STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105921	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardens Court	3803 Pga Boulevard Palm Beach Gardens, FL 33410

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on policy review, interview and record review, the facility failed to treat 3 of 4 sampled residents in a dignified manner (Residents #67, #103, and #35). The findings included: Review of the facility policy titled, dignity revised on 09/25/23, documented, each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input. All residents will be treated with dignity and respect. 1) Record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses that included: Anxiety Disorder. The quarterly Minimum Data Set assessment, reference date 06/14/24 recorded a brief interview for mental status score of 15, which indicated Resident #67 was cognitively intact. This MDS recorded no mood/behavior issues. The care plan dated 05/14/24 revealed Resident #67 was very hard of hearing and prefers things written down at times in order to communicate. On 07/08/24 at 10:34 AM, Resident #67 was observed alert and oriented. An interview process was started with her, and during this time, Resident #67 divulged that Staff A, a Certified Nursing Assistant (CNA), threw a wash cloth at her, and Staff A left her in the bathroom by herself and closed the door. Resident #67 also stated Staff A was rough with her during care. Resident #67 further stated that one time Staff A brought in her food tray, and at that time her purse was on the table. Staff A did not remove the purse from the table, but she placed the food tray on the counter. When Resident #67 asked Staff A how long it would take to put the purse on the bed and put the food tray on the table instead of the counter, Staff A screamed at her. Resident #67 stated Staff A was always screaming. Resident #67 denied telling anybody about the concerns because she was afraid of retaliation from Staff A. Resident #67 stated, Please don't tell Staff A or anybody that I said anything, or Staff A will be twice as mean to me, that's why I didn't say anything to the facility. Resident #67 stated she was sure other people had also complained about Staff A. When asked if she felt Staff A was verbally abusing her, Resident #67 stated she did not feel it was abuse but did not like the way she was being treated by Staff A. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 12:22 PM, a subsequent interview was held with Resident #67 she voiced she doesn't ever want Staff A in her room, she stated, I don't even want her to look at me. On 07/10/24 at 12:50 PM, an interview was held with the DON (Director of Nursing) and she voiced that she had spoken to Resident #67. The resident explained what happened, when it happened, and told the DON the name of Staff (Staff A). The DON revealed that she believed the resident, based on the information the resident had provided. The DON confirmed that Staff A usually speaks loudly, she has a strong loud tone of voice, and the DON said she has always told Staff A she was too loud and needed to lower her tone of voice and to respect the residents because this is their home. The DON informed Staff A of the accuracy of the events described by Resident #67, and the accuracy of the description the resident gave regarding Staff A. The DON stated, There's no way Resident #67 could make that up. The DON further stated, Staff A could be at the nursing station talking to somebody, and you could hear her all the way at the end of the hallway. 25404 2) Review of the record revealed Resident #103 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #103 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14, on 0 to 15 scale, indicating the resident was cognitively intact. This same MDS documented the resident had not exhibited any behaviors and required partial to total assistance for care. During an interview on 07/09/24 at 9:40 AM, Resident #103 stated he only had one complaint. The resident stated, I had trouble with one nurse in the middle of the night. She came in the room and yelled at me that the bed was too high. She was nasty. Resident #103 continued the nurse told him when he gets home he can put the bed as high as he wants, on the roof if he'd like, but not at the facility. When asked if he felt it was verbal abuse, the resident stated no. When asked if he felt as if she treated him with dignity, Resident #103 stated, [ ] no. She came in yelling the bed was too high. She didn't care. she had an attitude. It wasn't very nice telling me to put my bed on the roof. When asked if he reported the event to anyone, Resident #103 explained the next morning when he went to therapy, the therapist asked him how his night was, so he told his therapist what happened. When asked how the therapist responded, Resident #103 stated, They told me I should mention it to someone. When asked if he mentioned it to anyone else, the resident stated no. During an interview on 07/11/24 at 3:38 PM, the Social Services Director denied any knowledge of the event, but agreed it was inappropriate. 3) Review of the record revealed Resident #35 was admitted to the facility on [DATE]. Review of the current MDS dated [DATE] documented a BIMS score of 13, indicating the resident had minimal cognitive impairment. This same MDS documented the resident had not exhibited any behaviors and required partial to total assistance for care. During an interview on 07/09/24 at 11:12 AM, when asked if staff treat him with respect and dignity, Resident #35 stated, A couple of the aides and a nurse are mean. When asked how they are mean, the resident gave an example that at times he doesn't want his blanket over him because it is too heavy, but they make me have the blanket. A heavy blanket was noted over his legs. Resident #35 was unable to give any other examples, but again stated that some of the staff were mean.

