STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105733	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Pinellas	200 16th Ave SE Largo, FL 34641

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record review, the facility failed to ensure the residents' family and physician was notified of a significant change in condition for one (Resident #2) of two residents sampled. Cross-reference F684. Findings included:Review of Resident #2's medical record showed that her primary physician was listed as Medical Director. Review of Resident #2's progress notes from 4/7/26 to 4/8/26 revealed: - On 4/7/26 at 5:35 p.m., Staff A, Registered Nurse (RN), wrote, Patient c/o [complained of] middle back pain and became anxious. and Per nursing supervisor, patient vomited prior to alerting me that patient was feeling unwell. - On 4/8/26 at 9:30 a.m., Staff B, RN, wrote, Resident c/o chest pain that's radiating to her back. Upon assessment resident appeared clammy and sweating. - On 4/8/26 at 12:00 p.m., Staff B, RN, wrote, Resident called out to staff stating she is really wanting to go to ER [emergency room] and she wasn't feeling good at all. Nurse writing this went into residents [sic] room and once again resident appearing sweaty, pale and clammy to touch. Resident stated, ?I really want to go to the Hospital [sic] I don't feel good.' . - On 4/8/26 at 2:15 p.m., Staff B, RN, wrote, Nurse writing this went into DON [Director of Nursing] office and expressed grave concerns that resident needed to be sent to ER due to her c/o chest pain that was radiating to her back. An interview was conducted with Staff B, RN, on 5/11/26 at 2:36 p.m. Staff B confirmed Resident #2 was having chest pain. Staff B reported the facility had educated staff that they are only to call the nurse practitioner (APRN), We can't send them out, we can only go to them. Staff B verified that Medical Director was Resident #2's physician. Staff B described seeing Resident #2 at 8:30 a.m. as [NAME] as a ghost, she did not look good, she was sweating and clammy and complaining of chest pain. Staff B stated assessed again at 9:30 a.m. and reported Resident #2 stated not feeling good and kept saying she wanted to go out. Staff B reported expressing Resident #2 needed emergent care the whole day to the Former DON and APRN and their response was to schedule an in-house cardiology consult. Staff B reported expressing concerns six to eight times and was never informed that she could send Resident #2 directly to the emergency department. Staff B reported that the facility leadership recommended changing her documentation and stated that if the State was to look at the documentation, they would ask why she or anyone else did not send her (Resident #2) to the ER per her request. An interview was conducted with the APRN on 5/11/26 at 3:08 p.m. The APRN stated, I should have collaborated with the primary, unfortunately I did not. I was busy charting and handling other concerns. An interview was conducted on 5/11/26 at 3:37 p.m. with the Interim DON. He confirmed the expectations for a change of condition and stated staff should have completed one for Resident #2. He reviewed that a change of condition would include notification to the provider for further treatment and instructions. He stated the notification would have included notifying the family as well. An interview was conducted on 5/11/26 at 3:58 p.m. with Nursing Home Administrator (NHA). The NHA stated that the nurse practitioner is the one to communicate with the physician when needed. She reviewed Resident #2's record and determined a change of condition should have been completed and confirmed it was not. The NHA verified the physician and Resident #2's family were not notified of her change effective 4/7/26 and throughout the day on 4/8/26 up until the resident's expiration. An interview was conducted on 5/11/26 at 4:23 p.m. with the Former (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON. She reported that when a change of condition is completed it would trigger the nurse to call the physician and family. She confirmed Resident #2's physician and family should have been notified by staff from 4/7/26 to 4/8/26. An interview was conducted on 5/12/26 at 11:43 a.m. with Director of Quality Assurance and Risk Management. She confirmed the expectation would have been for staff to complete a change of condition, and after reading the progress note for Resident #2 on 4/7/26, confirmed that a change of condition was not documented which would have triggered further follow-up. She reported that she was not aware that facility staff did not notify the physician or family of Resident #2's change of condition from 4/7/26 to 4/8/26. She verified the family and physician should have been notified per facility procedure and expectation. An interview was conducted on 5/12/26 at 12:18 p.m. with Medical Director. She confirmed Resident #2 was her patient. She stated she was not notified of Resident #2's condition and stated the resident was very stable prior to 4/8/26. The Medical