STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105591	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Tampa	3612 E 138th Ave Tampa, FL 33613

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review the facility did not ensure medications were stored in accordance with current professional standards for 4 of 6 medication carts and 1 of 2 medication storage rooms.Findings included:1. An observation on 5/5/2026 at 2:31 P.M. of the C Wing Medication Room revealed:1 box of bisacodyl suppositories in the cabinet above the sink that expired 2/20261 syringe of Aplisol Tuberculin in the refrigerator that expired 5/2/20262. An observation on 5/5/2026 at 2:37 P.M. of the C Wing Team 2 Medication Cart revealed: 1 medication card for hydrochlorothiazide that expired 4/30/20261 medication card for hydrochlorothiazide that expired 3/31/20261 medication card for ondansetron that expired 2/28/20263. An observation on 5/5/2026 at 3:00 P.M. of the A Wing Team 3 Medication Cart revealed: 8 expired insulin pens6 boxes of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution opened and did not have an expiration date.2 boxes of bisacodyl suppositories that expired on 4/2025 and 2/20261 Trelegy inhaler opened on 3/21/2026 and did not have an expiration date1 Trelegy inhaler opened and did not have an expiration date1 medication card for Tamsulosin HCL that expired 3/31/20261 medication card for tizanidine that expired 9/30/20251 medication card for tizanidine that expired 4/30/20261 medication card for ondansetron that expired 3/31/20264. An observation on 5/6/2026 at 2:05 P.M. of the A Wing Team 1 Medication Cart revealed:1 medication card for ondansetron that expired 4/30/20265. An observation on 5/6/2026 at 3:40 P.M. of the A Wing Team 2 Medication Cart revealed:2 boxes of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution opened and did not have an expiration date.1 box of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution opened on 12/5/2025 and did not have an expiration date.1 box of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution opened on 1/22/2026 and did not have an expiration date.An interview on 5/5/2026 at 2:40 P.M. regarding C Wing Team 2 Medication Cart with Staff M, Registered Nurse (RN) was conducted. Staff M, RN said the unit managers are responsible for maintaining the medication carts. Staff M, RN said the medications had expired and should have been discarded.An interview on 5/5/2026 at 3:15 P.M. regarding A Wing Team 3 Medication Cart with Staff N, Licensed Practical Nurse (LPN) was conducted. Staff N, LPN said the floor nurses are responsible for maintaining the medication carts. Staff N, LPN said she was not aware the insulin pens were expired. Staff N, LPN said the boxes of inhaled solutions should have been dated when opened and have an expiration date. Staff N, LPN said the medications cards should have been removed when the medication was discontinued.An interview on 5/7/2026 at 1:35 P.M. with the Director of Nursing (DON) was conducted. The DON said he could not understand why A Wing Team 3 Medication Cart contained so many expired medications. The DON said the expired insulins found were unacceptable. The DON said the residents medications were discontinued or expired should have been removed and sent back to the pharmacy. The DON said the nurses and unit managers are responsible for cleaning out the medication carts. The DON said all the medications found should have been discarded; there should not have been any expired medications found in any of the medication carts.A review of a policy effective 12/01/2007, titled, Storage and Expiration Dating of Medications revealed the procedure of the facility was: 5: Facility staff should (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened; 5.1: Facility staff may record the calculated expiration date based on date opening on the primary medication container; 5.3: If a multi-dose injectable medication has been opened.the vial should be dated and discarded within 28 days.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility did not ensure specialized call light was within reach for one (Resident #3) of four residents sampled for call lights.Findings included:An observation on 5/4/2026 at 10:58 A.M. of Resident #3 revealed she was lying in bed; a red call light with a press pad was on the right side of the residents bed; not resting on Resident #3's pillow next to her head. Upon request Resident #3 could not reach her call light and press the pad.An observation on 5/6/2026 at 10:36 A.M. of Resident #3 revealed the call light was on the right side of the residents bed; not resting on Resident #3's pillow next to her head. Upon request Resident #3 could not reach her call light and press the pad.An observation and interview on 5/6/2026 at 3:58 P.M. of Resident #3 revealed the call light lying on the right side of the mattress and out of reach. Resident #3 said she was uncomfortable and wanted the fan placed on her.A record review of Resident #3's admission record showed he was admitted to the facility on [DATE] with diagnoses including but not limited hemiplegia and hemiparesis following cerebral infarction, quadriplegia, contractures of right and left hand. A review of Resident #3's minimum data set (MDS), section C, dated 4/11/2026 revealed a brief interview for mental status (BIMS) score of 13 indicating cognitively intact. A review of Resident #3's MDS section GG, dated 4/11/2026 revealed her functional limitation in range of motion included impairments on both sides of her upper