STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105682	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Jacksonville	5725 Spring Park Road Jacksonville, FL 32216

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews and a review of policies and procedures, the facility failed to provide food at a safe and appetizing temperature for residents on one of four items on the holding line in the main kitchen and for four of four items on a test tray provided after the last resident received their tray.The findings include:During an observation of the lunch service on 08/28/2025 at 1:10 PM, the temperature of the baked chicken read 104 degrees Fahrenheit (F).During an interview on 08/28/2025 at 1:15 PM, the Certified Dietary Manager (CDM) stated It shouldn't be that temperature.During an observation of a test tray on the hallway cart on 08/28/2025 at 1:35 PM, the temperature of hamburger read 128 degrees F, the temperature of the mechanical soft hamburger read 120 degrees F, the temperature of the green beans read 115.5 degrees F, and the temperature of the mashed potatoes and gravy read 120.5 degrees F.During an interview on 08/28/2025 at 1:40 PM, the CDM stated, I don't know what to say. It should be hotter than that.A Review of the facility's policy and procedure titled Record of Food Temperatures (effective 4/15/2024), revealed:Policy Explanation and Compliance Guidelines: 2. Hot foods will be held at 135 degrees Fahrenheit or greater. 11. No food will be served that does not meet the food code standard temperatures.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and a review of the facility's policies and procedures, the facility failed to ensure food was safely stored, labeled, or discarded for two (open, unlabeled beef base paste and spoiled green peppers) of six items in the walk-in cooler and for two (uncovered cake and open, unlabeled jelly) of four items in the main kitchen. Unsafe food handling practices represent a potential source of pathogen exposure.The findings include:On 8/25/2025 at 9:45 AM during a tour of the kitchen with the Dietary Supervisor, an open container of Beef Base Paste was found undated in the walk-in cooler. (Photographic evidence obtained) Two green bell peppers located in a carboard carton in the walk-in cooler, dated 8/12/2025, were noted to have shriveled, brownish black sections with a thick greenish substance oozing from them. (Photographic evidence obtained)During an interview on 8/25/2025 at 9:45 AM, the Dietary Supervisor stated, The paste should have been dated when opened and I'm not sure why someone hasn't thrown these peppers out.On 8/25/2025 at 9:55 AM during the kitchen tour with the Dietary Supervisor, an uncovered cake pan was sitting on a stainless-steel counter during the breakfast service. (Photographic evidence obtained) On 8/25/2025 at 9:55 AM an open jar of grape jelly was found undated. (Photographic evidence obtained)During an interview on 8/25/2025 at 9:55 AM, the Dietary Supervisor stated, The cake should have been covered and I'm not sure why that jar wasn't dated.During an interview on 8/25/2025 at 10:30 AM, the Certified Dietary Manager stated, Items should be dated when opened, covered when not being served, and discarded when expired.A review of the facility's policy titled Food Labeling and Dating (effective April 15, 2024), revealed:Purpose: Food shall be stored in a manner to prevent bacterial growth, contamination and be easily identified. Procedures: 7. Any opened products should be c. labeled and dated.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interviews and record review, the facility failed to properly document a discharge plan for two (Residents #11 and #118) of six residents reviewed for transfer/discharge. When the facility transfers or discharges a resident, the facility must ensure that the transfer or discharge is documented in the resident's medical record. The findings include:1.A review of Resident #11's medical record revealed that she was care planned to remain in long-term care at the center on 2/19/2025. Further review of the resident's record revealed a nursing note dated 8/7/2025 at 1:09 PM that read, Social Worker approached Writer and reported that the Resident would be discharge going home on 8/8/25 and for the Resident to go home with all her medication and pick up would be at 11:30. Will report to the upcoming nurse of the same.Further review of Resident #11's record revealed a physician's order dated 8/7/2025 that read, Discharge to Terrace of Jacksonville as per family request on 8/8/2025 with all medication. Transportation will be at 11:30.Further review of Resident #11's record revealed no additional documentation regarding the resident's discharge. No documentation was entered for the date of discharge.During an interview on 8/28/2025 at 11:00 AM, Care Plan Specialist (CPS) G stated With [Resident #11] when she was initially admitted , her initial plan was for the resident to remain long-term care. The day before discharge