STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of West Palm Beach	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, and interview, the facility failed to accurately assess 2 of 33 sampled residents. The Minimum Data Set (MDS) assessment was inaccurate related to indwelling urinary catheter use for Resident #79 and related to the discharge status for Resident #141. The findings included: 1. Review of the record revealed Resident #79 was admitted to the facility on [DATE] with a return to the facility on [DATE]. Review of the admission progress note on 03/15/24 at 8:48 AM documented the resident was readmitted to the facility with a Foley catheter (indwelling urinary catheter) in place. Additional progress notes, to include those on 03/25/24, 04/01/24, and 04/03/24, all referred to the use of the indwelling urinary catheter. An observation on 04/15/24 at 12:32 PM revealed Resident #79 in bed. An indwelling urinary catheter bag was noted to bedside drainage. Review of the Admission Minimum Data Set (MDS) assessments dated 03/21/24 lacked the documented use of the indwelling urinary catheter. During an interview on 04/18/24 at 11:00 AM, Staff D, MDS Coordinator, explained her process for the completion of the Admission MDS was mainly by review of the record and interview of the resident for the pain assessment. The MDS Coordinator agreed with the inaccurate Admission MDS for Resident #79, and stated she most likely missed it because of the lack of an order. 39026 2. On 04/15/24, a closed record review for hospitalization was conducted for Resident #141. The discharge MDS dated [DATE] revealed the resident was coded as going to a short term general hospital but had actually been discharged home. A review of a social service progress note dated 01/25/24 revealed the resident was discharged with belongings and home health care had been arranged for him. An interview was conducted with Staff D, MDS coordinator, on 04/17/24 at 3:55 PM. Staff D was asked to review the discharge MDS for Resident #141 then read the social service progress note. Staff D stated the discharge assessment was coded wrong since it should have been coded as going home and not hospitalized . She stated it would be modified.

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: 105607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

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Palm Garden of West Palm Beach	300 Executive Center Drive West Palm Beach, FL 33401

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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 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** 25404 Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for 1 of 1 sampled resident reviewed with an indwelling urinary catheter (Resident #79). The findings included: 1. Review of the record revealed Resident #79 was admitted to the facility on [DATE] with a return to the facility on [DATE]. Review of the admission progress note on 03/15/24 at 8:48 AM documented the resident was readmitted to the facility with a Foley (indwelling urinary catheter) in place. Additional progress notes, to include those on 03/25/24, 04/01/24, and 04/03/24, all referred to the use of the indwelling urinary catheter. An observation on 04/15/24 at 12:32 PM revealed Resident #79 in bed. An indwelling urinary catheter bag was noted to bedside drainage. Review of the current care plans lacked any care plans related to the use of the indwelling urinary catheter. During an interview on 04/18/24 at 11:00 AM, Staff D, Minimum Data Set (MDS) Coordinator, agreed with the lack of a care plan for the indwelling catheter for Resident #79, and stated she most likely just missed it as there was no other documentaiton.

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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	

