

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPLIER Palm Garden of Sun City		STREET ADDRESS, CITY, STATE, ZIP CODE 3850 Upper Creek Dr Sun City Center, FL 33573	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20536</p> <p>Based on interviews, record review, and policy review, the facility failed to protect the resident's right to be free from neglect related to not ensuring a safe transfer from a wheelchair to a bed for one resident (Resident #2) of three sampled residents requiring staff assistance with a mechanical lift for transfers.</p> <p>This failure created a situation where the resident fell from the mechanical lift to the floor, causing injuries resulting in transfer to a higher level of care for treatment.</p> <p>Findings included:</p> <p>Review of Resident #2's nurse progress notes dated 4/22/2025 at 6:23 p.m. and authored by Staff A, Licensed Practical Nurse (LPN), revealed the following Nursing Note:</p> <p>Writer was notified by [Certified Nursing Assistant] CNA that [Resident #2] was on floor. CNA came and informed me that another CNA stated she couldn't reach to hook sling up and when said CNA went to raise [name brand of full body mechanical lift], she didn't know that she wasn't hooked up properly and resident fell out of sling. Upon entering room, [Resident #2] was observed laying [sic] face down with on [sic] head pressed against leg of [name brand] mechanical lift, blood was observed on face and floor. Resident [#2] was crying out loud. Nurse immediately called for help and proceeded to call 911 due to positioning [sic] of [Resident #2]. Staff was informed not to touch resident, wait for [Emergency Medical Technician] EMT. [Medical Doctor] MD notified, [Director of Clinical Services] DCS notified, family notified. Resident sent out to ER [emergency room] for eval[uation] and [treatment].</p> <p>On 5/6/2025 at 10:10 a.m., an interview was conducted with Staff A, LPN. She revealed she was called to Resident #2's room on 4/22/2025 and found Resident #2 lying on the floor beside the mechanical lift. Staff A, LPN confirmed Resident #2 is a two person mechanical lift transfer and she was being transferred from a chair to the bed with the assistance from Staff B, CNA and Staff C, CNA. Staff A, LPN revealed Resident #2 fell from the mechanical sling to the floor and had head injuries. She noted the sling was loose or drooping, but couldn't recall whether all the loops were properly secured in the lift.</p> <p>(continued on next page)</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Adverse Incident Log revealed a documented incident dated 4/23/2025. It was noted an incident involving Resident #2 occurred resulting in Neglect. This incident was reviewed with the Nursing Home Administrator (NHA), Director of Clinical [NAME] (DCS), and the Regional Nursing Consultant (RNC).</p> <p>Through review of the facility's investigation, it was found on 4/22/2025 at approximately 4:15 p.m., Resident #2 was in her room being assisted out from her wheelchair and to her bed via a mechanical lift with Staff B, CNA and Staff C, CNA present. While Resident #2 was hoisted up approximately two feet from the wheelchair, she slid forward and off the mechanical lift sling, to the floor. The NHA and DCS both revealed Resident #2 had a head laceration and the primary physician ordered Resident #2 to the hospital for treatment. The NHA revealed Resident #2 did not return to the facility from the hospital.</p> <p>The NHA revealed the following as a result from their investigation:</p> <p>Staff B, CNA and Staff C, CNA reported to Resident #2's room to transfer her from her wheelchair to the bed with using a mechanical lift. Resident #2 was lying on the blue fabric sling and was ready to be lifted from the wheelchair with the mechanical lift. Staff C, CNA positioned herself directly behind the head of Resident #2's wheelchair as Staff B, CNA pushed the mechanical lift toward Resident #2's wheelchair. Staff C, CNA hooked the sling straps over the two front hooks and Staff B, CNA failed to appropriately hook the two back sling straps to the back hooks. When Staff B, CNA used the mechanical remote control to lift the resident, she was lifted approximately two feet in the air from the wheelchair and started to fidget. The NHA revealed at that point the back straps were not hooked in and while the resident was fidgeting, the straps on the right side of the resident fell off, resulting in Resident #2 falling forward and out from the sling to the floor.</p> <p>The NHA confirmed if the back straps were properly hooked into place, the mechanical lift transfer would not have failed and the resident would not have fallen to the floor. The NHA revealed Resident #2 received a head injury as a result from the fall from the mechanical lift due to poor judgement from both Staff B, CNA and Staff C, CNA, who did not utilize the mechanical lift's standard operating procedure. The NHA confirmed both Staff B, CNA and Staff C, CNA did not ensure the mechanical lift straps were fully secured to the hooks to ensure a safe transfer and both staff members were terminated.</p> <p>The NHA said he had his staff inspect the mechanical lift and sling in question and found there was nothing to indicate equipment faulty. He expressed he had a mechanical lift maintenance company look at the machine and the sling and that company found there had not been any faults with them.