STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105592	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Vero Beach	1755 37th Street Vero Beach, FL 32960

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure provision of their admission Agreement, that included a written notice of resident rights along with services, for 1 of 3 sampled residents, Resident #2.The findings included:Review of the record revealed Resident #2 was admitted to the facility on [DATE] after a hospital stay. Review of the resident documents lacked any signed admission Agreement.During a side-by-side review of the record and interview on 04/30/26 at 11:17 AM, when asked the process for obtaining a signed admission Agreement with resident rights for a newly admitted resident, the Director of Guest Services stated she would talk with the resident to determine if they were able to understand and sign the agreement, checking their cognition and or checking with social services for a Brief Interview for Mental Status (BIMS) score if needed. The Director of Guest Services further stated if the resident was cognitively intact, she would go over the admission Agreement and obtain a signature, and if not cognitively intact she would reach out to the Power of Attorney (POA) or spouse or other family member as applicable. When asked the time frame to complete the admission Agreement, the Director of Guest Services explained that she works part-time at the facility three times weekly, but stated, about 72 hours, depending on if the family was available. The Director further stated the admission Agreement could be done via eSign (electronic signatures) with an email address. Upon review of a blank admission Agreement, the prices for services not covered were not filled in on the form. The Director of Guest Services explained when she populates the form with the date, the prices and or cost of services would automatically populate.During this continued interview, the Director of Guest Services was asked to locate and provide the signed admission Agreement for Resident #2. The Director of Guest Services looked in the electronic medical record (EMR) and stated there was none. When asked what happened, the Director of Guest Services stated she did not know but did recall at the time of Resident #2's admission, she was the only person in Guest Services, and she did take a vacation during that time. When asked about the written notice of costs for services not covered for Resident #2 when her benefits ended, the Director of Guest Services stated the resident or representative would have had a conversation with the Business Office Manager (BOM) and or Social Services Director (SSD) when her insurance benefits ended.During an interview on 04/30/26 at 11:48 AM, when asked how the resident was informed in writing of the room rates when their insurance benefits ended, both the BOM and SSD agreed the information was in the admission Agreement. When asked if either had provided Resident #2 or the representative with the costs not covered, both stated they had talked with the resident and daughter daily and informed them of the costs, but that it was verbal conversations with no documentation.

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
	105592	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Vero Beach	1755 37th Street Vero Beach, FL 32960

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely and appropriate care and services for 4 of 5 sampled residents as evidenced by the failure to ensure a timely orthopedic follow up appointment for Resident #2, and failure to thoroughly monitor and assess for a change in condition for Residents #4, #6, and #9, all who were transferred to the hospital with shortness of breath.The findings included:1) Review of the record revealed Resident #2 was admitted to the facility on [DATE] after a hospital stay for an orthopedic procedure. Review of the hospital discharge instructions included the need for a follow-up appointment with the resident's orthopedic surgeon in two weeks, with the instructions to call for an appointment.Review of the record revealed an order dated 01/02/26, seventeen days after admission to the facility, for a follow up appointment with the orthopedic surgeon. An orthopedic progress note revealed the resident was seen in the surgeon's office on 01/12/26, four weeks after the procedure. The record lacked any documented reason for the delay.During an interview on 04/30/26 at 11:01 AM, the Independence [NAME] Clerk voiced difficulty in scheduling appointments with the orthopedic surgeon of Resident #2. The [NAME] Clerk reviewed the calendar for Resident #2 and found the appointment scheduled for 01/12/26 at 9:40 AM. When asked about the 2-week time frame, the [NAME] Clerk stated if the doctor was booked up, they would ask for a verbal order for the wound care nurse to discontinue staples, if needed. When asked if there was any documentation as to why the appointment was delayed for Resident #2, the [NAME] Clerk stated no, and agreed with the findings.2) During an interview on 04/29/26 at 2:17 PM, when asked the process when one of her nurse's identified a change in condition in a resident, the Seaway Clinical Services Coordinator (Nurse Supervisor) stated the nurse should do a head to toe assessment with a full set of vital signs, document it on the Change in Condition form, and notify both the physician and family. When asked specifically about the vital signs, the Clinical Services Coordinator explained they utilize a vital sign machine that will document the vitals taken directly into the electronic medical record (EMR) when they are completed. The Clinical Service Coordinator confirmed the vitals should include blood pressure, pulse, respirations, and oxygen saturation, was made aware of the following, and agreed with the findings.a) Review of the record revealed Resident #4 was admitted on [DATE] with a subsequent hospitalization on 03/12/26. Review of the Change in Condition form dated 03/12/26 at 11:22 PM documented the resident's change was shortness of breath that started that same night. This form documented the blood pressure, pulse, and temperature from 1:52 PM on 03/12/26, ten hours earlier than the actual event.b) Review of the record revealed Resident #6 was admitted to the facility on [DATE] with a subsequent hospitalization on 04/12/26. Review of the Change in Condition form dated 04/12/26 at 9:27 PM documented the resident's change was shortness of breath that started that same night. This form documented the blood pressure and oxygen saturation from 7:15 AM on 04/12/26, the resident's temperature from 5:49 PM that day.c) Review of the record revealed Resident #9 was admitted on [DATE] with a subsequent hospitalization on 03/29/26. Review of the Change in Condition form dated 03/29/26 at 2:16 AM documented the resident's change was shortness of breath that started that same morning. This form documented the resident's pulse from 03/28/26 at 10:04 PM.