and lower extremities, and dependent with all self-care needs as well as mobility. A review of Resident #3's care plan initiated on 12/30/2025 contained a focus of potential for pain r/t (related to) contractures with an intervention that included wedge call light within reach of head.An interview on 5/6/2026 at 4:02 P.M. with Staff O, Certified Nursing Assistant (CNA) was conducted. Staff O, CNA said Resident #3 usually had the call light next to her head so she could press it with her cheek. Staff O, CNA said if Resident #3's call light was not within reach he does not know Resident #3 would ask for assistance.An interview on 5/6/2026 at 4:06 P.M. with Staff P, CNA, was conducted. Staff P, CNA said the call light should be by Resident #3's head for her to utilize.An interview on 5/6/2026 at 5:25 P.M. with the Executive Director (ED) was conducted. The ED said the expectation is the call light should be within the resident's reach at all time. The ED said the facility does not have a policy regarding call lights, but the staff should adhere to the call light policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to develop care plans with goals and interventions for two residents (#52 and #105) of 2 residents reviewed for care plans, related to: 1. Not developing care plan to reflect Resident #105 who had a diagnosis of Post Traumatic Stress Disorder (PTSD); 2. Facility and Resident #52 having a video camera facing from the hallway into the room and the need for two or more staff members to enter the resident's room for any reason to include care and services.Findings included:1.On 5/4/2026 during a record review for Resident #105, it was found she was admitted with a diagnosis of Post Traumatic Stress Disorder (PTSD) with an onset date of 7/25/2024, Alzheimer's, and seizures.Review of Resident #105's medical record revealed she was admitted to the facility on [DATE] and with a readmission from the hospital on [DATE]. Review of the advance directives revealed Resident #105 had a responsible party for making her medical decisions. Review of the current month (5/2026) physician's order sheet revealed Resident #105 had orders to receive general psychiatric services with an order date 11/5/2024.Review of the most current Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; (Cognition/Brief Interview Mental Status or BIMS score of 00/15, which indicated Resident #105 was not cognitively intact; (Behaviors - none documented as exhibited during timeframe reviewed); (Active diagnosis - Traumatic Brain Injury - YES, Post Traumatic Stress Disorder - YES). Review of the nurse progress notes dated from 3/1/2026 through to 5/7/2026 did not have any documentation revealing Resident #105 presenting with PTSD, nor were there any documentation to support what types of specific trauma behaviors Resident #105 presents or presented with.Review of the last psychological care visits/assessments revealed;Psychological care visit 3/23/2026 revealed Resident #105 was seen as a follow up visit. Pt. admitted to this facility on 11/5/2024. She has a past medical history of PTSD, anxiety, Alzheimer's, and long term resident at facility. Assessment plan: Post Traumatic Stress Disorder, chronic, monitoring for PTSD symptoms, assessing their severity, and tracking the individual's progress over time. Check for the following signs: intrusive thoughts, avoidance, hyperarousal, changes in behavior, need for medicinal therapy.Psychological care visit 4/20/2026 revealed Resident #105 was seen as a follow up visit. Pt. admitted to this facility on 11/5/2024. She has a past medical history of PTSD, anxiety, Alzheimer's, and long term resident at facility. Assessment plan: . monitoring for PTSD symptoms, assessing their severity, and tracking the individual's progress over time. Check for the following signs: intrusive thoughts, avoidance, hyperarousal, changes in behavior, need for medicinal therapy.Review of the current care plans with a next review date 7/19/2026 revealed the following but not limited to:Seizure Disorder related to close head injury, with interventions in place as reviewed.It was determined through review of the entire care plan care plan problem areas, there were no problem areas with goals and interventions related to Resident #105 with diagnosis of PTSD.On 5/6/2026 at 12:55 p.m. an interview with Resident #105's 7-3 shift assigned nurse Staff D, Licensed Practical Nurse (LPN), stated she normally works the 100 unit, but has worked the 200 unit with Resident #105 enough times to know her and what her care needs were. Staff D was not aware Resident #105 had any past trauma/PTSD, nor knew if she had been presenting with any type of behaviors to support any past trauma. Staff D confirmed there were no current care plans that reflected problem areas with goals and interventions related to trauma/PTSD. She confirmed after reviewing the chart, there was a documented diagnosis of PTSD.On 5/7/2026 at 9:45 a.m. an interview with the Care Plan Coordinators, Staff H, LPN and Staff G, Registered Nurse (RN) both revealed they assess residents and implement care plan problem areas with specific goals and interventions based on quarterly Interdisciplinary Team (IDT) assessments, as well as their own assessments. Staff H and Staff G were both aware of Resident #105 and her general care and diagnoses. Staff H and Staff G were at first not aware Resident #105 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had diagnosis of past trauma/PTSD and then reviewed the medical record to then confirm she did, based on the