Director expressed frustration for not being notified of Resident #2 complaining of chest pain through the 24 - hour period. The Medical Director confirmed neither the APRN, nor the facility staff called her. The Medical Director stated she would have sent Resident #2 to the hospital right away, following the reported symptoms. Review of Facility policy titled, Nursing - Change in a Residents Condition or Status, effective October 2014, included:Policy: The facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status.Procedure:1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:- A significant change in the resident's physical/emotional/mental condition which includes discovery of the loss of vital bodily functions (loss of responsiveness to stimuli and loss of blood pressure, pulse, and respirations).- Instructions to notify the physician of changes in the resident's condition.2. Should the Attending Physician be unavailable and the change of condition is of an urgent nature, the facility will contact the Medical Director for guidance.3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse/designee will notify the resident's family or representative when:- There is a significant change in the resident's physical, mental, or psychosocial status

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F 0684 Level of Harm - 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 interviews and record review, the facility failed to provide care and treatment in accordance with professional standards and failed to send the resident to higher level of care, upon request for one (Resident #2) of two residents sampled. Resident #2 experienced a change of condition on [DATE] with a delay treatment according to professional standard of practice. Cross-reference F580. Findings included:Review of Resident #2's medical record revealed she was admitted to the facility on [DATE] and expired on [DATE]. Resident #2 had a primary diagnosis of heart failure, unspecified and additional diagnoses included type 2 diabetes mellitus with diabetic neuropathy, unspecified; essential (primary) hypertension; and hyperlipidemia, unspecified. Resident #2 had intact cognition and primary physician was listed as Medical Director. Review of Resident #2's progress notes from [DATE] to [DATE] revealed: - [DATE] at 5:35 p.m., Staff A, Registered Nurse (RN), wrote, Patient c/o [complained of] middle back pain and became anxious. Patient had previously asked day nurse for [antacid] and antifungal cream while ambulating in her wheelchair. Assessed patient. Lungs were clear bilaterally. Vitals BP [blood pressure] of 152/69, P [pulse] of 86, SPO2 [oxygen level] of 97%, and a T [temperature] 97.7 [degrees Fahrenheit]. Per nursing supervisor, patient vomited prior to alerting me that patient was feeling unwell. Patient did not vomit in my presence. Repositioned patient with pillow under her back facing R [right] with R side down. Patient expressed she no longer felt pain andwanted [sic] to rest at this time. 30 minute follow up, patient was resting in bed with no signs or symptoms of pain. Will provide report to next shift as well. - [DATE] at 9:30 a.m., Staff B, RN, wrote, Resident c/o chest pain that's radiating to her back. Upon assessment resident appeared clammy and sweating. APRN [Advanced Practice Registered Nurse] [Name] notified, and n/o [new orders] placed for STAT [immediately] EKG [electrocardiogram], CXR [chest x-ray], & blood work to be collected. - [DATE] at 10:00 a.m., Staff B, RN, wrote, Called [EKG/lab provider] and explained to the residents [sic] state and APRN wanted STAT EKG. Per [EKG/lab provider] ?unable to do STAT EKG and it could only be done and ordered routine and that they will reach out to dispatch and see where the field tech was and call back.' APRN [name] notified. - [DATE] at 11:15 a.m., Staff B, RN, wrote, APRN [name] returned from assessing the resident and stated she wanted to potentially give resident something for her anxiety to ?calm her down' however no n/o were placed at this time. - [DATE] at 12:00 p.m., Staff B, RN, wrote, Resident called out to staff stating she is really wanting to go to ER [emergency room] and she wasn't feeling good at all. Nurse writing this went into residents [sic] room and once again resident appearing [sic] sweaty, pale and clammy to touch. Resident stated, ?I really want to go to the Hospital [sic] I don't feel good.' Reported this to the APRN again and no n/o were placed. No call back from [EKG/lab provider] regarding ETA [estimated time of arrival] for STAT EKG/CXR. - [DATE] at 2:15 p.m., Staff B, RN, wrote, Nurse writing this went into DON [Director of Nursing] office and expressed grave concerns that resident needed to be sent to ER due to her c/o chest pain that was radiating to her back. DON discussed this with APRN [name] and n/o was put in to give resident 0.4 mg [milligrams] nitro [nitroglycerin] SL [sublingual] [administered under the tongue]. Verbalized these orders to the assigned nurse. On [DATE] at 2:30 p.m., Staff C, Licensed Practical