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	02/06/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, record review, and interviews, the facility failed to maintain resident dignity related to 1.) wearing of plastic informational bands for ten residents (#30, #50, #72, #33, #90, #121, #45, #34, #123, and #81) of sixty-seven sampled residents and 2.) failed to ensure a urinary catheter bag with contents was positioned in a private manner during two of four days observed (2/3/2025 and 2/4/2025), for one resident (#123) of fourteen residents who utilized indwelling catheters. Findings included: 1. On 2/3/2025 at 8:40 a.m., 11:00 a.m., and 1:00 p.m.; 2/4/2025 at 7:50 a.m. and 1:30 p.m.; 2/5/2025 at 8:00 a.m. and 1:45 p.m.; and 2/6/2025 at 7:50 a.m. and 10:00 a.m., the following residents were observed either in the hallways or in their rooms wearing white plastic and/or pink plastic wrist bands on their wrists. The white plastic wrist bands had photos of the face of the resident, numbers, and an electronic bar code. Resident #30 was observed with the white plastic wrist band on her right wrist. Resident #30 was interviewed during the observation and stated she did not know why she was wearing the wrist band and also stated, I would rather not wear it. A review of Resident #30's medical record revealed she was admitted to the facility on [DATE]. Review of the most current Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score 11 of 15, which indicated the resident had moderate cognitive impairment. Resident #50 was observed with a white plastic wrist band on his right wrist. Resident #50 was interviewed during the observation and stated, I don't want this on, it's filled with bacteria, gross. A review of Resident #50's medical record revealed she was admitted to the facility on [DATE]. Review of the most current Annual MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15 of 15, indicating the resident was cognitively intact. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #72 was not observed with a wrist bands on, but when interviewed stated, I take them off, don't like them on my wrist when discussing the wrist bands. She further revealed when she takes the bands off, she is supplied with more and keeps telling staff she does not want to wear it. A review of Resident #72's medical record revealed she was admitted to the facility on [DATE]. Review of the most current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15 of 15, indicating the resident was cognitively intact. Resident #33 was observed with no wrist band on, but when interviewed stated, I don't have one on now, they are supposed to get me another and I would rather not have one if that is ok when discussing the wrist bands. A review of Resident #33's medical record revealed she was admitted to the facility on [DATE]. A review of the most current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15 of 15, indicating the resident was cognitively intact. Resident #90 was observed with a white and pink plastic wrist band on his right wrist. Interview with Resident #90 revealed he did not like the feel of the bands and did not want to wear them. He revealed the facility asked him to wear the bands and he does not know why. He preferred to not wear them as they are not comfortable. A review of Resident #90's medical record revealed he was admitted to the facility on [DATE]. The most current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15 of 15, indicating the resident was cognitively intact. Resident #121 was observed with a white plastic wrist band on her right wrist. An interview was conducted with the resident following the observation. She revealed she did not like the band on and did not know why she had to wear it. A medical record review revealed Resident #121 was admitted to the facility on [DATE]. A review of the most current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 9 of 15, which indicated the resident had moderate cognitive impairment. Resident #45 was observed with a white plastic wrist band on her right wrist. An interview was conducted with the resident following the observation. She revealed she did not know what the band was for and she would rather not wear it. She further revealed the band gets caught on things and she does not like the feeling of wearing it. A brief record review revealed Resident #45 was admitted to the facility on [DATE]. A review of the most current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 8 of 15, which indicated the resident had moderate cognitive impairment. Resident #34 was observed with a white plastic band on her right wrist. An interview was conducted with the resident following the observation. Resident #34 revealed she would rather not wear the band and was not told why she had to wear it. A review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Review of the current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 7 of 15, which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #123 was observed wearing a white plastic band and a pink plastic band on his right wrist. Interview with the resident revealed he was not aware of why he had to wear the bands and did not know what they were for. Most of the photo and bar code on the white plastic band were worn away and was no longer in a readable state. Resident #123 revealed he did not feel comfortable wearing the bands and would rather not wear them. A brief review of the medical record revealed Resident #123 was admitted to the facility on [DATE] and recently readmitted from the hospital on 1/28/2025. Review of the most current 5 day MDS assessment, dated 12/9/2024 revealed under Section C - Cognitive Patterns, a BIMS score of 15 of 15, indicating the resident was cognitively intact. Resident #81 was observed wearing a white plastic band on his right wrist. An interview with the resident revealed he did not know why he was wearing it and they just put it on. He also revealed he does not like wearing the band. A brief review of the medical record revealed the resident was admitted to the facility on [DATE]. Review of the most current Quarterly MDS assessment dated [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15 of 15, indicating the resident was cognitively intact. On 2/6/2025 at 10:00 a.m., an interview with Staff J, Registered Nurse/Unit Manager (RN UM) and the Director of Nursing (DON), confirmed the facility implemented the use of wrist bands about three to four months ago. Staff J, RN UM and the DON also confirmed the bands were to identify the resident with first and last name and with a photo of them. The DON further explained the bar code on the band was for staff to obtain medical information from the resident's medical record. Staff J, RN UM and the DON were not able to provide consent forms for the above mentioned residents or any other resident in the facility who were wearing wrist bands. The DON explained the wrist bands were used to ensure staff had the right resident they were providing care and service to. She also explained they would accommodate residents who did not want to wear the wrist band by not placing them on, but was unaware of any residents who did not want to wear them. The DON was also unaware there were so many residents who were not understanding of the purpose of the wrist bands. 2. On 2/3/2025 at 10:00 a.m. and 2:10 p.m., and on 2/4/2025 at 7:50 a.m., 8:50 a.m., and 10:18 a.m., Resident #123's room was observed with the door open. An indwelling catheter bag was observed hanging from the left side of the resident's bed, visible from the hallway and nurses station. The catheter bag was not placed in a privacy bag. (Photographic Evidence Obtained) On 2/4/2025 at 1:50 p.m., Resident #123 was observed in his room seated upright in bed with his over the bed table and lunch meal tray positioned in front of him. An indwelling catheter bag was observed hanging from the left side of the resident's bed, visible from the hallway and nurses station. The catheter bag was not placed in a privacy bag and was approximately 1/2 full of yellow liquid. On 2/5/2025 at 7:29 a.m., Resident #123 was observed resting in bed. An indwelling catheter bag was observed hanging from the left side of the resident's bed, visible from the hallway. The catheter bag was not placed in a privacy bag and was approximately 1/2 full of yellow liquid. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/2025 at 7:56 a.m. Resident #123 was observed in his room lying in bed and had just received his breakfast meal tray from staff. The room light was on the indwelling catheter bag was lying on the floor. At 7:59 a.m., Staff R, Certified Nursing Assistant (CNA) was observed walking in the room and assisted the resident with setting up the breakfast tray. She left the room and came back in the room with another breakfast tray at 8:03 a.m. for the resident's roommate. She left the room and did not see or attempt to reposition the catheter bag. (Photographic Evidence Obtained) At 8:19 a.m., Staff J, RN UM was observed walking by the room and looked in the room. Staff J, RN UM repositioned the catheter bag to the side of the bed, below the mattress. The catheter bag and contents were visible from the hallway and nurses station. At 9:10 a.m., an interview was conducted with Staff J, RN UM. Staff J, RN UM confirmed she walked by Resident 123's room earlier and saw the catheter bag was lying on the floor. She revealed she went inside and immediately repositioned it on the side and bottom of the bed frame, ensuring the bag was up off the floor. Staff J, RN UM revealed she left the room to retrieve a privacy bag to place the catheter bag in. She could not remember if the bag was without a privacy bag the last two days. Staff J, RN UM stated the resident's catheter bag should have been placed in a privacy bag so the contents were not visible from the hallway. A review of the current Care Plans with a next review date 3/12/2025, revealed the following areas: Risk for complications related to use of indwelling catheter, with interventions in place to include: Anchor to thigh to decrease trauma, Change [indwelling] catheter and bag [as needed], Keep bag below level of bladder, and Privacy bag. On 2/6/2025 at 3:00 p.m., the Nursing Home Administrator (NHA) provided the Admission Packet, which is provided to newly admitted residents and/or their representatives. Within the Admission Packet was a booklet related to Resident Rights, with a last amended date of 3/8/2022, which revealed: (a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility, including those specified in this section. (1) A facility must treat with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. (c) Planning and Implementing Care. (4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. (6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimented research, and to formulate an advance directive. (d) Respect and dignity. The resident has the right to be treated with respect and dignity, including: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48223 Based on observations, interviews, and record review, the facility did not ensure prompt efforts were made to resolve grievance for two residents (#109 and #268) out of three residents sampled for grievances. Findings included: During an interview and observation on 2/3/2025 at 12:29 p.m., Resident #109 stated repeated concerns regarding meals and care and the facility does not listen to her. During an interview on 2/4/2025 at 11:13 a.m., Resident #109 stated continued concern regarding meals and care. A review of the Grievance Logs from November 2024 to February 5, 2025, did not reveal grievance concern for Resident #109. Review of the grievance log for June 2024 revealed a grievance written for Resident #109 on 6/21/2024. During an interview on 2/5/2025 at 9:23 a.m., the Dietary Manager (DM) stated they spoke with Resident #109 on 2/3/2025 regarding meal concerns and updated the meal ticket. The DM continued to state I receive concerns from residents. I will meet with the resident and discuss, I do not document the concerns. I am trying to get better at that. During an interview on 2/5/2025 at 10:19 a.m., the DM presented Resident #109's meal ticket dated 2/5/2025, showing for breakfast the resident prefers cornflakes. The DM said on 2/3/2025, the meal ticket was updated but the update was not reflected until 2/5/2025 and prior to the update the resident's breakfast preference was oatmeal. During an interview on 2/6/2025 at 10:19 a.m., with Staff M, Licensed Practical Nurse and Care Plan Specialist (LPN/CPS) stated Resident #109 had a care plan meeting on 2/3/2025 during which time Resident #109 did have care and food concerns. Staff M, LPN/CPS stated referred Resident #109's concerns to the Unit Manager (UM). During an interview on 2/6/2025 at 10:35 a.m., Staff J, Registered Nurse/Unit Mansager (RN/UM) stated they spoke with Resident #109 regarding the concerns and stated anyone can file a grievance. Staff J, RN/UM stated upon receipt of a grievance, staff will document and send the grievance to the appropriate department for resolution. Once these steps are completed and the resolution occurs, the grievance is given to the Social Service Director. During an interview on 2/3/2025 at 9:55 a.m., Resident #268 stated having concerns about care and food temperatures since admission on 1/28/2025. Resident #268 also stated he reported the concerns to everyone, certified nursing assistants (CNAs), nurses, and unit manager and nothing has changed. A Review of the Grievance Log from January 2025 to February 5, 2025, did not reveal grievance concerns for Resident #268. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 2:00 p.m., Staff N, CNA confirmed Resident #268 complained about the temperature of the food and some other things. Staff N, CNA also stated they don't really have time to complete the grievance, that is for something really big. During an interview on 2/5/2025 at 2:33 p.m., Staff O, RN stated anyone can fill out a grievance and they place the completed form in the Unit Manager's office for follow-up. During an interview on 2/5/2025 at 8:00 a.m., the DM stated they did not know of a consistent problem with cold food. The DM also stated there have been concerns with food temperatures but very sporadic and nothing that would need a grievance for. During an interview on 2/5/2025 at 2:25 p.m., the Social Services Director (SSD) confirmed being responsible for the grievance process. The SSD explained grievances can be completed by anyone (i.e. staff, family, resident) for the facility to work on. The grievance is filled out and given to her or kept by the manager who filled it out. The grievance is then brought to the morning meeting for discussion and logging. The grievance is given to the appropriate department for follow up and resolution with the resident. Once the department manager resolves the grievance with the resident, the completed form is turned in to the SSD for filing and tracking. The SSD stated they try to resolve the grievances quickly, 3-5 days but she doesn't follow up with any of the residents regarding issues unless they were related to Social Services. The SSD stated they will summarize the areas of concern, weekly and monthly, for the Quality Assurance Committee and they have noticed some trends in call lights and food temperatures, but they were not sure if anything has happened with those trends. During an interview on 2/6/2025 at 10:08 a.m., the Nursing Home Administrator (NHA) stated the grievance process is coordinated by the SSD and anyone can complete a grievance. The grievance is received and logged by the SSD, then taken to the next manager meeting, which is held twice daily, in the morning and at the end of the day, for discussion and assignment for investigation/resolution. Discussion occurs regarding the grievance at the meetings daily until resolved, usually 3-5 days. The SSD tracks and trends the data for discussion at the Quality Assurance Committee. Review of the facility's policy and procedures titled Grievances with revision date of March 2024 revealed the following: Purpose: F585 - 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. Definitions: Prompt effort to resolve includes the center's acknowledgment of a grievance and to actively work toward a documented resolution of that grievance. Policy: The Grievance Official and Social Services personnel will serve as guest/resident liaisons/advocates in the concern grievance procedure. 4. The guest/resident has the right to file a grievance orally or in written format. 5. The center will make a prompt effort to resolve any grievance received. Grievances will be reviewed, investigated, resolved and documented in five days. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The center will review with the guest/resident/legal representative/family the final resolution of the grievance. Procedure: The Grievance Official and Social Services personnel will serve as resident liaisons/advocates in the concern grievance procedure. 1. A grievance is defined as any formal expression (verbally or in writing) of interest regarding the well-being of a guest/resident. 4. The center will designate a Grievance Official with whom the grievance can be filed and will post his or her name, business address (mailing and email) and business phone number. Any team member can write or assist in the writing of a grievance. 5. The Grievance Official is the Social Service Director/designee. 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. 5. The Grievance Official will close the grievance and reflect the conclusion/outcome of the grievance investigation or abuse investigation. 6. The Grievance Official will provide the guest/resident/legal representative with a written decision about the filed grievance upon request. 7. The grievances will be brought to the morning stand up meeting daily. They will be reviewed out loud with all the leadership team members. The grievance forms will come to the stand up meeting daily until resolved. 9. Below is a list of items that the investigating team member will include on the grievance form and the Grievance Official will be responsible to assure is completed when a written decision is requested. A written decision will only be provided by the Grievance Official/designee. a. The date the grievance was received. b. The guest/resident name that is involved in the grievance. c. A summary of the guest/resident/legal representative/family grievance. (What is the grievance)? d. The steps that were taken to investigate the grievance. e. A summary of the pertinent findings or conclusions of the investigation regarding the grievance. f. A statement as to whether the grievance was confirmed or not confirmed. g. Documentation of any corrective action taken or to be taken by the center. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Upon receipt of the grievance, documentation on the grievance form will be initiated by the Grievance Official/designee or whichever professional team member receives the concern. Instructions for completion are outlined on the Addendum. a. The Grievance Official/designee will document the date the grievance is received on the Grievance Log and copies are made and distributed to the Executive Director and the referenced department representative.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51097 Based on interview and record reviews, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were accurate for twelve residents (#1, #126, #44, #97, #71, #119, #116, #60, #90, and #39) out of 32 residents sampled. Findings included: 1. Review of Resident #1's Admission Record showed Resident #1 was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia. Other diagnoses include major depressive disorder and anxiety disorder. Review of the Level I PASRR dated 11/2/2024 showed in Section II: Other Indications for PASRR Screen Decision-Making, 5. Does the individual have a primary diagnosis of dementia, was marked No. A Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Review of Section IV: PASRR Screen Completion revealed: Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 2. Review of resident #126's Admission Record showed Resident #126 was admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder, major depressive disorder, and unspecified dementia. Review of the Level I PASRR dated 9/24/2024 showed in Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Depressive Disorder, was checked. Anxiety Disorder was not checked. Section II: Other Indications for PASRR Screen Decision-Making revealed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 3. Review of Resident #44's Admission Record showed Resident #44 was admitted to the facility on [DATE] with diagnoses of major depressive disorder, unspecified dementia, and generalized anxiety disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Level I PASRR dated 7/30/2023 showed in Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Anxiety Disorder, Depressive Disorder, and Psychotic Disorder, were checked. Section II: Other Indications for PASRR Screen Decision-Making revealed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 4. Review of Resident #97's Admission Record showed Resident #97 was admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia with a date of 4/10/2023. Other diagnoses include major depressive disorder. Review of the Level I PASRR, dated 4/5/2023 showed in Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): No diagnoses were checked. Section II: Other Indications for PASRR Screen Decision-Making revealed under question 6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis of a Serious Mental Illness or Intellectual Disability?, Yes was marked. Section II also revealed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 5. Review of Resident #71's Admission Record showed Resident #71 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder. Other diagnoses include dementia with a date of 6/4/2021, and anxiety disorder with a date of 7/15/2023. Review of the Level I PASRR, dated 07/17/2023 showed in Section II: Other Indications for PASRR Screen Decision-Making revealed under question 6. Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis of a Serious Mental Illness or Intellectual Disability?, Yes was marked. Section II also revealed under question 7. Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)?, Yes was marked. Section II revealed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 6. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #119's Admission Record showed Resident #119 was admitted to the facility on [DATE] with a diagnosis of unspecified dementia. Other diagnoses include major depressive disorder with a date of 12/24/2024, and anxiety disorder with a date of 1/23/2025. Review of the Level I PASRR, dated 12/5/2024 showed in Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Depressive Disorder was checked, but Anxiety Disorder was not checked. Section II: Other Indications for PASRR Screen Decision-Making revealed a Level II PASRR evaluation must be completed if the individual has a primary or secondary diagnosis of dementia or related neurocognitive disorder (including Alzheimer's disease), and a suspicion or diagnosis of a Serious Mental Illness. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 20536 7. Review of Resident #116's medical record revealed he was admitted to the facility on [DATE] and readmitted from the hospital on 4/23/2024. Review of the diagnosis sheet revealed diagnoses to include but not limited to: Anxiety (onset 10/7/2023), Adjustment disorder with depressed mood (onset 3/7/2023). Review of a Level I PASRR screen was completed on 1/31/2023 revealed under Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Anxiety Disorder was checked, but Depressive Disorder was not checked. On 2/6/2025 at 9:00 a.m., an interview with the Director of Nursing (DON) was conducted. The DON confirmed there were no other current Level I PASRR screens that reflected Resident #116 having a diagnosis of depression. She confirmed Resident #116 had an onset diagnosis of depression as of 3/7/2023. She revealed she would now update the Level I PASRR screen to reflect the diagnosis. 8. Review of Resident #60's medical record revealed she was admitted to the facility on [DATE] and readmitted from the hospital on 10/14/2024. Review of the diagnosis sheet revealed diagnoses to include but not limited to: anxiety (onset date 7/29/2024) and major depression (onset date 7/29/2024). Review of a Level I PASRR screen completed on 10/8/2024 revealed under Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Depressive Disorder was checked, but Anxiety Disorder was not checked. On 2/6/2025 at 9:00 am., an interview with the DON confirmed there were no other Level I PASRR screens reflecting Resident #60 having a diagnosis of Anxiety. She confirmed Resident #60 had an onset diagnosis of Anxiety as of 7/29/2024. She revealed she would now update the Level I PASRR screen to reflect the diagnosis. 49227 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Review of the admission record showed Resident #90 initial admission to the facility was on 9/22/2024 and readmitted on [DATE] with diagnoses to include anxiety disorder, mood affective disorder, psychosis, and depression. Review of a Level I PASRR for Resident #90 dated 12/26/2024 revealed under Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Anxiety Disorder, Depressive Disorder, and Other (specify): Mood Disorder were checked, but Psychotic Disorder was not checked. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. 48223 10. Review of the Admission Record showed Resident #39 was admitted on [DATE] with a diagnosis of major depressive disorder. Review of Resident #39's PASRR Level I screen dated 10/29/2024 revealed under Section I: PASRR Screen Decision-Making, section A. MI (Mental Illness) or Suspected MI (check all that apply): Depressive Disorder was not checked. Under Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required, was marked. During an interview on 2/6/2025 at 12:30 p.m., the Nursing Home Administrator stated the facility does not have a policy and procedures for PASRR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on observations, record review, and interviews, the facility failed to follow physician orders and provide wound care in accordance with professional standards of practice for three residents (#5, #138, and #266) of five residents reviewed for surgical and non-surgical wound care. Findings included: 1. Review of the Admission Record for Resident #5 showed initial admitted to the facility was on 3/29/22 with diagnoses to include need for assistance with personal care and disorders of the bone density and structure. Review of Resident #5's care plan revealed the following: Focus initiated 1/18/23 and revision on: 8/20/24: [Resident #5] is at risk for alteration in skin integrity related to: weakness .terminal prognosis. Goal: Skin will remain intact through the next review, revised on 12/3/24. Interventions: Left forehead abrasion cleanse with N/S (normal saline,) pat dry, apply xeroform and cover with dry dressing every other day (QOD) and as needed (PRN) until healed, date initiated 1/24/25. During an observation on 2/3/25 at 8:16 a.m., Resident #5 was lying in bed with a light pink wound dressing with borders secured to the skin on the left side of her forehead dated 2/1/25. During an observation on 2/4/25 at 11:19 a.m., Resident #5 was lying in bed with a light pink wound dressing with borders secured to the skin on the left side of her forehead dated 2/1/25. During an interview, record review, and observation on 2/4/25 at 11:24 a.m., Staff I, Registered Nurse (RN) confirmed the dressing on Resident #5's left forehead was dated 2/1/25. Staff I, RN reviewed Resident #5's Treatment Administration Record (TAR), which showed the wound dressing was completed on 2/3/25 at 10:10 p.m. During an interview on 2/4/25 at 11:30 a.m., Staff J, RN, Unit Manager (UM) said she would check into the date and time the dressing change was documented and the date on Resident #5's current dressing. During an interview on 2/4/25 at 1:56 p.m., Staff J, RN UM said Staff K, Licensed Practical Nurse (LPN) told her on 2/3/24 she documented Resident #5's dressing was changed and did not change the dressing. During a telephone interview on 2/4/25 at 2:18 p.m., Staff K, LPN said on 2/3/25 Resident #5's wound care was documented as completed and the wound care was not completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's February 2025 TAR revealed an order dated 1/23/25 and discontinued on 2/4/25 at 11:42 a.m., showed left forehead wound: Cleanse with normal saline, pat dry. Apply xeroform and cover with a dry dressing every other day and PRN (as needed) if loose or soiled. Review of Resident #5's nursing progress note dated 2/4/25 at 11:52 a.m. showed . forehead treatment, scheduled for yesterday evening, was not performed. 