diagnoses sheet and the most current MDS assessment dated [DATE]. Staff H and Staff G stated they then remembered when Resident #105's son was present as part of care plan meetings, he had mentioned Resident #105 had been in a war, but was not sure which war, nor when. Staff H and Staff G confirmed they had documented past diagnoses of trauma/PTSD in the MDS assessments and then confirmed the past Psychological care visits/assessments did mention Resident #105 had PTSD, but they never developed a care plan with that problem area to show goals and interventions. Staff H and Staff G confirmed they both missed it and that Resident #105 should have been care planned with specific trauma behaviors for PTSD, and what to look out for so staff can de-escalate and continue to reduce triggers for those types of specific behaviors. Staff H and Staff G both confirmed at this time there were no assessments, and no behavior monitoring plans to support Resident #105's possible behaviors to past trauma/PTSD. Staff H and Staff G were not sure how staff are or were trained on what things (behaviors) to look out for when it comes to residents who present with past trauma/PTSD. On 5/7/2026 at 8:20 a.m. an interview with the Social Service Director revealed she was aware of Resident #105's care and services and that her family do visit routinely and are part of care plan meetings. The Social Service Director was not aware Resident #105 had trauma/PTSD and after reviewing the medical record she did confirm there was a medical diagnosis of PTSD. The Social Service Director was not aware Resident #105 was presenting with any type of behaviors that would be triggered from trauma/PTSD. The Social Service Director confirmed Resident #105 was being seen by psych. services but was not aware if psych. services was monitoring/assessing for trauma/PTSD. The Social Service Director further confirmed during the admission process, the facility should evaluate and go over past diagnoses with family, decision makers to make sure they appropriately develop care plans with problem areas, goals and interventions to reduce specific triggers that create trauma/PTSD behaviors. She further confirmed this was not done with regards to Resident #105. 2.On 5/4/2026 at 10:40 a.m. Resident #52 was lying in bed , bed in low position , resident appears to be clean and free of odors . Resident #52 was not presenting with any behavior's pains or discomfort; resident resides in private room .On 5/4/2026 at 1:15 p.m. an interview with Resident #52's Power of Attorney (POA) reports the only issue she has had in the past is them doing oral care with a pink sponge and she wanted oral care done with special wipes. She advised she wanted a camera in the room so that she can verify the care Resident #52 is getting.On 5/4/2026 at 2:00 p.m. an observation was made of a wall mounted video camera in the main hallway on the wall across from Resident #52's room. Further observations revealed the camera was pointed directly into Resident #52's room and the resident would be within view of that camera. Resident #52's POA had stated she and the Nursing Home Administrator agreed on the use of the video cameraOn 5/6/2026 at 8:45 a.m. Resident #52 appears to be asleep in bed, the camera has now been repositioned to face end of the hall.A review of resident # 52's medical record revealed she was admitted to the facility 11/26/2025 with diagnoses to include but not limited to , adult failure to thrive, dementia in other diseases classified elsewhere, moderate, with mood disturbance.Review of the most current annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status or BIMS score 99 /15, indicating resident #52 is not cognitively intact.Review of the most current Care plans with a next review date 6/27/2026 did not have a problem area with goals and interventions related to video monitoring.On 5/6/2026 at 12:21 p.m. an interview with Staff A, Certified Nursing Assistant (CNA) was conducted. Staff A stated Resident #52 has not been combative with others, is a total care resident and always needs 2 staff members to go in the room. Staff A stated they put up a [NAME] in front of the room about 6 months ago and does not know why the [NAME] was moved on 5/6/2026. Staff A stated she has not received any education on the video camera.On 5/6/2026 at 1:00 p.m. an interview with Staff D, LPN, was conducted. She stated they always go in with 2 staff members and has never been informed of camera/video system within the facility. Staff D stated no education was provided.On 5/6/2026 at 2:46 p.m. an interview with Staff E , (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistant social worker was conducted. Staff E stated during Resident #52's care plan meeting they have not discussed the video camera.On 5/7/2026 at 9:45 a.m. an interview with MDS care plan team Staff G, RN and Staff H, LPN was conducted. Staff G and Staff H both stated they were not told about the video monitoring being used for Resident #52; if they had known, they would have updated the resident's care plan to include the new safety measures and interventions. Staff G and Staff H both reported they did not know staff were expected to always enter the resident's room in pairs (2 staff members) and if they had known about this expectation, they would have updated the resident's care plan to reflect that two staff members should always be present when entering the room.On 5/7/2026 at 10:51 a.m. an interview with Nursing Home Administrator was conducted. The NHA stated that the resident's family is