Nurse (LPN), wrote, Resident stated medication helped BP [blood pressure] 145/81, PRN (as needed) Administration was: Effective. On [DATE] at 2:40 p.m., Staff B, RN, wrote, Resident stated that SL nitro was helping with her chest pain. VSS [vital signs stable]. Contacted [EKG/lab provider] again to expedite the EKG. Per [EKG/lab provider] they were going to contact the field team. [Name APRN] provider present. Ok to hold off on ER transport. On [DATE] at 2:40 p.m., Staff B, RN, wrote, SL Nitro given and went in to reassess resident. VSS stable see VSS documented. On [DATE] at 3:10 p.m., APRN wrote, Notified by unit manager at 0930 that pt [patient] was requesting to go to the hospital for pain. Pt found in her room (0935), sitting up in bed and at her baseline. No distress noted; calm and cooperative. She complained about having a throbbing pain in (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	her chest area that started a day or so ago. Stated that when she burps the pain goes away for a while. Denies any changes to her diet. No radiating to her arms, back or jaw, no diaphoresis or SOB [shortness of breath] noted. VSS at this time; slightly hypertensive 145/81 and O2 [oxygen sat [saturation] on RA [room air] is 98%. Agreeable to having labs and diagnostics performed at SNF [skilled nursing facility]. Orders for STAT CBC [complete blood count], CMP [comprehensive metabolic panel], UA w/C&S [urine analysis with culture and specificity], CXR, EKG placed. Notified by unit manager that pt wanted to speak to APC (advanced practice clinician) (1100) as she was anxious and wanting to go to the hospital. Approx 1400-1415, DON approached APC about pt and c/o chest pain. Ordered for NTG [nitroglycerine SL] PRN and to give dose now w/VS prior to and after administration. Also ordered for her to have O2 NC [nasal canula] place for comfort and prophylaxis. Notified by unit manager approx 15-20 mins later that relief w/NTG and pt refused to have O2 NC placed. Nurse on other cart approached APC and stated that pt is c/o wanting to go to the hospital. Verbal order given to send pt out to the ED [emergency department]. Notified approx 15 mins after that pt was unresponsive up in her w/c in her room. APC entered room and pt unresponsive in w/c, slumped over w/agonal breathing. Staff moved pt back to her bed and cyanosis noted around her lips. She is a DNR (do not resuscitate) code status; EMS (emergency medical services) was called and no carotid or radial pulse felt, no heart sounds w/auscultation noted. EMS arrived and placed on monitor, PEA (pulseless electrical activity) on monitor. Pronounced at 1504. On [DATE] at 3:40 p.m., Staff B, RN, wrote, At approximately 1500 [3:00 p.m.], the DON entered my office and reported that the resident was unresponsive in her wheelchair. I immediately proceeded to the resident's room and found her in the wheelchair with agonal respirations and cyanotic lips. I attempted to sternal rub, but the resident demonstrated only minimal response to painful stimuli. Myself [sic] and three other nursing staff members assisted in transferring the resident back to her bed. APRN [NAME] at bedside and assessed the resident, after checking for one minute, determined that the resident was pulseless. Time of death was pronounced at that time. EMS arrived shortly thereafter and confirmed the absence of a heartbeat. Review of Resident #2's electronic record from [DATE] to [DATE] revealed no change of condition documented, one set of vitals, and no diagnostics were completed. Review of Resident #2's physician orders revealed the following:-[DATE] at 9:50 a.m., 2v [two view] CXR to be done for chest pain, STAT for chest pain, ordered by APRN, confirmed by Staff B, RN, on [DATE] at 1:03 p.m. -[DATE] at 9:51 a.m., 12 lead EKG for chest pain vs GERD (gastroesophageal reflux disease) w/interpretation, STAT for chest pain vs. GERD, ordered by APRN, confirmed by Staff B, RN, on [DATE] at 1:02 p.m. -[DATE] at 9:52 a.m., CBC and CMP STAT for chest pain vs. GERD, STAT for chest pain vs GERD, ordered by APRN, confirmed by Staff B, RN, on [DATE] at 1:02 p.m. -[DATE] at 2:21 p.m., Nitroglycerin Tablet Sublingual 0.4 mg, Give 1 tablet sublingually every 15 minutes as needed for Chest Pain x 3 doses. If no relief, call MD., ordered by APRN, confirmed by Former DON, on [DATE] at 2:21 p.m. -[DATE] at 2:29 p.m., OK to transfer to ER, one time only for resident insist for 1 Day, created and confirmed by Staff C, LPN. An interview was conducted with Staff B, RN, on [DATE] at 2:36 p.m. Staff B confirmed Resident #2 was having chest pain. Staff B reported the facility had educated staff that they are only to call the nurse practitioner, We can't send them out, we can only go to them. Staff B verified that Medical Director was Resident #2's physician. Staff B described seeing Resident #2 at 8:30 a.m. as [NAME] as a ghost, she did not look good, she was sweating and clammy and complaining of chest pain. Staff B assessed again at 9:30 a.m. and reported Resident #2 stated she was not feeling good and