was the day it was communicated to us that she was going to be discharged . There is a note from the nurse on 8/7/2025 that she is going to be going home. I was unable to locate a note regarding the reason for her discharge.2.A review of Resident #118's medical record revealed that she was care planned to remain in long-term care at the center. There were no updates to the care plan indicating a pending discharge.Further review of Resident #118's record revealed a note which read, Resident was discharged to facility on 7/18/2025 at 10:00 am via transport accompanied by family .There was no documentation of the reason for the resident's discharge in the medical record. There was no physician's discharge order present in the medical record.During an interview on 8/28/2025 at 10:15 AM, the Director of Clinical Services (DCS), stated, I was told that there were some family dynamics and only one daughter was visiting her (Resident #118) and the other facility was closer to the daughter.During an interview on 8/28/2025 at 11:15 AM, Care Plan Specialist (CPS) E stated, I'm recalling from my memory that one of the Social Workers was contacted by the family that the family contacted the facility and notified us either the same day. When asked if there was a discharge order, CPS E stated, No Ma'am, I don't' see one. A review of the facility's policy titled Transfer and Discharge Requirements (revision date July 2024), revealed:Procedure: 1. The Social Services Director/designee will coordinate all resident discharges and transfers and will be responsible for documenting interventions and plans in the progress notes and appropriate forms.

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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 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** Based on interviews, record review, and a review of the facility's policies and procedures, the facility failed to provide necessary treatment and services, consistent with professional standards of practice to promote healing and prevent infection for one (Resident #101) of two residents reviewed for wound care from a total survey sample of 46 residents. The findings include: A review of the medical record revealed that Resident #101 was admitted to the facility on [DATE] with a re-entry on 1/30/25. His diagnoses included cerebrovascular disease, 9/27/23, hemiplegia/hemiparesis following cerebral infarction affecting the left non-dominant side, 10/5/23, type II diabetes mellitus with diabetic neuropathy, 11/7/23, a history of falling, 11/7/23, low back pain, 4/24/24, peripheral vascular disease, 5/21/24, pain in left shoulder, 9/23/24, acquired absence of other right toe(s), 5/21/24, acquired absence of other left toe(s), 10/2/24, and idiopathic aseptic necrosis of left toe(s). A review of the quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/25/25, revealed that the resident had a brief interview for mental status (BIMS) score of 15/15 points, indicating intact cognition. He had one stage four (IV) pressure injury and one venous/arterial ulcer.The wound care physician's note, dated 8/12/25, revealed that the left lateral foot grew Pseudomonas (bacterial infection). Patient refuses care and requests physician to sign off the case. Patient advised on risks of refusal of care including deterioration of wound. Patient advised on results of culture and recommendation for antibiotics. Will sign off at request of patient. A review of the Dressing Treatment Plan included: Primary dressing(s) Alginate calcium w/silver apply once daily and as needed: if saturated, soiled, or dislodged. For 23 days; Gentamicin sulfate topical 0.1%, apply once daily and as needed: if saturated, soiled, or dislodged. For 23 days; Secondary Dressing(s) Gauze island with border, apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days. A review of the resident's physician's orders related to wound care included:8/5/25 - Right foot great toe: Apply Betadine, and cover with dry dressing every day shift for arterial ulcer8/5/25 - Left partial foot amputation site: Apply Calcium Alginate, dry dressing every day shift for arterial ulcer.(There was no Gentamicin order)In an interview on 8/28/25 at 2:35 PM, Registered Nurse (RN)/Wound Care Nurse K stated when the wound care physician made a recommendation, he notified the attending physician to ensure he/she agreed with the recommendation. When asked about the order for Gentamycin for Resident #101 as noted in the wound care notes, RN K stated the resident refused to be seen by the wound care physician. When asked if the resident refused the wound treatment, RN K stated he contacted the hospice nurse and there were no new orders. When asked for verification of his contact with the hospice provider, RN K stated he could not find the documentation. A follow-up interview was conducted on 8/28/25 at 2:35 PM with Resident #101. He stated he refused to be seen by the current wound care physician but did not refuse the wound treatment or