very involved in her care and visits almost every day. The NHA stated that staff often provide care with two staff members present. She stated the resident was not formally care planned to always require two staff members during care. The NHA also reported the care plan team did not know the camera was being used.Review of the policy, Person center comprehensive care plan, with an effective date October 2022 for review revealed the following: Policy: Overview: The guideline outlines the practice of developing and implementing a person-centered comprehensive care plan that addresses the guest/resident's nursing, medical, physical, mental, and psychosocial needs. The plan is designed to include measurable objectives and timeframes to meet individual preferences and goals. Key Points: The interdisciplinary team reviews and revises the care plan after each assessment, including both comprehensive and quarterly reviews, and when there are significant changes in the guest/resident's condition. Collaboration between the interdisciplinary team, guest/resident, responsible party, and/or family members is essential to ensure the care plan reflects personal preferences, goals, and objectives. The care plan is based on the Minimum Data Set (MDS) to assess clinical condition, cognitive and functional status, and use of services. Care Plan Must Address: Services to attain or maintain the guest/resident's highest practicable physical, mental, and psychosocial well-being. Trauma-informed care/interventions/potential triggers. The center will invite the guest/resident and representative to attend the care planning meetings and participate in the care planning process. The center will offer care plan meetings based on the preference of the guest/resident and representative. Attendance will be documented in the medical record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not ensure one (Resident #11) was provided with adequate pain management out of three residents sampled for pain management.On 5/04/26 at 2:09 p.m., an interview was conducted with Resident #11. Resident #11 stated she had a Leave of Absence (LOA) from the facility the morning of 4/24/26 and returned to the facility on the morning of 4/26/26. On 4/24/26, Resident #11 stated she was provided one Oxycodone tablet when she left on LOA. She stated her nurse told her there was only one tablet remaining in her prescription. She stated she experienced pain while on LOA, and one tablet was not enough to address the pain. Resident #11 stated a family member provided her with Tylenol, but it was not enough for her pain. Resident #11 stated she was not offered an option to delay her LOA until her prescription was refilled.Review of Resident #11's admission record revealed the resident was admitted on [DATE]. The record includes diagnoses not limited to unspecified abnormalities of gait and mobility, ulcerative colitis, hydronephrosis with renal and ureteral calculous obstruction, and chronic obstructive pulmonary disease.Review of Resident #11's active orders revealed the following:-Oxycodone hydrochloride (HCL) oral tablet 5 milligrams: Give 1 tablet by mouth every 4 hours as needed for pain immediate release tablet.-May leave with the resident representative or escort.Review of Resident #11's care plan dated 3/25/26 revealed the following:-Resident has potential for pain related to history of back pain with sciatica, with an intervention to Administer and monitor for effectiveness and for possible side effects of pain medication.Review of Resident #11's Medication Administration Record (MAR) dated April 2026 revealed Oxycodone HCL Oral Tablet was administered as needed when the resident's pain levels were marked as a 5 or higher, which indicates moderate to severe pain. On 4/24/26, Resident #11's pain level was a 6, which indicates moderate pain.On 5/06/26 at 2:00 p.m., an interview was conducted with Staff I, Licensed Practical Nurse (LPN). She stated when Resident #11 went on LOA on 4/24/26, there was only one oxycodone tablet remaining in her order. She stated if the resident ran out of medication while on LOA, the resident's family is expected to manage the resident's pain until the resident returns to the facility.On 5/06/26 at 4:12 p.m., an interview was conducted with Staff L, Registered Nurse (RN). She stated when a resident goes on LOA, she would review the resident's orders to confirm how many medications the resident will need. If she identified a resident was running low on a medication, she stated she would recommend that the Resident delays the LOA until the medications are received.On 5/07/26 at 8:51 a.m., during an interview was conducted with Staff J, LPN. She stated when a resident goes on LOA, she checks their medication administration record (MAR) and orders to determine how much medication the resident will need while they are away from the facility. She stated if she determined a resident would not have enough medications while on LOA, she would check the medication storage system. She would also contact the pharmacy and stat the medication order. She stated she would speak with the resident and their family and encourage them to delay leaving the facility until the medication arrived.On 5/07/26 at 9:20 a.m., an interview was conducted with Staff K, Unit Manager, LPN. She stated if a resident is going on LOA, she would check their MAR to determine if they have enough medication for the month and send the resident the medications they need while on LOA. She stated she would make a copy of the medication list for the family. She