

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2025
NAME OF PROVIDER OR SUPPLIER Palm Garden of West Palm Beach		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Executive Center Drive West Palm Beach, FL 33401	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure care and services to prevent pressure ulcers, as evidenced by no interventions ordered or in place to prevent, 1 of 3 sampled residents, Resident #3, from acquiring pressure ulcers. The findings included:Record review revealed Resident #3 was readmitted to the facility on [DATE]. Review of the admission assessment dated [DATE] documented Resident #3 had redness to her buttocks area. Review of the quarterly minimum data set assessment dated [DATE] documented Resident #3 was dependent on staff for toileting and required moderate assistance for turning right to left in bed.Review of the physician orders for Resident #3 did not reveal any orders to prevent skin breakdown. Review of a skin assessment dated [DATE] documented Resident #3 had an open wound to her sacrum and left buttocks.Review of a progress note dated 04/25/25 revealed documentation that staff called Resident #3's daughter to inform her of an open area and redness to the resident's buttocks area. It further stated that staff told the daughter the Resident had non blanchable redness to her buttocks when she returned to the facility and the daughter said she was not aware or informed about the redness.Review of the care plan did not reveal any documented focus that stated Resident #3 was at risk of developing pressure ulcers.Review of a wound care consult dated 04/28/25 revealed documentation that Resident #3 had a Stage 4 pressure ulcer to the sacrum and a Stage 3 pressure ulcer to the left buttocks. During an interview with the Director Of Nursing (DON) on 12/29/25 at 4:18 PM, she was asked if Resident #3 had facility acquired pressure ulcers. She stated, I pulled some information regarding her wounds; let me get it for you. The DON returned with copies of progress notes regarding other skin issues the resident had. When asked if she was aware of when Resident #3 got the pressure ulcers to her sacrum and left buttocks and if there were any interventions in place to prevent them, she stated I wasn't here at that time. I will get the person that does the care plans. During an interview on 12/29/25 at 4:25 PM, Staff A, Care Plan Specialist, Staff A was asked if there were any interventions ordered or in place to prevent Resident #3 from getting pressure ulcers. She looked in her computer and stated, I see a care plan that was initiated on 04/22/25 that said she was at risk and is being treated for pressure ulcer. When asked whether there was anything prior to her getting the pressure ulcers, she stated, No I don't see anything care planned.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105607
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