kept saying she wanted to go out. Staff B reported expressing Resident #2 needed emergent care the whole day to Former DON and APRN and their response was to schedule an in-house cardiology consult. Staff B verified speaking with [EKG/lab provider] and was informed they could not perform STAT EKGs. She reported that she expressed concerns six to eight times and was never informed that she could send Resident #2 directly to the emergency department. Staff B reported that approximately around 2:45 p.m., Former DON stated, Just [derogatory term] send her (Resident #2) out. Staff B, RN, described Resident #2 was stable (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	prior to the incident. She reported the facility recommended she change her documentation and that if the State was to look at the documentation, they would ask why she or anyone else did not send her (Resident #2) to the ER. She reported the event as traumatic. An interview was conducted with the APRN on [DATE] at 3:08 p.m. She verified that she arrived at the facility on [DATE] between approximately 9:00 to 9:30 a.m. She ordered STAT labs, EKG, and CXR for Resident #2 around 9:30 a.m. She confirmed facility staff had informed her that Resident #2 was reporting chest pain and wanted to go to the hospital. She denied that these concerns were assessed by her or communicated by Resident #2 to her. She confirmed she ordered nitroglycerin around 2:30 p.m. for chest pain, and the next thing I head she was unresponsive in her w/c. She reported that the death was not expected and said, I did not know her [Resident #2] very well. She also stated, I should have collaborated with the primary, unfortunately I did not. I was busy charting and handling other concerns. An interview was conducted on [DATE] at 3:37 p.m. with Interim DON. He confirmed the expectations for a change of condition and staff should have completed one for Resident #2. He reviewed that a change of condition would consist of an assessment, notification to the provider for further treatment and instructions, and documented in the charting system. He reviewed Resident #2's record and stated, If the resident was asking to go to the hospital, they have the right to do so. Looking at those symptoms, they are signs of a cardiac issue, they should have been sent out. An interview was conducted on [DATE] at 3:58 p.m. with Nursing Home Administrator (NHA). NHA stated that the nurse practitioner is the one to communicate with the physician. She reviewed Resident #2's record and determined a change of condition should have been completed and was not. She verified that Resident #2's family was not notified prior to expiration. NHA agreed Resident #2 reported chest and back pain to staff, reported wanting to go to the ER to staff, and was not sent to the ER. An interview was conducted on [DATE] at 4:23 p.m. with Former DON. She reported that Resident #2 was stable prior to [DATE]. She reported she was the one who found Resident #2 in the doorway of her room unresponsive and called 911. She reported that APRN was in the facility all day and she was handling it. She stated that if Resident #2 wanted to go to the ER, they should be sent as residents have the right to seek medical care outside of the facility. She stated APRN wanted Resident #2 to stay for treatment. She reported that if a change of condition was completed on [DATE] when Resident #2 first reported symptoms it would trigger for review during the [DATE] clinical meeting and for the nurse to call the physician and family. An interview was conducted on [DATE] at 10:08 a.m. with Staff C, LPN. Staff C, LPN, was Resident #2's assigned nurse on [DATE]. He reported that Resident #2 stated she was not feeling well during morning medication administration. He stated, She did not know what was bothering her.she was a little bit restless.a little paler than usual. He stated that he checked on Resident #2, unable to specify a time, and she remained restless. He denied any conversation with Staff B, RN, or APRN until approximately 2:30 to 2:45 p.m. on [DATE]. He stated they told him that everything was going to be done in-house for Resident #2 and that was normal procedure. Staff C, LPN, stated Resident #2's death was unexpected and that he did not know she passed until [DATE]. An interview was conducted on [DATE] at 11:43 a.m. with Director of Quality Assurance and Risk Management. She reported she did not complete a complete an investigation of Resident #2's death. She reported that corporate completed an investigation. She agreed on the expectation for staff completing a change of condition after reading the progress note for Resident #2 on [DATE] and confirmed no change of condition was documented. She reported she is not aware that the facility has the capability to perform a STAT EKG and confirmed an EKG was not completed. She verified the facility provided education to the staff regarding resident rights and regarding calling 911 for emergent situations. An interview was conducted on [DATE] at 12:18 p.m. with Medical