stated if she determined a resident would not have enough medication while on LOA, she would check the medication storage system to see if the medication was in stock. If the medication is not available, she would contact the pharmacy and ask if they could stat the medication order.On 5/7/26 at 12:15 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated he was not aware that the resident did not have enough pain medication when she went on LOA. If a resident who is going on LOA does not have enough medication, he stated his expectation would be for the nurse to ask the resident/resident representative if they could delay going on LOA or call the physician to see if there is an alternative medication that could be provided. He stated the facility has (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an Emergency Drug Kit (EDK) that could also be checked for additional medications if needed.A review of the facility's policy titled Resident's Leave of absence effective date March 2018 with a revision date of August 2024, revealed: Procedure 5. The center will provide the resident/ resident representative the number of doses of the resident's physician ordered medication to cover the period of time that the resident will be absent from the center.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one of two residents (#105) who were diagnosed with Post Traumatic Stress Disorder (PTSD), were assessed and monitored for specific trauma related behaviors and failed to ensure care staff were aware of resident #105 having PTSD, and having knowledge of what specific trauma based behaviors to look out for. Findings included: On 5/6/2026 at 9:15 a.m. and multiple other observations Resident 105's room was approached and entered after knocking. During all times observed, Resident #105 was observed in her room lying flat under the covers and presenting with her eyes closed. The call light was placed within her reach. Resident was noted sleeping most to all of the days observed and did not appear to be up out from her bed. Interviews with passing staff members had confirmed Resident #105 likes to stay in her room but did not know the reasons of why she did not spend time out from her room much. Resident #105 did resident in a room with a roommate and there did not appear to be any concerns between them. On 5/6/2026 at 10:00 a.m. the facility's Nursing Home Administrator (NHA) and the Director of Nursing (DON) provided a facility matrix document, which was created for completion on 5/6/2026, for review. The facility matrix document revealed Resident #105 was checked as having Post Traumatic Stress Disorder (PTSD).On 5/6/2026 at 11:30 a.m. an interview with Staff F, Licensed Practical Nurse/Unit Manager (LPN/UM), confirmed he was not aware of Resident #105 having any types of behaviors and was unaware if she had a diagnosis of Post Traumatic Stress Disorder (PTSD). A review of Resident #105's medical record revealed she was admitted to the facility on [DATE] and with a readmission from the hospital on [DATE]. Review of the advance directives revealed Resident #105 had a responsible party for making her medical decisions. Further review of medical record to include the diagnosis sheet, revealed diagnoses to include but not limited to: Alzheimer's, Seizures, and PTSD (order date 7/25/2024).Review of the current month (5/2026) physician's order sheet, revealed Resident #105 had orders to receive general psychiatric services with an order date 11/5/2024.Review of the most current Quarterly Minimum Data Set (MDS) assessment, dated 4/12/2026 revealed; (Cognition/Brief Interview Mental Status or BIMS score of 00 - 15, which indicated Resident #105 could not speak related to her medical care and services); (Behaviors - none documented as exhibited during timeframe reviewed); (Active diagnosis - Traumatic Brain Injury - YES, Post Traumatic Stress Disorder - YES). Review of the nurse progress notes dated from 3/1/2026 through to 5/7/2026 did not have any documentation revealing Resident #105 presenting with PTSD, nor were there any documentation to support what types of specific trauma behaviors Resident #105 presents or presented with. Review of the last psychological care visits/assessments, revealed;-Psychological care visit 3/23/2026 revealed Resident #105 was seen as a follow up visit. Pt. admitted to this facility on 11/5/2024. She has a past medical history of PTSD, anxiety, Alzheimer's, and long term resident at facility. Assessment plan: Post Traumatic Stress Disorder, chronic, monitoring for PTSD symptoms, assessing their severity, and tracking the individual's progress over time. Check for the following signs: intrusive thoughts, avoidance, hyperarousal, changes in behavior, need for medicinal therapy.-Psychological care visit 4/20/2026 revealed Resident #105 was seen as a follow up visit. Pt. admitted to this facility on 11/5/2024. She has a past medical history of PTSD, anxiety, Alzheimer's, and long term resident at facility. Assessment plan: . monitoring for PTSD symptoms, assessing their severity, and tracking the individual's progress over time. Check for the following signs: intrusive thoughts, avoidance, hyperarousal, changes in behavior, need for medicinal therapy.Review of the current care plans with a next review date 7/19/2026 revealed the following but not limited to:Seizure Disorder related to close head injury, with interventions in place as reviewed. It was determined through review of the entire care plan care plan problem areas, there were no problem areas with goals and interventions related to Resident #105 with diagnosis of PTSD.It was also determined there was no additional (continued on next page)