50570 2. On 2/3/25 at 12:37 p.m., an observation of Resident #138 revealed she was ambulating herself in a wheelchair down the B unit hall. Further observations revealed her left pant leg was raised up and exposed an undated bandage on her shin. On 2/4/25 at 10:45 a.m., an observation of Resident #138 revealed she was in bed with the head of bed at approximately a 45-degree angle. An observation of the resident's left shin revealed an undated bandage. A review of Resident #138's Admission Record revealed an original admitted [DATE] and re-admitted [DATE]. Further review of the resident's Admission Record revealed diagnoses including type 2 diabetes mellitus without complications, unspecified protein-calorie malnutrition, unspecified dementia, moderate, with agitation, weakness, and history of falling. A review of Resident #138's Active Orders revealed the following, Left shin: Cleanse skin tear with normal saline, pat dry. Apply xeroform and cover with a foam dressing every three days and PRN [as needed] if loose or soiled. as needed for loose or soiled dressing, with an order/start date of 2/4/25. Further review of Active Orders revealed the following, Left shin: Cleanse skin tear with normal saline, pat dry. Apply xeroform and cover with a foam dressing every three days and PRN if loose or soiled. every day shift every 3 day(s) for reopened skin tear, with an order/start date of 2/4/25. A review of Resident #138's January 2025 TAR revealed the following, Left shin skin tear: Cleanse with NS [normal saline], pat dry, apply xeroform and DCD [dry clean dressing] q [every] 3 days and PRN until resolved. every evening shift every 3 day(s), with an order date of 1/16/25 and a discontinued date of 1/31/25. A review of Resident #138's wound care notes revealed documentation by Staff G, LPN Wound Care on 1/31/25 and 2/5/25. The note on 2/5/25 by Staff G, LPN Wound Care revealed the following, Previously healed skin tear now noted with weakened most skin to superior aspect of original site . New order received and initiated. No other documentation related to Resident #138's left shin skin tear was observed in the resident's electronic health record from 1/31/25 to 2/4/25. On 2/5/25 at 10:33 a.m., an interview was conducted with Staff F, RN. She stated Resident #138 has orders for the left shin skin tear and received xeroform and a dry dressing. She stated the resident's bandage was changed by the wound care nurse. Staff F, RN stated the orders are for wound care every three days, or as needed. She stated Resident #138 is seen by the wound care nurse weekly. Staff F, RN stated floor nurses follow wound orders, and she monitors Resident #138's bandage daily. She stated the wound care nurse dates the resident's bandage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 10:37 a.m., an observation of Resident #138's left shin was conducted with Staff F, RN. An observation of the bandage revealed a date of 2/4/25. She stated the initials on the bandage was the wound care nurse. On 2/5/25 at 10:51 a.m., an interview with Staff P, LPN/Unit Manager (UM) revealed whoever is changing the wound dressing should be documenting and labeling the bandage. She stated the wound care nurse wouldn't be treating a skin tear. Staff P, LPN/UM stated the floor nurse is supposed to treat the skin tear. She confirmed the expectations for wound care is to date the bandage. Staff P, LPN/UM stated, If you see a dressing with no date, who's to say how long it's been there? On 2/5/25 at 4:38 p.m., an interview with the Director of Nursing (DON) and Staff G, LPN Wound Care revealed Staff G, LPN Wound Care put Resident #138's dressing on 2/4/25. She stated she resolved treatment and discontinued orders on 1/31/25. Staff G, LPN Wound Care stated she received a call from the floor nurse stating Resident #138 had a dressing on with no date or physician's orders. The DON and Staff G, LPN Wound Care stated they don't know who put the dressing on. Staff G, LPN Wound Care stated, Staff aren't supposed to put anything on without dating it. The DON stated they shouldn't be putting a dressing on without orders. 48223 3. Review of the Admission Record revealed Resident #266 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction due to internal left knee prosthesis and bacteremia. On 2/4/25 at 10:20 a.m., Resident #266 was observed sitting up in a chair and had a dressing on the left knee dated 2/1. Review of Resident #266's Clinical Admission evaluation dated 1/31/25 at 10:26 p.m. revealed the resident was admitted with a surgical wound to the left knee. Review of Resident #266's hospital discharge summary dated 1/31/25 revealed dressing to remain until post op day #7 unless it becomes saturated, then change. The incision must remain covered until postop day #14. Review of Resident #266's February 2025 Order Summary Report showed no orders for treatment to the left knee until 2/4/25. During an interview on 2/5/25 at 2:33 p.m., Staff O, RN stated if a dressing is removed or replaced there should be a physician's order and if a resident is admitted with orders to leave a dressing intact then this order should be transcribed, so other nurses don't have to search for the information at a later date. During an interview on 2/5/25 at 4:17 p.m., the DON confirmed there was not an active order for Resident #266's left knee surgical incision until 2/4/25. Her expectation is the facility follow physician orders and call the physician for orders if needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled Clean Dressing Change (Wound/Surgical Site) Clean, dated 7/23 revealed the following Procedure: 1. Verify physician's order for dressing change and pain medication. 15. Follow treatment order for application of topical medication, if ordered. 18. Document date, time dressing changed, and initials on a piece of tape and place on dressing. 23. Document the following in the electronic medical record: - Date and time of dressing change. 25. Change dressings according to treatment protocols and/or physician orders. 26. Notify the physician of any changes or concerns with wound or surrounding skin. 27. Review and revise treatment plan, as indicated and per physician order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews, and record reviews, the facility failed to ensure care to prevent pressure ulcers was received in accordance with professional standards of practice for one resident (#30) of five residents sampled for skin conditions. Findings included: Review of the medical record revealed Resident #30 was admitted to the facility on [DATE]. Review of the diagnosis sheet revealed diagnoses to include but not limited to palliative care, weakness, muscle weakness/atrophy, reduced mobility, need for assistance with personal care, and risk for pressure ulcers. Review of Resident #30's February 2025 Order Summary Report revealed the following orders: - Resident to wear right offloading boot when in bed as tolerated; remove for care and skin checks. Re: right heel DTI (deep tissue injury) every shift, order date 11/22/2024. - Offload bilateral heels while in bed as tolerated every shift for preventative, order dated 11/13/2024. On 2/3/2025 at 8:50 a.m., Resident #30 was observed noted in her room and lying upright. Resident #30's feet were observed sticking out from the bed covers at the end of the bed. Resident #30 was not wearing any splint or boot orthotics during the time of the observation. Staff R, CNA was observed going in the room and assisted with breakfast meal/tray set up. Staff R, CNA was interview following the observation and stated she was not sure if Resident #30 had any weakness or contractures in her upper or lower extremities. Staff R, CNA confirmed she had Resident #30 on her assignment regularly during the 7 a.m. to 3 p.m. shift. On 2/5/2025 at 7:40 a.m., Resident #30 was observed in her room lying in bed with both feet observed sticking out from the bed linen. Both feet were bare and were without any type of splint/orthotics. At 7:55 a.m. , an interview with Resident #30's assigned CNA Staff CC, CNA, who revealed she knows the resident and her daily care needs. She also revealed she did not know if Resident #30 had any upper or lower extremity weakness or has any contractures and confirmed she was unaware if the resident utilizes any splints or orthotics, to include use of a soft resting/offloading boot. On 2/5/2025 at 11:00 a.m. and 12:43 p.m., Resident #30 was observed in her room and lying in bed and was not wearing any type of foot splint/orthotic offloading boot during times of the observations. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/2025 at 1:10 p.m., Resident #30 was observed in her room and was. The resident was asked if she wears any type of splints or boots and she said, bunny boots, but could not remember the last time she wore them. She could not remember a time when she refused to wear them. Following the interview, resident's assigned CNA Staff AA, CNA, was interviewed. Staff AA, CNA confirmed she had Resident #30 on her assignment regularly and revealed the resident is dependent on staff for all her ADLs. Staff AA, CNA was not able to state if the resident wore any splints or boots on her feet. Staff AA, CNA entered Resident #30's room and asked the resident if she could open her stand up closet door. After obtaining permission from the resident, Staff AA, CNA opened the door and at the bottom of the closet was a light blue colored soft boot, right footed. Staff AA, CNA revealed she was not aware of the boot before. The resident saw the boot and said, yes I have worn that before. She continued to say she did not want it anymore because it hurt her foot. She confirmed staff did not offer her to wear it for a while and did not know it was part of a doctor's order. Review of the current Quarterly MDS assessment dated [DATE], revealed; Cognition/BIMS score - 11 of 15, which revealed the resident had mild cognitive impairment. It was evident through review of the nurse progress notes and interviews with the assigned CNA, the resident was not offered to wear the right side offloading boot for at least three days observed 2/3/25, 2/4/25, 2/5/25. Review of Resident #30's Care Plans with a next review date 3/6/2025 did not reveal problem areas/interventions related to Resident #30's right heel, as indicated in the current Order Summary Report. On 2/6/2025 at 7:55 a.m., Resident #30 was observed in her room seated upright in her bed and under the bed sheets/covers. Both of her feet were sticking out from the sheets and were noted with no orthotic or splint/soft boot on her right foot. On 2/6/2025 at 10:00 a.m., an interview with Staff J, RN UM revealed she was knowledgeable of Resident #30 with relation to her daily medical care and services. Staff J, RN UM revealed Resident #30 usually stays in her room throughout the day and does not wish to participate in group activities or eat in the community dining room. Staff J, RN UM confirmed Resident #30 usually does not like to get out from bed to a chair and has right side weakness and skin integrity with risk for pressure ulcers. Staff J, RN UM confirmed the resident was ordered a right foot boot to wear use daily and as tolerated. Staff J, RN UM was not sure if the resident had behaviors of refusing to wear the boot, but revealed staff are to assist with the boot daily, per the order, and to document if used or refused. Staff J, RN UM reviewed Resident #30's medical record and could not find any documentation or care planning behavior problem areas relating to Resident #30 refusing to wear the boot on her right foot. Review of the February 2025 MAR revealed documentation on the 7 a.m. to 3 p.m. shift on 2/3/2025, 2/4/2025, and 2/5/2025 indicating Resident #30 was offered and assisted with the right foot offloading boot. Observations during the 7 a.m. to 3 p.m. shift and interview with the resident and Staff AA, CNA and Staff CC, CNA during the same days observed, revealed Resident #30 was not offered or wearing the boot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2025 at 11:00 a.m., an interview with the Rehabilitation Director confirmed the Rehabilitation Department both Physical Therapy and Occupational Therapy were not currently seeing Resident #30 on their caseload. The Rehabilitation Director revealed the offloading boot would not come recommended or ordered from their department as this boot was that was ordered from the physician was for pressure ulcer reducing risk.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536 Based on observations, interviews, and record review, the facility failed to follow contracture maintenance programs for one resident (#81) of sixty-seven sampled residents. It was found the resident was not assisted with donning and doffing of their splint device during four of four days observed (2/3/2025, 2/4/2025, 2/5/2025, and 2/6/2025). Findings included: On 2/4/2025 at 2:30 p.m., Resident #81 was noted in his room and lying in bed and under the covers. Resident #81's right hand appeared contracted and he was not wearing any splints or orthotics. There was no evidence in the room of a splint or orthotic. During an interview with the Resident's assigned Certified Nursing Assistants (CNAs) Staff R, CNA and AA, CNA, both revealed they know the resident and have him on their routine assignments. Staff R, CNA and AA, CNA were unaware Resident #81 had any right hand weakness or contracture and were unaware if he utilized any splints or orthotics on that hand. On 2/5/2025 at 7:23 a.m., 8:43 a.m., and 1:40 p.m., Resident #81 was noted in his room and in bed with the room lights off. Resident #81's right hand was observed without any splint or orthotic on. There was no evidence in the room of any hand splints or orthotic for use. On 2/5/2025 at 8:43 a.m., Resident #81 was observed awake and alert. It was found he was hard of hearing, could speak, but interview questions needed to be written on a pad of paper for him to read. He permitted an interview and it was communicated via pen and paper. The following questions were written for Resident #81 to read, and he communicated back verbally: 1. Are you in any physical pain, to include your ear? Resident #81 responded, Not in any pain, but I am supposed to see an ear doctor. 2. Which hand do you eat with? Resident #81 responded, I eat with my left hand and try with my right hand. 3. Are you in any pain in your right hand? Resident #81 responded, No pain, but I can't use it much. 4. Are you seeing Therapy for your right hand weakness/contracture? Resident #81 responded, I did before but not recently. 5. Do you wear a splint or orthotic on your right hand? Resident #81 responded, No, but I have a splint hanging in my closet. 6. Do you or do staff assist you with wearing of the splint on your right hand? Resident #81 responded, Staff are supposed to help put it on, I can't get it or put it on myself. (continued on next page)

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	105581	A. Building B. Wing	02/06/2025

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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was observed the splint was in a yellow bag and hanging on the door. 7. When was the last time staff assisted with putting the splint on your right hand? Resident #81 responded, I can't even remember, it has been awhile and I actually forgot about it. 8. Would you wear it if staff assisted placing it on your right hand? Resident #81 responded, Yes, I would, I know it helps with my weakness. 9. In the past, did you wear the splint on your right hand during the day or during the night? Resident #81 responded, I believe I was helped with it at night, but it's been awhile since I have had it on, and the night staff have not helped put it on. Review of Resident #81's February 2025 Order Summary Report revealed the following order: - Patient to wear R (right) resting hand splint at tolerated, don R hand splint status post p.m. care, doff R hand splint status post a.m. care with frequent checks for redness, edema, or pressure areas. If so, immediately contact Occupational therapy. Order date 3/20/2023. Review of the 1/2025 and 2/2025 Medication Administration Record (MAR)/Treatment Administration Record (TAR) did not reveal documentation related to the right hand splint order or documentation to support the order was followed. Review of the current care plans, with next review date 4/20/2025, revealed the following: - At risk for falls related to: weakness, possible medication side effects, impaired vision. Interventions in place to include: Pressure relieving cushion, right resting hand splint as ordered and tolerated, and keep adaptive equipment within reach. - Resident has self-care deficit related to CVA (cerebrovascular accident) with right sided weakness, functional quadriplegic, requires extensive assistance with ADL's (activities of daily living) and requires mechanical lift and assist of two for transfers. Interventions include: Resident to wear right resting hand splint as tolerated, put on right hand splint after P.M. care, take off right hand splint after A.M. care with frequent skin checks for redness, edema, or pressure areas. On 2/5/2025 at 10:10 a.m., an interview with the Rehabilitation Director revealed she was familiar with Resident #81 and both Physical Therapy (PT) and Occupational Therapy (OT) completed therapy with him but she was going to have OT re-evaluate him for his splint use very soon. The Rehabilitation Director revealed the Rehabilitation Therapy department send the plan and direction out for nursing to follow and usually it is the responsibility of the aide on shift at nights to position the right hand splint, and then to remove during care and also during the days. The Rehabilitation Director was not aware staff were not placing the right hand splint on Resident #81 per the order and plan of care. She also was not aware the Medication Administration Record (MAR), and Treatment Administration Record (TAR) did not have the order to show this splint was offered/placed/removed on a daily basis. Staff BB was aware this Right hand splint was care planned with interventions for nursing staff to place on daily and as tolerated. On 2/6/2025 at 7:30 a.m., Resident #81 was noted in his room and lying flat in bed. The