recommendation. He further stated the wound care physician was debriding the wound and making it worse, yet the wound was almost closing up. A review of the facility's policy and procedure titled Skin Care and Wound Management (revised July, 2017), revealed:As part of an ongoing Quality Assurance process, skin care and wound management guidelines are to provide necessary treatment and services to promote healing, prevent Infection, control pain, and prevent development of pressure injury(s) unless the resident's clinical condition demonstrates that they were unavoidable. The resident's right to pain management will be respected and supported. The resident will also be encouraged to be a partner in care. PROCEDURE Residents will be evaluated for risk of pressure injury(s) upon admission, no less than quarterly, upon hospital return, and with significant change.Guidelines for Skin Care and Wound Management Included: Identify residents at risk of developing pressure injury(s) and initiate early prevention plans. Stabilize, reduce, or remove identified risk factors for skin Impairment. Skin inspection on a regular and ongoing basis to provide documentation and prompt interventions of any changes noted. Manage wound care using guidelines based upon current standards of practice. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manage pain before, during and after wound treatment. Observe for signs of infection and manage infection. Monitor resident response to interventions for prevention and/or treatments and revise the care plan based on response, outcomes, needs and resident wishes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and a review of facility policies and procedures, the facility failed to 1) Ensure medications were properly labeled for one resident (#110) to facilitate safe medication administration, and 2) Ensure medications were properly stored for one resident (#97) to prevent unauthorized access to medications, out of five residents reviewed for medication storage/labeling, from a total survey sample of 46 residents.The findings include:1.On 8/25/25 at 10:25 AM, Resident #97 was observed lying in bed awake. Anti-diarrheal medication was observed in a clear plastic bag at the bedside. (Photographic evidence obtained) The resident was asked if someone in the facility had given her the medication. She stated, I brought it with me when I came here. I was having the worse diarrhea, going several times a day. The resident mentioned that she received visits from a relative. She stated, My cousin comes weekly to visit. She was asked if her cousin brought the anti-diarrheal medication to her here in the facility. She replied, No. On 8/26/25 at 10:43 AM, Resident #97 was observed lying in bed awake. Anti-diarrheal medication was observed in a plastic bag located on the nightstand. (Photographic evidence obtained)On 8/27/25 at 11:11 AM, a record review revealed that Resident #97 was admitted to the facility on [DATE] with diagnoses including poly-osteoarthritis, scoliosis and major depressive disorder.A review of the resident's Annual MDS (minimum data set) assessment dated [DATE], revealed a BIMS (brief interview for mental status) score of 15/15 (intact cognition) with no behaviors. She required set-up or clean-up assistance with eating, substantial assistance with toileting, partial/moderate assistance with bed mobility, substantial/maximal assistance with transfers, and she was incontinent of bladder and urine. The resident received antiplatelets, and antidepressant medications during the assessment look-back period.A review of the physician's orders revealed:Sennosides Tablet 8.6 mg (milligrams), 1 tablet by mouth every 12 hours as needed for constipation May give two doses. If no results give Lactulose. Nurse to chart effectiveness (6/9/25)Polyethylene Glycol 3350 Powder, Give 17 grams by mouth as needed for constipation. Mix in 6-8 ounces of water and or juice. Hold for loose stools (6/9/25)Enema Disposable, insert 1 application rectally as needed for constipation. If no results 1 day after suppository, call MD (physician) (6/9/25)Dulcolax Suppository 10 mg, insert 1 suppository rectally as needed for constipation daily. If no results from MOM (milk of magnesia)(6/9/25)Milk of Magnesia (MOM) Suspension 400 MG/5ML (milligrams per milliliter), Give 30 ml by mouth as needed for constipation. Give 30 ml by mouth as needed for constipation at bedtime if no BM (bowel movement) in 3 days (6/9/25)Loperamide HCl (hydrochloride) Capsule 2 mg, Give 1 capsule by mouth as needed for loose stools after each loose stool (6/9/25)Pantoprazole Sodium Tablet Delayed Release 40 mg, Give 1 tablet by mouth at bedtime for GERD (gastroesophageal reflux disease) (6/9/25)Lactulose Solution 10 gm/15 ml (grams per milliliter), Give 15 milliliters by mouth every 6 hours as needed for constipation (6/10/25)Monitor and document behavior concerns using codes provided Behavior code: 0 - no behavior, 1 - Fear/panic, 2 - Anger, 3 - Scream/yell, 4 - Danger/self/others, 5 - Delusions, 6 - Hallucinations, 7 - Sad/tearful, 8 - Emotion/Act Withdrawal, 9 - Other(describe) Interventions: 1 - Redirect , 2- 1 on 1, 3 - Ambulate, 4 - Activity, 5 - Return to room, 6 - Toilet, 7 - Give food, 8 - Give fluids, 9 - Change position, 10 - Encourage to rest, 11 - Back rub, 12 - PRN (as needed) med. Outcome: I - Improved, S - Same, W - Worse. Side Effects: 0 - None, 1 - EPS (extrapyramidal symptoms), 2 - Tardive Dyskinesia, 3 - Hypotension - every shift (6/9/25). A review of the care plan revealed the following focus areas:Resident has behavior problems as evidenced by refused medication related to diagnosis of major depressive disorder (initiated 06/10/2025, revised 06/12/2025).Resident is active in daily routine of facility. Independently attends scheduled group activities and engages in independent activities in room. Reads, spends time outside, spends time with visitors (initiated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/18/2025, revised 06/18/2025).Resident has diagnosis of depression and has potential for adverse consequences of antidepressant medication (initiated 06/11/2025, revised 06/11/2025).Further review of the record revealed that the resident received psychiatric services on 8/14/25 and the resident's thought processes were documented as: Organized. Thought associations: Intact. Insight and Judgement: Fair. Orientation: Alert, oriented to person, place, and time. The resident received psychiatric services on 8/18/25 with documented Cognitive Status: Patient is cognitively impaired but still can process psychotherapy and benefit from it.On 08/26/2025 at 10:50 AM, an interview was conducted with Registered Nurse (RN) A. He stated he was responsible for administering medications to all the odd-numbered rooms, which included room [ROOM NUMBER] (Resident #97's room). He explained that he started his medication pass on the 100 unit first and had already medicated the residents in room [ROOM NUMBER].On 08/26/2025 at 2:05 PM, another interview was conducted with RN A. He was asked what kinds of observations he made when he was in a resident's room administering medications. He stated, I ask them if they are having pain; I check if the room is clean; I look to see if the clothing is clean; I check on the resident. RN A was asked to accompany the surveyor to Resident #97's bedside. He was asked if he administered medications to this resident today. He stated, Yes. He was asked to observe the clear plastic bag that was on the nightstand. He confirmed the anti-diarrheal medication that was in the clear plastic bag. He removed the medication from the bag and relocated it to the locked medication room on the unit. He was asked if residents were supposed to have medications at the bedside. He stated, No, they are not supposed to have them. All the medicine comes from the nurse. He was asked if the resident was permitted to self-medicate. He replied, No.On 8/26/25 at 2:12 PM, an interview was conducted with Certified Nursing Assistant (CNA) B, the CNA providing direct care for Resident #97. She was observed coming out of his room and was asked if she had been providing his care. She replied, Yes. She was asked if she noticed any medication in the clear plastic bag on the nightstand. She stated, No, I didn't notice it. She was asked how she should handle a situation where she observed medication at the bedside or in the resident's possession. She stated, I would tell the nurse.On 8/27/2025 at 1:59 PM, an interview was conducted with the Director of Nursing (DON). She was asked if the facility provided training/education on medication administration for licensed personnel. She stated, Yes, during orientation for the new nurses and ongoing education for the existing nurses. She was asked to explain the medication administration process. She explained that the nurse should ensure the five rights: the right patient; right medication; right dose; right route; and the right time. We also want the nurse to use proper infection control and handwashing. They should make sure the patient takes the medication and monitor for side effects. She was asked if medications should be left at the bedside. She stated, There should not be any medications left at the bedside by the nurse. She was asked if the staff was trained on what to do if any medications were observed in the resident's possession. She stated, They should alert the nurse, and the nurse should confiscate it. If it's a medication that was ordered, the physician should be notified. A review of the facility's Pharmacy Services and Procedures Manual, 5.3 Storage and Expiration Dating of Medication, Biologicals, LTC Facilities Receiving Pharmacy Products and Services from Pharmacy (effective 12/01/07, revision 7/21/22), revealed:Applicability: This Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needles.Procedure:3. General Storage Procedures^3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 2.On 08/28/2025 at 11:07 AM, a fingerstick blood sugar check was observed for Resident #110. The plastic bag that contained the insulin pen that was to be administered was labeled with the incorrect insulin pen information. (Photographic evidence obtained). The insulin pen injector that the nurse removed from the bag to administer was Lispro insulin, but it did not have a label or a resident name on it. RN I was asked how the insulin was labeled when it arrived from the pharmacy. He stated, The plastic bag is labeled with the resident's name, room number, the name of the medication, and the (continued on next page)