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	105591	A. Building B. Wing	05/07/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation within Resident #105's medical record to support what type of trauma/PTSD she had, nor did the record indicate what types of specific triggered behaviors to monitor for in order to reduce those specific behaviors. On 5/6/2026 at 12:20 p.m. an interview with Resident #105's assigned Certified Nursing Assistant (CNA) Staff A, revealed she has provide care for Resident #105 and she normally likes to stay in her room and does have family visit her often. Staff A was unaware if Resident #105 received psychiatrc services but did confirm Resident #105 had not presented with any type of behaviors other then from time to time declining care and services. Staff A stated she did not believe Resident #105 had any type of behaviors, or at least she had not shown any. Staff further confirmed she was not aware Resident #105 had a past history of trauma/PTSD, nor was she ever trained/inserviced on how to handle residents with trauma/PTSD. Staff A confirmed she would not know what specific trauma/PTSD behaviors to monitor for. Staff A continued to state if residents on her assignment had behaviors, she would know by review of the care plan KARDEX, and the nurses would tell her of those specific behaviors. Staff A again confirmed nursing had not made her aware of Resident having trauma/PTSD, nor were those types of diagnoses listed on her care plan KARDEX. On 5/6/2026 at 12:55 p.m. an interview with Resident #105's 7-3 shift assigned Licensed Practical Nurse Staff D, stated she normally works the 100 unit, but has worked the 200 unit with Resident #105 enough times to know her and what her care needs were. Staff D confirmed Resident #105 had not presented with any types of behaviors in the past other than the occasional swatting away when not wanting care, and routinely wanting to stay in her room and in bed. Staff D stated the few times Resident #105 had swatted away, she (Staff D) will leave and give her space and come back another time to try again. Staff D stated she was not aware of any other types of behaviors from Resident #105. Staff D was unaware of Resident #105 having any type of past trauma/PTSD and if she had those types of behaviors/diagnoses, she would find them on the care plans and within her medical record. Staff D was unaware Resident #105 did have a diagnosis of PTD, and it was also listed in her MDS assessments. Staff D stated that during daily stand up meetings, and shift pass down meetings, this diagnosis and trauma behaviors should have then been passed down to her for her knowledge and to further monitor and assess for. Staff D confirmed she would not know what types of specific trauma related behaviors to look out for as par of her PTSD diagnosis. Further, Staff D revealed she had not been trained or inserviced with specific training on how to identify and handle residents who present with PTSD. Staff D was unaware if there were any psych. assessments/visits that spoke to Resident #105 having past trauma/PTSD.On 5/7/2026 at 9:45 a.m. an interview with the Care Plan Coordinators, Staff H and G both revealed they assess residents and implement care plan problem areas with specific goals and interventions based on quarterly Interdisciplinary Team IDT assessments, as well as their own assessments. Staff H and G were both aware of Resident #105 and her general care and diagnoses. Staff H and G were at first not aware Resident #105 had diagnosis of past trauma/PTSD and then reviewed the medical record to then confirm she did, based on the diagnoses sheet and the most current MDS assessment dated [DATE]. Staff H and G stated they then remembered when Resident #105's son was present as part of care plan meetings, he had mentioned Resident #105 had been in a war, but was not sure which war, nor when. Staff H and G confirmed they had documented past diagnoses of trauma/PTSD in the MDS assessments, and then confirmed the past Psychological care visits/assessments did mention Resident #105 had PTSD, but they never developed a care plan with that problem area to show goals and interventions. Staff H and G confirmed they both missed it and that Resident #105 should have been care planned with specific trauma behaviors for PTSD, and what to look out for so staff can deescalate and continue to reduce triggers for those types of specific behaviors. Staff H and G both confirmed at this time there were no assessments, behavior monitoring plans to support Resident #105's possible behaviors to past trauma/PTSD. Staff H and G were not sure how staff are or were trained on what things (behaviors) to look out for when it comes to residents who present with past trauma/PTSD. On 5/7/2026 at 8:20 a.m. an interview with the Social Service Director revealed she was aware of Resident #105's care (continued on next page)