resident was not wearing a splint or orthotic on his right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2025 at 7:36 a.m., an interview with Staff W, Licensed Practical Nurse (LPN) revealed she was knowledgeable of Resident #81 and she has him on her routine daily assignment. She confirmed Resident #81 is hard of hearing and communicates by way of writing on a note pad with a pen. Staff W, LPN revealed Resident #81 can verbalize, he just cannot hear. She further confirmed he has right side upper extremity/hand weakness and he wears an orthotic/splint at night. She stated she believes he refuses the orthotic/splint but verified there was no documentation in the resident's chart to support that. She also confirmed he did not have any Behavior care plans to support refusal of care and treatment. Staff W, LPN revealed the order shows Resident #81 is to wear a right hand splint during the nights and by the time she gets to work for the 7 a.m. to 3 p.m. shift, the splint should already be removed, so she would not know if he wore it in the evenings or not. Staff W, LPN also confirmed the MAR did not support any information to document if the splint was offered, worn, or refused on a daily basis. On 2/6/2025 at 10:00 a.m., an interview with Staff J, RN Unit Manager (UM) confirmed she was knowledgeable of Resident #81 and his care. She revealed he stays in his room by choice most of the day and receives assistance from staff with most of his ADLs. She revealed he has right sided weakness, to include his upper extremity and right hand. Staff J, RN UM further revealed the resident was on a splinting program, which was ordered by the physician, based on education and recommendation by the OT department. She revealed Resident #81 was to wear a resting hand splint on his right hand in the evenings and as tolerated. She also revealed nursing staff, to include CNAs, are responsible for applying and removing of the splint daily. Staff J, RN UM also revealed Resident #81 will refuse the splint at times but was not able to confirm this through the resident's record documentation. Staff J, RN UM confirmed there was no documented evidence to support Resident #81 refuses to wear the right hand splint. Staff J, RN UM revealed Resident #81 is able to make his daily decisions and was interviewable with knowledge of his medical care and services. Review of the medical record revealed Resident #81 was admitted to the facility on [DATE]. Review of the advance directives revealed he was his own responsible party. Review of the diagnosis sheet revealed diagnoses to include but not limited to hemiplegia, muscle spasms, and repeated falls. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed; Cognition/Brief Interview Mental Status (BIMS) score 15 of 15, which indicated the resident was cognitively intact. ADL - Upper extremity impairment one side. Active Diagnoses - Hemiplegia and Paraplegia. Review of Resident #81's medical record revealed the following: - Admission/Preadmission Nursing Evaluation dated 10/14/2020 revealed; Section Q under Mobility, resident very limited and makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Notes revealed resident has right sided weakness. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Occupational Therapy Evaluation and Plan of Treatment for certification period of 9/11/2023 to 12/9/2023 revealed primary diagnoses of hemiplegia affecting right dominant side and abnormal posture. The Assessment further revealed objectives and goals to re-establish hand/wrist splint wear to prevent further skin and or joint breakdown. Right wrist 30 degree flex contraction with note slight radial deviation. Patient recently was on OT caseload for splinting and states has not been wearing splint. Target: 9/24/2023. The baseline 9/11/2023 revealed patient reports has been wearing right hand splint. Goal #2 revealed to educate staff/patient on proper splint wear and wheelchair management to prevent further joint and or skin breakdown with target date of 12/9/2023. - Review of the Occupational Therapy Discharge Summary dated 9/21/2023 revealed the reason for discharge from therapy was the resident's maximum potential achieved. Comments on 9/21/2023 revealed the resident states he has not been wearing the splint. Further notes revealed; Patient/staff claims to have continue to be wearing right resting splint, Therapist noted decreased tone in RUE (right upper extremity) from last encounters. Patient has been observed wearing splint early mornings. Staff educated on wear, care, and frequent skin checks with good understanding. The summary note revealed; Patient and Caregiver Training: Patient/Staff/caregivers have been provided with therex (therapeutic exercises), theract (therapeutic activities), NMR (neuromuscular reeducation), and ADL prothesis training/education with facility, PROM (passive range of motion)/stretch. The discharge status and recommendation section of the discharge summary revealed; OT recommending PT/Staff continue right hand/wrist resting hand splint to prevent further tone/contracture and ROM (range of motion) of BUE HEP (home exercise program) (specific to RUE) while perform ADL, and encouragement to participate in OOB (out of bed) activities to maintain current level of function. - Review of Nurse Progress Notes dated from 11/5/2024 - 2/5/2025 did not reveal any documentation to support Resident #81 refusing to wear the right hand splint at nights or documentation to support use of the right hand splint. The Rehabilitation Director provided a Rehab to Nursing Communication Form, dated 3/13/2023 for review. The form revealed a topic of: Splint wearing schedule. The remarks revealed; Pt (patient) to wear right resting hand splint as tolerated splint to be put on during p.m. care and removed with a.m. care. Monitor for changes in skin integrity and perform hand and nail hygiene as needed. The form was signed and dated by a therapist on 3/13/2023, nurse on 3/13/2023, Rehabilitation Director on 3/14/2023, and a Unit Manager, not dated. Review of a Splinting and Wheelchair Positioning Program sheet identified precautions and instructions for use of the right hand splint. The sheet revealed precautions to include frequent skin checks and instructions and adaptive equipment to include: Resting hand splint as tolerated, Pt able to don (apply) independently, requires assistance to doff (remove). The notes revealed: Pt to utilize right resting hand splint as tolerates recommended on with p.m. care and doff with a.m. care, receive frequent skin checks; Pt able to doff independently. On 2/6/2025 at 1:00 p.m., the Nursing Home Administrator (NHA) provided the SPLINT and BRACE Program procedure for review. The document did not have a last review date. The procedure revealed; Splints to be worn according to the schedule outlined in the Referral from therapy that then placed in Tasks and the Kardex. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Therapy will train the CNAs and nursing team members how to put the device on and off with the specifics on the SPLINTING PROGRAM form. Each guest or resident with a splint will have a SPLINT BOX or designated splint storage container when it is not in use. It should be labeled with the resident/guest's name and located in their room. The SPLINTING PROGRAM form will be stored in the top of the splint box for reference and any other place deemed appropriate by the center [Interdisciplinary Team]. Cleaning of the splint should be done according to manufacturer's guidelines. Examples of Typical splints seen in our centers are: The Resting Hand Splint, The Ankle-Foot Orthosis (AFO).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48223 Based on interviews, observations, and record review, the facility failed to ensure sufficient staffing in order to provide timely meal service to residents on two units (B & D units) of four units in the facility. Findings included: During an interview on 2/3/2025 at 8:00 a.m., Resident #268 stated concerns regarding the food temperature, stating it was always cold. During an interview on 2/3/2025 at 9:55 a.m., Resident #266 stated having concerns regarding the temperature of the food when served. During an interview on 2/3/2025 at 10:17 a.m., Resident #269 stated having concerns regarding the temperature of the food when it is received. During an interview on 2/3/2025 at 10:30 a.m., Resident #270 stated having concerns regarding the food temperatures, everything is always cold. On 2/3/2025 at 12:34 p.m., the first meal cart arrived at B unit and at 12:42 p.m., the staff started to serve the trays from the cart. At 1:07 p.m., the last tray was passed for the first cart. The staff observed for meal service was three Certified Nursing Assistants (CNAs) and one nurse. On 2/3/2025 at 12:38 p.m., the second meal cart arrived at B unit and at 12:45 p.m., the cart was taken to D unit. At 12:55 p.m., the cart was taken back to B unit for rooms 240-260. At 1:01 p.m., the staff started passing the trays and the last tray was removed at 1:15 p.m. The staff observed for meal service was three CNAs and two nurses. On 2/3/2025 at 1:18 p.m., a third meal cart arrived at B unit abd the staff took the cart to D unit. At 1:25 p.m., the staff started to serve trays and at 2:00 p.m., the last tray was removed and served. Two CNAs and one nurse were available to pass the trays. During an interview on 2/4/2025 at 2:40 p.m., Resident #266 stated the food was still cold, especially breakfast, but all meals have been so far. During an interview on 2/4/2025 at 2:44 p.m., Resident #39 stated the meals have been ice cold. During an interview on 2/4/2025 at 2:48 p.m., Resident #268 stated the food was better than usual, but still not warm. During an interview on 2/4/2025 at 2:52 p.m., Resident #269 stated the food has remained cold. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/5/2025 at 8:40 a.m., a test tray was requested for D unit. The meal to be served was baked egg casserole, toast, oatmeal, and two links of sausage. The facility utilized top and bottom insulated domes and plate warmer. At 8:55 a.m., the eggs were plated at 146 F; the sausage 160 F, with the toast. The oatmeal was placed in an insulated bowl and temperature was 164 F. At 8:57 a.m., the tray was placed on an open cart with five other trays as the insulated meal delivery cart did not have enough room for those six trays. At 8:59 a.m., the trays arrived on to D unit. The staff available to assist with meals was the Nursing Home Administrator (NHA), the Director of Nursing (DON), the Infection Control Nurse (ICN), and two CNAs. The last tray was served at 9:00 a.m. The egg casserole's temperature was 164 F, sausage temperature was 172 F, and the oatmeal's temperature was 86 F. Two state surveyors tasted the meal; egg casserole was warm and oatmeal was lukewarm. During an interview on 2/5/2025 at 8:03 a.m., the Dietary Manager (DM) stated not being aware of cold food issues and the facility would be happy to heat up anyone's meal who needed it. During an interview on 2/6/2025 at 11:15 a.m., Staff Q, CNA stated they were responsible for 10-13 residents. Staff Q, CNA stated anything over 10 makes it difficult to give good patient care. During an interview on 2/6/2025 at 10:45 a.m., Staff R, CNA stated they were responsible for 11 residents. Staff R, CNA also stated being able to accomplish her tasks most of the time, but not always. Staff R, CNA stated they have been requested to stay late for hours on a regular basis and the administration does not ask about staffing. During an interview on 2/6/2025 at 8:55 a.m., Staff P, CNA stated they were responsible for 13 residents and the facility does not ask the staff for opinions in staffing, to her knowledge everything is based on numbers. During an interview on 2/6/2025 at 8:50 a.m., Staff O, Registered Nurse (RN) stated documentation sometimes does not occur as patient care is the priority. During an interview on 2/6/2025 at 8:39 a.m., Staff U, CNA/Staffing Coordinator (SC) stated they were responsible for staffing the building. The facility bases everything off of the census. The facility tries to have more staff on the rehab side of the facility, as these units have more visitors coming and going. Staff U, CNA SC stated they review the census daily to ensure they are staffing appropriately and they don't change the number of staff from the week to the weekend unless the census changes. During an interview on 2/6/2025 at 9:20 a.m. with the NHA and DON, the NHA stated the facility staffs the building on acuity and needs of the residents. There is no difference in the staffing from the weekends to the weekdays for direct patient care. The facility does have four unit managers (32 hours/day) throughout the week and on the weekends they go to a 12 hour/day supervisor. The facility has a staffing coordinator in the facility seven days per week to ensure coverage and assist if there happens to be a call off. A nurse manager is on call to ensure coverage. A policy and procedure for staffing was requested from the NHA. The NHA stated she was not certain if the facility had a policy and procedure or if they just followed the regulations. The facility did not provide a staffing policy and procedure.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48223 Based on interviews, and record review, the facility failed to offer a nourishing snack at bedtime for five (#268, #266, #269, #39, and #270) out of six residents sampled for dining. Findings included: During an interview on 2/3/2025 at 8:00 a.m., Resident #268 voiced concerns regarding the food. A follow-up interview occurred on 2/5/2025 at 12:19 p.m. Resident #268 stated not being offered an evening snack and they (the facility staff) said I needed to request a snack from the kitchen, although the kitchen is closed when I call. During an interview on 2/3/2025 at 9:55 a.m., Resident #266 voiced concerns regarding the food. A follow-up interview occurred on 2/5/2025 at 12:23 p.m. Resident #266 stated when requesting a snack, the evening of 2/3/2025, the staff stated they did not have snacks available. The evening of 2/4/2025 the staff member stated they did not usually have snacks, but would see what could be found, and they brought back a moon pie. During an interview on 2/3/2025 at 10:17 a.m., Resident #269 voiced concerns regarding the food. A follow-up interview occurred on 2/5/2025 at 12:15 p.m. Resident #269 stated the staff do not offer snacks after dinner and it would be nice if the facility did offer snacks after dinner. Resident #269 stated enjoying something sweet before going to bed when at home. During an interview on 2/5/2025 at 12:37 p.m., Resident #39 stated not being offered evening snack, although they would like a snack. During an interview on 2/5/2025 at 12:30 p.m., Resident #270 stated the staff did not offer an evening snack, although that would be wonderful. During an interview on 2/5/2025 at 2:46 p.m., the Dietary Manager (DM) stated snacks are sent to the units each evening for residents' that have requested one. The snacks are sent to the unit with the resident's name so the staff know who they are for. We also send a variety of other snacks (i.e., graham crackers, saltines, oatmeal cream pie, applesauce, pudding, and peanut butter crackers) in case a resident requests one. During an interview on 2/5/2025 at 4:17 p.m., the Registered Dietitian (RD) reviewed the facility Meal Delivery Schedule and stated there was at least 15 hours between dinner and breakfast. The RD continued to state not having reviewed this as the facility and corporate choose the times for the meals. Review of the facility's Meal Delivery Schedule, not dated, revealed the following: (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dinner: 1A Wing - 4:30 p.m. for Rooms: 100-200; 2C Wing - 4:40 p.m. for Rooms: 300; 3A Wing - 4:50 p.m. for Rooms: 20/40/60; 4C Wing - 5:00 p.m. Rooms: 300 Assist; Main DR (Dining Room) - 5:10 p.m. for Main; 5A Wing - -5:30 p.m. for Rooms: 40/60 Assist; 6B Wing - 5:40 p.m. for Rooms: Rooms #1; 7B Wing - 5:50 p. m. for Rooms: #2; 8D Wing - 6:00 p.m. for Rooms: All. - Breakfast: 1A Wing - 7:30 a.m. for Rooms: 100-200; 2C Wing - 7:40 a.m. for Rooms: 300; 3A Wing - 7:50 a. m. for Rooms: 20/40/60; 4C Wing - 8:00 a.m. for Rooms: 300 Assist; 5A Wing - 8:10 a.m. for Rooms: 40/60 Assist; 6B Wing - 8:20 a.m. for Rooms: #1; 7B Wing - 8:30 a.m. for Rooms: #2; 8D Wing - 8:40 a.m. for Rooms: All. Review of the Meal Delivery Schedule revealed 15 hours between dinner and breakfast for 1A, 2C, 3A, and 4C and 14 hours and 40 minutes for 5A, 6B, 7B, and 8D. Review of the facility's policy and procedure titled Frequency of Meals dated April 15, 2024, revealed: Purpose: The center will ensure that each resident/guest receives at least three meals daily without extensive time lapses between meals. Policy Explanation and Compliance Guidelines: 1. The center has scheduled three regular mealtimes, comparable to normal mealtimes in the community, per day and bedtime snack. 3. There will be no more than 14 hours between an evening meal and breakfast the following day, unless a nourishing snack is served at bedtime; then, up to 16 hours may elapse between an evening meal and breakfast the following day if the resident/guest council agrees to this meal time span. Review of the facility's policy and procedure titled Snacks, HS Snacks and Nourishments dated April 15,2024 revealed: Purpose: Snacks are provided in accordance with the prescribed diet and in accordance with state law and according to residents'/guests' preferences and requests. Individual and/or bulk snacks are available at the nurses' station or other designated locations, i.e., Pantry or Nourishment Rooms. Procedure: . 2. At least one (1) snack is offered at bedtime daily and is included in the menu nutritional analysis. Additional snacks should be available throughout the day per residents'/guests' preferences and requests. 3. Bulk snacks may also be available in the Pantry/Nourishment Room as part of a par level stocking program. 4. A minimum of two (2) of the following four food components is offered to all residents for the bedtime snack and is considered nutritionally complete snack: a. Fruit or Fruit Juice b. Whole grain or enriched variety crackers c. Variety of cookies; (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Bedtime snacks for restrictive therapeutic diets, i.e., Renal, Liberal House Renal, Gluten Restricted, etc should be outlined on the menu. Diabetics on insulin should also receive a labeled bedtime snack. Snacks should be: a. Labeled with resident's/guest's name, room number, and date. b. Delivered to each nursing unit by the Culinary department. c. Offered to the residents/guests by the Nursing department d. Delivered on ice or placed directly into the Pantry/ Nourishment Room refrigerator or freezer and held at appropriate temperatures (</= 41 degrees or </= 0 degrees).