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to obtain emergency dental care to meet the needs of one (Resident #101) of 46 residents in the total survey sample who was experiencing dental pain. The findings include:During a facility tour on 08/25/2025 at 1:01 PM, Resident #101 was observed guarding the left side of his face. He stated as he talked the air was getting to his tooth, and it was very painful. He rated his pain at a 6 on a scale of zero to 10 with zero indicating no pain and 10 indicating the worst possible pain. He stated the pain was intermittent when something cold came into contact with the tooth.A review of the medical record revealed that Resident #101 was admitted to the facility on [DATE] with a re-entry on 01/30/2025. His diagnoses included cerebrovascular disease, 09/27/2023, hemiplegia/hemiparesis following cerebral infarction affecting the left non-dominant side, 10/05/2023, type 2 diabetes mellitus with diabetic neuropathy, 11/07/2023, a history of falling, 11/07/2023, low back pain, 04/24/2024, peripheral vascular disease, 05/21/2024, pain in the left shoulder, 09/23/2024, acquired absence of other right toe(s), 05/21/2024, acquired absence of other left toe(s), 10/02/2024, and idiopathic aseptic necrosis of left toe(s).A review of the quarterly minimum data set (MDS) assessment, with an assessment reference date (ARD) of 05/25/2025, revealed a brief interview for mental status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. No dental issues were noted.A review of the eINTERACT change-in-condition form dated 8/18/25 revealed: Toothache to left side with tenderness on palpation. Reported 8/10 pain. Clinician was notified on 8/18/25 with the following recommendation: Resident to see on-site dentist. The resident representative notified.A review of the care plan, initiated on 08/24/2025, revealed that the resident had oral/dental health problems related to tooth pain (left side). Interventions included: Coordinate arrangements for dental care as needed/as ordered. In an interview on 08/28/2025 at 2:18 PM, Registered Nurse (RN)Unit Manager M stated nurses and certified nursing assistants (CNAs) notified her of any issues going on in the unit. She added that she made rounds and residents could voice any concerns. When asked about Resident #101, RN M stated he was alert and oriented and was able to make his needs known. The resident had a sister that spoke out for him as well. RN M stated she was aware of the dental concern and mentioned that the resident wanted to see an on-site dentist and that was what was ordered on 08/18/2025. When asked if she notified the dentist, she replied that the Director of Social Services made the appointment, and she reported the issue to her. She stated she had not been updated as to when the dentist was coming to see the resident. A follow-up interview was conducted on 08/28/2025 at 2:35 PM with Resident #101. He stated he was still having tooth pain, especially when air got to the tooth. He stated he did not choose any provider (in-house or outside of the facility); all he wanted was for the tooth to be taken care of as soon as possible. He stated he was notified that the in-house dentist had no openings sooner and no other alternative was provided to him for the care of his tooth.During interview with the Director of Nursing (DON) on 08/28/2025 at 3:45 PM, she stated the Director of Social Services (DSS)was on vacation. When asked how dental issues were being handled during the DSS' absence, the DON stated the facility had an in-house dental provider. Most residents were seen routinely and if there was a dental issue, the provider was notified to add the resident with concerns to their list. The provider sent the list of residents to be seen during the next visit at least two weeks in advance. When asked about dental emergencies, the DON stated if the in-house provider could not see the resident soon enough, they would be sent for outpatient services. She was asked for a list of residents to be seen on the next visit. She provided a list indicating that the next visit was on 09/22/2025. Resident #101 was on the list and next to his name was a comment indicating priority patient due to complaint of dental pain. The DON was asked if Resident #101 had been seen by anyone yet. She replied, no. She added that she was told by the Unit Manager that the resident requested to see the in-house dentist. She said she would follow up with the resident.