</p> <p>Review of Resident #2's medical record revealed she was admitted to the facility on [DATE] and discharged to hospital with no return on 4/22/2025.</p> <p>Review of Resident #2's Minimum Data Set (MDS) Quarterly assessment dated [DATE], revealed under the Activities of Daily Living (ADL) section - Impairment one side to both upper and lower extremities, chair/bed, bed/chair transfers = Dependent on staff.</p> <p>Review of Resident #2's care plans with a next review date 5/28/2025 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- ADL/Mobility - Decline in function mobility and self-care requiring assist and rehab interventions due to limitations associated with multiple falls/multiple fx (fracture) (prior to admission), with interventions in place to include but not limited to: mechanical lift with transfers assistance x 2.</p> <p>On 5/6/2025 during the 7 a.m. to 3 p.m. (7-3) shift, Staff D, CNA, Staff E, CNA, and Staff F, CNA revealed anytime a resident required a transfer from bed to chair or from chair to bed should be done with a mechanical lift and there are always to be two staff members; one who operates the lift and one at standby next to the resident for support. Staff D, CNA, Staff E, CNA, and Staff F, CNA noted the four straps of the lift sling must be hooked appropriately so they don't slip off machine.</p> <p>On 5/6/2025 during the 7-3 shift nurses Staff A, LPN and Staff G, LPN were interviewed. Staff A, LPN and Staff G, LPN revealed they conduct rounds throughout the shift and look at how staff are caring for their assigned residents. Staff A, LPN and Staff G, LPN revealed they ensure the mechanical lifts are charged and always ready for use and when staff use the lifts, there are always two staff members in the room during the transfer.</p> <p>Review of the facility's Nursing Procedures Manual - Transfer Techniques dated 7/2023, revealed the following:</p> <p>Purpose: To safely transfer a guest/resident while minimizing the risk of injury to the guest/resident and caregiver.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Review any special precautions or approaches to take when transferring a guest/resident. Obtain assistance as needed and utilize a gait belt, as indicated. 3. Assemble equipment, as needed, in the guest/resident room. 5. Complete transfer, as indicated and review Transfer Basics in this procedure. 6. Document any observations made during transfers. Observations may include, but are not limited to: <ul style="list-style-type: none"> - Refusal of transfer. - Changes in clinical condition. - Complaints of pain or discomfort. - Guest/resident level of participation in transferring. - Guest/resident response. <p>Review of the manufacturer's manual for the mechanical full body lift used by the facility revealed the following under Patient Lifting:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>7.1.1 Positioning the Lift for use: .</p> <ol style="list-style-type: none"> 1. Press the Legs Open button on the hand control to open the legs of the patient lift to maximum. 2. Position the patient lift using the steering handle. 3. Press the Boom Down button on the handle control to lower the boom for easy attachment of the sling. <p>7.1.2 Attaching Slings to the Lift</p> <ol style="list-style-type: none"> 1 . Place the straps of the sling over the hooks on the hanger bar. 2 . Match the corresponding colors on each side of the sling for an even lift of the patient. <p>7.2 Lifting/Moving the Patient:</p> <p>Do not lock the rear casters of the patient lift when lifting an individual. Locking the rear casters could cause the patient lift to tip and endanger the patient and assistants.</p> <p>Do not move the patient if the sling is not properly connected to the hooks of the hanger bar. When the sling is elevated a few inches off the stationary surface and before moving the patient, check again to make sure the sling is properly connected to the hooks of the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary surface and correct this problem; otherwise, injury or damage may occur. Do not use slings and patient lifts from different manufacturers. [Manufacturer name] slings are made specifically for use with [manufacturer name] patient lifts. Injury or damage may occur.</p> <p>Review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation, last revision date of 9/2023, revealed the following:</p> <p>Policy: The center recognizes each resident's right to be free from abuse, neglect, and exploitation (ANE), misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Neglect: Neglect is defined in statute 483.5 is the failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This occurs when the center was aware of or should have been aware of goods or services that the resident(s) required but the center failed to provide them resulting in or may result in physical harm, pain, mental anguish, or emotional distress.</p> <p>This does not mean that all services must be provided by the center but that the center is responsible to ensure that the residents receives the necessary/required services. Goods and services fall into categories. Those categories are structures and processes and individual.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Employee Obligation: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating the resident's rights. Any employee who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin or misappropriation of resident property, is obligated to report such information immediately.		