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to ensure ordered labs were completed timely for 1 of 5 sampled residents, Resident #194. The findings included: Review of the record revealed Resident #194 was admitted to the facility on [DATE], after a hospitalization for a hip replacement. Review of the record revealed a physician order dated 04/05/24, for a Complete Blood Count (CBC) and a Basic Metabolic Panel (BMP) to be drawn on 04/06/24. Review of the record revealed a CBC was collected on 04/08/24. The record lacked a BMP on or about 04/06/24. Review of the progress notes lacked any documentation related to the failure to obtain the CBC on 04/06/24 as ordered, the reason for the late collection on 04/08/24, and or the failure to obtain the BMP. An additional order dated 04/16/24 at 8: 23 AM ordered a CBC, CMP (comprehensive metabolic panel), and BMP for a follow up. The record revealed intravenous fluids were ordered on 04/17/24 at 4:27 PM for dehydration, and a progress note revealed the fluids were initiated on 04/18/24 at 12:35 AM. During an interview and side-by-side record review on 04/18/24 at 10:34 AM, the Unit Manager explained the process for obtaining physician ordered labs was to enter the order into the electronic record so that it will be generated for the night shift to fill out the requisition for the laboratory technician. When asked about the failure to obtain the BMP for Resident #194 on 04/06/24 as per physician order, the Unit Manager was unaware. The Unit Manager obtained information directly from the laboratory's website that documented on 04/08/24 at 11:31 AM, they had rejected the order because they did not receive a specimen in accordance with the testing ordered. Additional details were documented as, Incorrectly ordered a CMP but testing would not be able to be completed due to only receiving a lavender vial. Note a lavender vial is used by the laboratory for a CBC but is not able to be used for a CMP. During an interview on 04/18/24 at 12:35 PM, the Director of Nursing (DON) verbalized the same process for ordering labs and ensuring the requisition was in the binder. The DON stated they review the labs during the morning meetings. When asked how or why the facility did not catch the missing BMP order, the DON had no answer. A side-by-side review of the CBC that was completed on 04/08/24 revealed it had been reviewed by the Unit Manager.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, and interview, the facility failed to ensure accurate and complete resident records for 4 of 33 sampled residents, as evidenced by: the record for Resident #79 lacked an order for the indwelling urinary catheter; the record for Resident #36 lacked documentation related to a change in a code status; the record for Resident #57 had inaccurate documentation related to a dressing change; and the record for Resident #92 lacked documentation related to blood sugar monitoring. The findings included: 1. Review of the record revealed Resident #79 was admitted to the facility on [DATE] with a return to the facility on [DATE]. Review of the admission progress note on [DATE] at 8:48 AM documented the resident was readmitted to the facility with a Foley catheter (indwelling urinary catheter) in place. Additional progress notes, to include those on [DATE], [DATE], and [DATE], all referred to the use of the indwelling urinary catheter. An observation on [DATE] at 12:32 PM revealed Resident #79 in bed. An indwelling urinary catheter bag was noted to bedside drainage. Review of all orders on [DATE] and [DATE], both current and discontinued, lacked the documented use of the indwelling urinary catheter. Review of the record on [DATE] revealed an order as of [DATE] at 4:11 PM for the indwelling urinary catheter. As per the Unit Manager, the nursing staff informed her today that there was no order for the urinary catheter. The Unit Manager agreed the record had lacked the order for the past month, which led to the inaccurate Minimum Data Set (MDS) assessment and lack of associated care plan. 39026 2. Resident #36 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction without residual deficits, Type 2 Diabetes Mellitus, and Pressure Ulcer of sacral region. Resident #36's Brief Interview for Mental Status (BIMS) documented a score of 11 on the Minimum Data Set (MDS) admission assessment with an assessment reference date of [DATE], indicating the resident had mild cognitive impairment. On admission to the facility, the resident's code status was full code. On [DATE], a DNR (Do Not Resuscitate) was signed by the resident and the Medical Director. On [DATE], the DNR was rescinded by resident request and a CPR (Cardio-Pulmonary Resuscitation) order was signed by the Medical Director. Upon review of the electronic health record (EHR), the surveyor could not find any documentation of a conversation with the resident about the change in code status. There was no documented conversation that the resident understood what CPR was or what DNR was. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Service Director (SSD) on [DATE] at 10:45 AM. The SSD was asked about the change in code status for Resident #36 and if there was any documentation regarding the change. On [DATE] at 11:10 AM, the SSD produced a Partners in Care POC / Individualized Plan of Care (IPOC) summary that stated on [DATE] she met with the resident to discuss Advance Directives. The document documented: 'The resident expressed wishes of changing from DNR to CPR [full code]. The Medical Director would be notified and update records. Hospice to be updated.' The note did not indicate who explained DNR to the resident or if it had been explained to the resident. The SSD stated a nurse was with her at the time of the visit. An interview was conducted with Staff C (Licensed Practical Nurse / Unit Manager) on [DATE] at 11:13 AM. Staff C revealed when the patient was first admitted he was asked what his wishes were and he wanted to be DNR. He was his own responsible party. He said he wanted to live when interviewed on [DATE] and he wanted to change from DNR to CPR and the family also wanted him to have CPR. She stated she was in the room when the SSD discussed the Advance Directives. Staff C stated she fully explained what CPR meant and the resident said that he wanted to live. The findings were discussed with the Administrator on [DATE] at 11:30 AM that these code status notes should have been in the EHR. The Administrator agreed with this surveyor. 