoc meetings were performed on 05/14/2026, 05/18/2026, 05/28/2026, and 06/04/2026 with the Interdisciplinary team.Review of facility education and competencies revealed all nursing staff signed that they received: Advance Directive Acknowledgement, Palm Garden Clinical Competency, Exam: Advanced Directive Code Status.Interviews were conducted with 41 staff members: 19 licensed nurses, 19 CNAs, and 3 ancillary staff across all shifts. The staff members were able to state that they had been trained and were knowledgeable about the new policies. The facilities corrective actions plan included:1. (continued on next page)

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	06/10/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 expired in the center on 5/14/26. No corrective measures could be implemented for resident #1. Resident's family was immediately notified of events, investigation and corrective measures implemented on 5/14/26. The nurse who initiated compressions was removed on 5/14/26 and subsequently terminated and reported to the Board of Nursing. An immediate self-report was filed 5/14/26. The nurse who initiated compressions was questioned and verbally and in writing admitted she was aware of the P&P but did not follow it.2. An immediate audit was completed by medical records, and social services on 5/14/26 for all other residents that included code status order verification, care plan audit including advanced directive review, DNRO if applicable, and emergency code status back up binders, there were no concerns identified. The HR director audited all licensed nurses CPR certification cards, and all were in compliance on 5/14/26.3. The Director of quality assurance, director of education, and all Unit managers were present and initiated immediate re-education will licensed nurses to include the following; attestation of Advanced Directive Acknowledgement, Clinical Competency for CPR which included nurse to verify code status order before initiating CPR, and if a DNRO was identified CPR would be halted to honor resident wishes, Advanced Directive Code Status Quiz for competency, Abuse Neglect and Exploitation (ANE) policy, and Resident Rights including honoring wishes all of these action items were completed by 5/18/26. Any new licensed nurses will be provided with the same re-education during orientation. The Director of Quality Assurance/designee immediately initiated on 5/14 Code Blue Drills to include after action review for opportunities with on-the-spot re-education this was done 3x daily for the first 15 days, on all three shifts with weekly ad hoc QAPI. All licensed nurses had completed a drill by 5/18/26.4. The Director of Quality Assurance/designee will conduct ongoing competency audits utilizing code blue drills with after action reviews and questionnaires, a minimum of 3 x weekly on all shifts, including weekends and holidays a minimum of 30 days, then 3 x monthly ongoing with any concerns corrected on the spot. These drill audits will be presented weekly to the QAPI committee for a minimum of 30 days and then monthly ongoing for plan review and revision.