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	02/06/2025

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50570 Based on observations, record review, and interviews, the facility did not follow professional standards for food service safety in the kitchen and one of four nourishment rooms. Findings included: On 2/3/25 at 8:26 a.m., a tour of the kitchen was conducted with the Certified Dietary Manager (CDM). Upon entrance to the kitchen, an observation of three staff revealed they were on the tray line for breakfast. An observation of Staff D, [NAME] revealed he was wearing a restraint not fully covering his hair and more than a quarter of an inch was exposed. The same concerns were observed at 8:40 a.m. On 2/3/25 at 8:45 a.m., observations of the walk-in fridge were conducted with the CDM. A clear container containing boiled eggs, without the shell, was observed. An observation of the container of boiled eggs revealed they were not labeled. An interview with the CDM revealed the container of boiled eggs should have been labeled. She was observed labeling the container with a date of 2/2/25. Further observations of the walk-in fridge revealed a box of green and red whole peppers that had wrinkles across the surface, noticeable softness, and dark brown/black spots, which appeared not good for use. The CDM was observed removing the box of peppers. Further observations of the walk-in fridge revealed a sheet pan rack with trays of dessert. The CDM confirmed the desserts were going to be used for meal service that day. Observations of the top tray of desserts, which were in individual clear containers, had no label or date. The CDM was observed labeling the top tray of desserts with a date of 2/3/25. On 2/3/25 at 8:49 a.m., observations of the walk-in freezer revealed frozen vegetables were scattered on the floor along with other food particles/debris. Further observations revealed unidentifiable frozen food and debris toward the back of the freezer, underneath a metal rack where French fried potatoes were placed on top. (Photographic Evidence Obtained) On 2/3/25 at 9:05 a.m., a tour of the four facility nourishment rooms was conducted with the CDM. An observation of the inside of the A wing microwave revealed food particles were stuck to the sides and top. Splatters of food were observed that appeared to be dried. The CDM stated it should be clean and was observed calling a staff member to clean the microwave. She confirmed resident food is re-heated in the microwaves in the nourishment rooms. On 2/4/25 at 9:20 a.m., an observation of the dish machine in use revealed Staff A, Culinary Assistant was using her cell phone while putting clean kitchen items on the drying rack. An interview with the CDM revealed Staff A, Culinary Assistant's role is considered, Catcher, as they are responsible for placing clean kitchenware to dry or putting away as needed. Further observation of the dish machine in use revealed Staff C, Culinary Assistant's hair restraint was not fully covering her hair. The hair restraint appeared to be coming off, towards the back of her head. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/5/25 at 11:12 a.m., an observation of the lunch meal service revealed Staff D, [NAME] was taking temperatures of the hot food items. Staff D, [NAME] was observed touching his pants with his hands before he started taking food temperatures. He was not observed performing hand hygiene after touching his pants. At approximately 11:13 a.m., Staff D, [NAME] was observed removing a wipe from the wrapper to wipe down the probe of the digital thermometer. A piece of the wrapper was observed on a clean plate in front of him. Staff D, [NAME] was observed removing the piece of wrapper from the clean plate with his un-gloved hand. He was not observed performing hand hygiene before or after this task. During the observation of lunch meal temperatures, Staff D, [NAME] did not wipe the thermometer probe between mashed sweet potato and whole sweet potato. Further observation of the lunch meal temperatures revealed the ribs had an internal temperature of 129 degrees Fahrenheit (F). Staff D, [NAME] stated he completed and recorded the temperatures about 10-15 minutes before this observation and the temperature was 147 F. He stated the ribs needed to go back into the oven as he expected a temperature of 145 F. On 2/5/25 at 11:20 a.m., an observation of Staff A, Culinary Assistant revealed she was taking the temperatures of the cold food/beverage items to include cake, pudding and milk. Observations of Staff A, Culinary Assistant revealed she did not perform hand hygiene before taking the temperatures of the cold food/beverage items. An observation of the temperature of the cake revealed it was 46 F and the pudding was 42 F. Staff A, Culinary Assistant stated the pudding and cake were taken out of the fridge and placed on the sheet pan rack around 11:12 a.m. Further observations of Staff A, Culinary Assistant revealed she did not wipe down the thermometer probe between taking the temperatures of the cake and pudding. Both food items were not observed being discarded and remained on the rack. On 2/5/25 at 11:25 a.m., an observation of the kitchen hood, over the stove, revealed the vents and sides had a brown rusted color. Further observation of the hood revealed areas of oxidation as evidenced by a white color/residue. An interview with the CDM revealed when the vents are removed every Friday, they are oily and have some residue. She stated the dietary staff do a deep clean of the hood every month. The Director of Maintenance (DOM) provided an invoice of the last time the hood was cleaned by [Vendor name], which revealed a date of 9/25/24. (Photographic Evidence Obtained) On 2/6/25 at 11:07 a.m., a review of the meal temperature log for 2/3/25 to 2/9/25 was conducted with the CDM. A review of Wednesday's log revealed the entree for lunch had a temperature of 170 F. The CDM stated the cook took the final cooking temperature, but they are not expected to document it. She could not confirm why the cook documented 170 F, however, during the lunch meal observation on 2/5/25 he stated the entree was 147 F when he tested it. The CDM stated she educated the cook on keeping the food covered, as she noticed it was not covered while on the tray line and thinks that's what contributed to the low temperature. The CDM stated the temperature of the ribs on 2/5/25 was not appropriate, as they are looking for a minimum of 135 F. She stated she tried to observe the cooks on the tray line monthly. On 2/6/25 at 11:10 a.m., an interview with the CDM revealed her expectation is the thermometer probe should be wiped with probe wipes between each food when taking and recording meal temperatures. She stated she's not sure if staff were educated on this task prior to her starting as CDM in August 2024. An interview with the CDM regarding hand hygiene revealed she expected staff to wash their hands before and after they complete meal temperatures. Regarding cold food temperatures, she stated cold food and beverages should be 41 F or below. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/6/25 at 11:16 a.m., the CDM stated if staff have a quarter inch of hair or longer, they need to wear a hair restraint. She stated it's the same rule for beards. An interview with the CDM related to labeling/dating revealed she tries to complete rounds every morning. She stated there is a poster on the walk-in fridge and freezer door for staff to refer to regarding labeling/dating expectations. She stated she's provided multiple in-service trainings related to labeling/dating and how long food and beverage items are good for. She stated herself, the assistant food service manager, and/or cook are expected to review the labels/dates. On 2/6/25 at 11:23 a.m., an interview with the CDM revealed the whole dietary team is responsible for cleanliness of the kitchen. She stated floors are cleaned after lunch and at night. The CDM stated staff clean between meals, as needed. She stated the green beans that were observed on the floor on 2/3/25 should have been cleaned up. On 2/6/25 at 11:32 a.m., an interview with the CDM revealed dietary aides are responsible for cleaning the nourishment rooms. She stated, I should be the second set of eyes. She stated the dietary aide goes to the nourishment rooms every night as it's an evening shift task. An interview with the CDM regarding cell phone use revealed staff, Shouldn't be using cellphones at all. She stated she's educated staff multiple times regarding cell phone use in the kitchen. A review of the facility's policy titled, Personal Hygiene, with an effective date of April 15, 2024, revealed the following: Purpose: Guidelines for personal hygiene to promote a safe and sanitary department must be followed. Procedure: . 2. Clean Hands and Fingernails: a. Hands must be washed prior to beginning work. 3. Head Covering Worn: .b. Hair must be appropriately restrained or completely covered. 4. Conduct: .e. Team members' personal items are to be stored in designated areas away from the food preparation area. A review of the facility's policy titled, Food Labeling & Dating - Refrigeration, with no effective date, revealed the following: Purpose: The center adheres to a labeling and dating system to ensure the safety of ready-to-eat, time/temperature control for food safety. Policy Explanation and Compliance Guidelines for Staffing: . 2. The food shall be stored, covered, marked for contents, and dated when placed in the refrigerator or freezer. 4. The individual opening or preparing a food shall be responsible for covering, labeling, dating and storying the food at the time of production or end of the meal service. 7. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 8. The Culinary Manger, or designee, shall spot check refrigerators for compliance, and document accordingly. Corrective action shall be taken as needed. A review of the facility's policy titled, Record of Food Temperatures, with an effective date of April 15, 2024, revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Purpose: It is the policy of this center to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled. Policy Explanation and Compliance Guidelines: .2. Hot foods will be held at 135 degrees Fahrenheit or greater. 4. Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit . 8. If the food temperature falls into an unsafe range, immediately follow procedures for reheating previously cooked food . 14. Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy. A review of the facility's policy titled, Handwashing - Culinary and Glove Use, with an effective date of April 15, 2024, revealed the following: Compliance Guidelines: 1. Culinary team members shall keep their hands and exposed portions of their arms clean. 6. Frequency of Handwashing: a. Culinary team member shall clean their hands and exposed portions of their arm immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations: . ii. After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc. iii. After hands have touched bare human body parts other than clean hands (such as face, nose, hair etc.)