41837 3. Review of the facility's policy, titled, Midline Catheter Dressing Change, with a revised date of ,d+[DATE], included, in part, under Guidance: 1. Sterile dressing change using transparent dressing is performed: 1.1 Upon admission 1.1.1 If transparent dressing is dated, clean, dry, and intact, the admission dressing change may be omitted and scheduled for 7 days from the date on the dressing label. Record review for Resident #57 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE]. The resident's diagnoses included: Severe Protein-Calorie Malnutrition, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Personal History of Urinary (Tract) Infections. Review of the Minimum Data Set (MDS) assessment for Resident #57 dated [DATE] documented in Section C, a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #57 revealed an order dated [DATE] for Midline Insertion Date: Arm Circumference: Total Catheter Length: External Catheter Length: Measure arm circumference and external catheter length with each dressing change and PRN [as needed] one time only for Midline placement for 1 Day Measure circumference 10 cm above antecubital and in the morning every 7 day(s) for Midline evaluation Measure arm circumference 10 cm above antecubital. Contact MD if external measurement has changed from previous measurement and as needed for Midline evaluation Measure arm circumference 10 cm above antecubital. Contact MD if external measurement has changed from previous measurement. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders for Resident #57 revealed an order dated [DATE] for Change Dressing on admission, 24 hours after insertion if applicable, then weekly and as needed in the morning every 7 day(s) for Midline Care Use transparent dressing, no gauze on site and as needed for Midline Care Use transparent dressing, no gauze on site and one time only for Midline Care for 7 Days Use transparent dressing, no gauze on site. Review of the Medication Administration (MAR) for Resident #57 for the month of [DATE] documented the midline dressing was changed on [DATE] by Staff B, Registered Nurse (RN). Review of the Care Plans for Resident #57 dated [DATE] documented a focus on: the resident has an active infection (UTI) in the urine and is on antibiotic intravenously. The goal was for the resident to maintain adequate hydration as evidenced by moist mucous membranes, supple skin turgor, stable lab values and administration of IV antibiotic until resolution of infection process by [DATE]. The interventions included: educating family / visitor on contact precautions as needed. Encourage good, clean hygiene techniques, especially hand washing. Enhanced Precautions. Isolation as ordered. Medication as ordered. Observe IV site for infiltration. Offer and encourage increase PO fluids intake. On [DATE] at 11:59 AM, an observation was made of Resident #57 lying in bed with a midline central catheter dated [DATE] in the resident's right upper arm. Photographic Evidence Obtained. On [DATE] 9:30 AM, an observation was made of Resident #57 lying in bed with midline central catheter in resident's right upper arm with dressing dated [DATE]. During an interview conducted on [DATE] at 9:33 AM with Resident #57, who was asked if the dressing for the midline central catheter had been changed today or in the past 2 -3 days, he said 'no it has never been changed, it is supposed to come out soon because I finished the medicine.' An interview was conducted on [DATE] at 10:35 AM with Staff A, Licensed Practical Nurse (LPN), who was asked to look at the midline central catheter dressing for Resident #57. The LPN acknowledged the date on the dressing was [DATE]. Staff LPN. An interview was conducted on [DATE] at 10:55 AM with the Director of Clinical Services (DOCS) who acknowledged the dressing for the midline central catheter for Resident #57 was dated [DATE]. The DOCS also acknowledged the Medication Administration Record for Resident #57 documented the midline dressing was changed on [DATE] by Staff B, RN. A telephone interview was conducted on [DATE] at 11:03 AM with Staff B, RN, who stated she works at the facility PRN (as needed). When asked if she remembered taking care of Resident #57 on [DATE], she said she did. When asked if she performed a midline dressing change on [DATE] for the resident, she said no she did not. She said at most places where she works, the dressing changes are performed by the night shift. When asked why she documented on Resident #57's MAR that she did a midline dressing change, she said she must have clicked on it by accident, she has no problem doing the dressing changes. 32078 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Record review revealed Resident #92 was admitted on [DATE] with diagnoses that included Diabetes Mellitus 2. Review of physician orders included an order for Humulin R to be administered per sliding scale, with a note that if blood glucose reading, which was to be taken before meals and at bedtime, was greater than 401, 22 units of insulin was to be administered and the physician or nurse practitioner was to be notified. Review of the [DATE] electronic Medication Administration Record (eMAR) for Resident #92 showed no blood sugar results recorded for [DATE] at 6:30 AM or [DATE] at 9:00 PM. There was no nurse documentation as to why the blood sugar results were not recorded, nor were there any notes to document if any insulin was given, and if not, why the insulin was not provided. On [DATE] at 9:16 AM, the Director of Nursing (DON) was informed of the missing 'nurse initials' and documentation regarding Resident #92's sliding scale insulin. She stated she would look into the concern and report back after her investigation. On [DATE] at approximately 2:00 PM, the DON stated that she had spoken with the resident's nurse, and the nurse had made a late entry addressing the missing documentation.