Director. She confirmed Resident #2 was her patient. She stated she was not notified of Resident #2's condition and Resident #2 was very stable prior to [DATE]. She stated, We always listen to the patient, if they want to be sent out, we send them right away. She denied being aware that a STAT EKG was ordered and not completed. She stated Resident #2 should have been sent right away to the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hospital and that suspected cardiac concerns could not be monitored in the nursing home setting. Medical Director expressed frustration for not being notified of Resident #2's change in condition and if she was notified, she would have sent Resident #2 to the hospital right away. She reported that she does not supervise or provide oversight to the APRN. She stated she was in the process of identifying the physician that supervises the APRN The Medical Director stated the Former DON or a nurse could have called 911 and stated that they are also responsible for the residents. An interview was conducted on [DATE] at 2:16 p.m. with Staff D, Certified Nursing Assistant (CNA). She worked with Resident #2 often and described that she had become more independent. She described Resident #2 as loving to attend activities and had planned to go on leave of absence for a shopping trip the following day. She reported that around 7:30 a.m. on [DATE], Resident #2 had put on her call light that she was having chest pain and that she wanted to go to the hospital. Staff D, CNA, confirmed reporting this finding to Staff B, RN, and Staff C, LPN. Staff D, CNA, described Resident #2 as In distress and not comfortable. She reported that Resident #2's death was unexpected. Staff D, CNA, reported being affected by the sudden death and being upset that the Resident did not go to the hospital when she requested. Review of Mayo Clinic's heart attack symptoms for women showed: Chest pain is the most common symptom of heart attack in men and women. But women are more likely than men to have symptoms that may seem unrelated to a heart attack, such as nausea and brief pain in the neck or back.Women often describe heart attack chest pain as pressure or tightness. But it's possible to have a heart attack without chest pain.Women are more likely than men to have these symptoms of a heart attack: Neck, jaw, shoulder, upper back or upper stomach pain. Shortness of breath. Pain in one or both arms. Nausea or vomiting. Sweating. Lightheadedness or dizziness. Unusual fatigue. Heartburn, also called indigestion.These symptoms may be vague but more noticeable than chest pain. Review of the facility's policy and procedure titled Nursing - Change in a Residents Condition or Status dated [DATE] showed:Policy: The facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level ofcare, billing/payments, resident rights, etc.). In the event of a medical emergency, the facility will notify the attending physician and/or call 911 according to the resident's advance directives.Procedure: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: . A significant change in the resident's physical/emotional/mental condition which includes discovery of the loss of vital bodily functions (loss of responsiveness to stimuli and loss of blood pressure, pulse, and respirations). A need to transfer the resident to a hospital/treatment center; . 2. Should the Attending Physician be unavailable and the change in condition is of an urgent nature, the facility will contact the Medical Director for guidance. 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse/designee will notify the resident's family or representative when: . There is a significant change in the resident's physical, mental, or psychosocial status; . Review of the facility's job description for Registered Nurse, dated [DATE], included: Essential Functions:- Assesses, plans and evaluates clinical care delivered to guests requiring long-term or rehabilitative care.- Delivers clinical care to guests requiring long-term or rehabilitative care.- Initiates emergency support measures (i.e., CPR (Cardiopulmonary Resuscitation), protects guest from injury).Marginal Functions:- Information is relayed to other members of the health care team (i.e. physicians, respiratory therapy, physical therapy, social services, etc.).- Decisions are made that reflect knowledge and good judgment and demonstrate an awareness of guests/family/physician needs.- Assessment identifies changes in the guests physical or psychological condition (i.e. changes in lab data, vital signs, mental status).Specific Requirements:- Must possess the ability to make independent decisions when necessary.- Communicates with the medical and clinical team members and other department supervisors. Review of the Medical Director Services Agreement, dated [DATE] between Facility and Medical Director, included:- 3.8 Direct and coordinate:- 3.8.4 resident care in emergency situations, upon Operator requests, or when attending (continued on next page)

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