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	105591	A. Building B. Wing	05/07/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and services and that her family do visit routinely and are part of care plan meetings. The Social Service Director was not aware Resident #105 had trauma/PTSD and after reviewing the medical record she did confirm there was a medical diagnosis of PTSD. The Social Service Director was not aware Resident #105 was presenting with any type of behaviors that would be triggered from trauma/PTSD. The Social Service Director confirmed Resident #105 was being seen by psych. services but was not aware if psych. services was monitoring/assessing for trauma/PTSD. The Social Service Director further confirmed during the admission process, the facility should evaluate and go over past diagnoses with family, decision makers to make sure they appropriately develop care plans with problem areas, goals and interventions to reduce specific triggers that create trauma/PTSD behaviors. She further confirmed this was not done with regards to Resident #105.It was found through observations on 5/4/2026 through to 5/7/2026 and interviews with direct care staff who care for Resident #105, staff were not aware Resident #105 had any past trauma/PTSD and further did not know of what types of specific triggers to look out for to reduce the risk for trauma/PTSD behaviors. On 5/7/2026 at 12:00 p.m., Nursing Home Administrator provided the Trauma-Informed Care Comprehensive Care Plans policy and procedure, with an effective date of 10/20222 for review. The policy stated; It is the practice of the center to develop and implement a comprehensive person-centered care plan to ensure each guest/resident receives care and services that account for experiences and address the needs of trauma survivors by minimizing triggers and /or re - traumatization while helping them to attain and maintain the highest practicable psycho-social well-being. The interventions in the guest/resident's care plan will reflect the individual guest/resident's needs and preferences and align with the guest/resident's personal experiences and circumstances including previous traumatic events. The Process section of the policy stated; The center will use a multi-prong approach to identify each guest/resident's history of trauma including the Minimum Date Set (MDS), guest/resident interview, family/responsible party information, the physician's history & physical, and other interdisciplinary assessment tools.The interdisciplinary team will work collaboratively with the guest/resident, responsible party and/or family members if appropriate other mental health professionals to develop a comprehensive person - centered care plan that identifies previous trauma, and potential triggers which could re-traumatize the guest/resident and individualized interventions to reduce or eliminate re-traumatization. Definitions:Trauma - Results from an event, or serious of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, emotional, or spiritual well-being. Trauma-informed care - is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma- informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in guests/residents and incorporates knowledge about trauma into care plans to avoid re-traumatization.Post Traumatic Stress Disorder (PTSD - is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or who have been threatened with death, sexual violence or serious injury.Triggers - is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. Examples of Trauma (not an all-inclusive list): Military Veterans, Survivors of natural or man-made disasters, Holocaust survivors, Individuals with a history of physical, sexual, or emotional abuse, Victims of violent crimes, Homelessness, Traumatic loss of a loved one, Previous imprisonment, Sexual abuse/rape, Ethic/Racial genocide.Examples of common triggers (most triggers are very individualized): Feeling confined or claustrophobic - fear of small confined spaces, Loud noises/Alarms/Loud voices, Bright light and/or flashing lights, [NAME] of privacy, Sounds, smells, and even physical touch, Certain sights or objects associated with previous abuse.Care Planning to Address Past Trauma:The interdisciplinary team will attempt to identify triggers which may re-traumatize the guest/resident and develop care plan interventions which minimize or eliminate the (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effect of the trigger on the guest/resident.Trigger specific interventions will identify ways to decrease the guest/resident's exposure to triggers.Trigger specific interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, anxiety and/or behaviors.Trigger specific interventions will be developed to recognize the guest/resident's need for respect, independence with making their own decisions, access to information, and their involvement in the development of the comprehensive plan of care.Individualized interventions will include appropriate mental health services and/or support groups if guest/resident express a desire to participate in such groups.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interviews and record review, the facility did not ensure medication recommendations were reviewed for one (Resident #4) of five residents sampled for unnecessary medications.Findings included:A review of Resident #4's pharmacy recommendations revealed:3/12/2026-3/13/2026 - Not signed by attending physician or medical directorHydrocodone-Acetaminophen tablet 10-325mg - Give 1 tablet by mouth every 6 hours as needed for pain. Recommendation: Please reduce PRN (as needed) analgesic therapy until the lowest effective dose is achieved.A review of Resident #4's active physician orders as of 5/6/2026 revealed:Hydrocodone-Acetaminophen Tablet 10-325 MG Give 1 tablet by mouth every 6 hours as needed for PainA review of Resident #4's pharmacy recommendations revealed:2/13/2026-2/14/2026 - Not signed by attending physician or medical directorInsulin Glargine Solostar SQ (subcutaneously) - Inject 10-unit SQ in the morning. Recommendations: Please adjust the diabetes regimen by initiating Metformin 250mg BID (twice a day) with food and increasing insulin glargine to 15 units SQ in the morning.A review of Resident #4's active physician orders as of 5/6/2026 revealed:Insulin Glargine Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously in the morning for DM (diabetes mellulitis)No order (discontinued or active) for Metformin foundAn interview on 5/7/2026 at 9:27 A.M. with the Pharmacist was conducted. The Pharmacist said the pain medication frequency should have been changed. The Pharmacist said he would expect Resident #4's attending physician to call him if there were any questions regarding his recommendations.An interview on 5/7/2026 at 9:39 A.M. with Resident #4's Attending Physician (AP) was conducted. The AP said if the pharmacy recommendations are not placed in his folder for review, then the recommendations would not get reviewed. The AP said he expects the facility to place pharmacy recommendations for him in the folder at each nursing station. The AP said he did not remember speaking with any staff member about the above recommendations.An interview on 5/7/2026 at 1:43 P.M. with the Director of Nursing (DON) was conducted. The DON said he signs the pharmacy recommendations and does not check any of the boxes indicating if Resident #4's physician approved or denied the recommendation. The DON said he did not know if the recommendations were approved or denied. The DON said the AP had folders at each nursing station and does not know if the recommendations were placed in the folders for the AP.A review of a policy effective 11/28/2016, titled: Medication Regimen Review revealed: 7.1: For those issues that require physician/prescriber intervention, facility should encourage the physician/prescriber to either accept and act upon the recommendations contained within the MMR (medication regimen review), or reject the recommendations contained in the MMR and provide an explanation as to why the recommendation was rejected. 7.2.1: If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility did not provide therapy services needed for one (Resident #38) of one resident sampled for specialized rehabilitative services .Findings included:An observation on 5/4/2026 at 9:15 A.M., Resident #38 was sleeping; her breakfast tray was on the bedside table and was not eatenAn observation on 5/4/2026 at 1:00 P.M., Resident #38 was sleeping: her lunch tray was on the bedside table and was not eaten.A record review of Resident #38's evaluations revealed a referral to therapy was made on 4/30/2026 related to a decline in self-feeding.A review of Resident #38's quarterly minimum data set (MDS) dated [DATE] and 1/27/2026 revealed Resident #38 required supervision or touching assistance with eating.A review of Resident #38's annual MDS dated [DATE] revealed Resident #38 required supervision or touching assistance with eating.A review of Resident #38's culinary profile valuation dated 4/30/2026 revealed Resident #38's average meal intake was 25% and her eating assistance was independent.A review of Resident #38's progress notes revealed a communication note dated 4/30/2026, Note Text: Family is reporting resident having a difficult time self-feeding and requests a ST referral. Referral submitted on resident's behalf.A review of Resident #38's weight history revealed the following weights with a weight loss of 7.23% in thirty-four days:5/6/2026 124.4 pounds 4/2/2026 134.1 pounds An interview on 5/6/2026 at 10:55 A.M. with the Speech Language Pathologist (SLP) was conducted. The SLP said Resident #38 was eating and she had not had a decline in self-feeding. The SLP said Resident #38 requires full setup from the staff. The SLP said Resident #38 had not experienced weight loss and she was not seeing Resident #38 for therapy services. The SLP said the Director of Rehab (DOR) would receive notification of a therapy referral and then notify the SLP.An interview on 5/6/2026 at 11:43 A.M. with the DOR was conducted. The DOR said Resident #38 was recently discharged from physical therapy on 2/11/2026 and speech therapy on 3/23/2026. The DOR said nursing staff would send a speech therapy referral to the therapy department through point click care and then the therapy department would evaluate Resident #38 within 24-48 hours after the referral was received. The DOR said there had been a therapy referral for weight loss by the Director of Nursing (DON) completed on 5/6/2026. The DOR said there had been another therapy referral placed on 4/30/2026 for a decline in self-feeding. The DOR stated, apparently there is one on 4/30/2026 that I did not see, she was not screened because I am just seeing it now.An interview on 5/7/2026 at 1:57 P.M. with the DON was conducted. The DON said the therapy department should have evaluated Resident #38 within 24-48 hours of receiving the referral. The DON said that when nursing staff requests a referral from therapy, the nursing staff should have also notified the therapy department.A review of a policy revised on 10/13/2023 titled, Therapy Screening Process indicates the procedure was: .Therapists will perform screening: Upon request or referral by any individual (member of the nursing team, resident's family, facility staff member, or physician) and upon any changes in the resident's condition.the following are some examples of the type of changes that should be monitored for appropriate therapy referrals: g. decreased ability to perform activity of daily living (ADL): eating, dressing, and/or bathing.