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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 policy review, record review, and interview, the facility failed to ensure complete and accurate documentation in the medical records for 3 of 28 sampled residents. The record lacked the refusal to utilize an anchor to prevent infections during the use of an indwelling urinary catheter for Resident #44; contained two orders for the use of the indwelling urinary catheter with two different sized catheters for Resident #44; lacked any documentation related to an observed dressing the left elbow of Resident #103, and lacked complete information related to an issue with a wound dressing for Resident #159. The findings included: Review of the policy titled, Nursing Documentation revised 08/10/23 documented, Medical Records . The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. 1) Review of the record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included Urinary Retention with Obstruction. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a scale of 0 to 15, indicating the resident was cognitively intact. This MDS also documented the use of an indwelling urinary catheter. Review of the record revealed two current orders for the use of an indwelling urinary catheter, one for the use of a size 18 catheter with a 10 cc (cubic centimeter, amount of fluid held) balloon, and the other for a size 20 catheter with a 30 cc balloon. The orders and care plan lacked any information related to the use of an anchoring device, which should be used to help prevent urinary tract infections. During an interview on 07/08/24 at 10:20 AM, Resident #44 stated he was going to the urologist later that day to get his indwelling urinary catheter removed. During an observation on 07/09/24 at 9:15 AM, Resident #44 was in bed and staff at his bedside. The drainage tubing for the urinary catheter was noted. During a subsequent interview on 07/10/24 at 12:03 PM, Resident #44 confirmed he went to the urologist the previous day, the indwelling catheter had been removed, but had to be reinserted. When asked if he had an anchor for the indwelling urinary catheter, Resident #44 responded, I don't like to wear that. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/24 at 2:38 PM, when asked about the anchor for the indwelling urinary catheter for Resident #44, the Second Floor Unit Manager stated there should be an order for the anchor and the resident should be wearing one. During an observation by the Unit Manager, Resident #44 did not have the anchor and stated he did not want the catheter tied down in any way. The Unit Manager agreed there should be documentation in the medical record regarding the anchor and or refusal. Further review of the record lacked any documentation related to the resident's refusal to wear the anchor, or education as to the risks versus the benefits. 2) Review of the record revealed Resident #103 was admitted to the facility on [DATE], with a readmission after a short hospital stay on 06/14/24. Review of the current MDS assessment dated [DATE] revealed a BIMS score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. This MDS documented the resident had a skin tear at that time. A progress note dated 06/18/24 by the Wound Care Nurse (WCN) documented the resident had a dry scab formation to his left elbow that was left open to air, or without a dressing. The progress notes and current orders lacked any documentation related to a current issue with the resident's left arm. During an observation on 07/08/24 at 10:43 AM, Resident #103 was in bed and a large gauze wrap was noted to the resident's left elbow. There was no documented date on that dressing. When asked about the dressing, the resident stated he thought there was some oozing or something, but he was unsure. Resident #103 denied any pain and no drainage was noted. On 07/09/24 at 9:24 AM, the same gauze wrap was noted to the resident's left elbow. When asked about the dressing, the resident stated he thought it was bruised and was oozing. There was still no drainage noted. During an interview on 07/11/24 at 1:52 PM, Staff B, Certified Nursing Assistant (CNA) stated the resident did not have any current dressing to his left arm, but she thought there had been one last week, but she was not sure. During an interview on 07/11/24 at 2:21 PM, Staff C, Registered Nurse (RN) explained there was some edema (swelling) and slight oozing to the resident's left elbow, and she thought the dressing had been applied by the Wound Care Nurse but was unsure. The RN stated she had removed the dressing the day before last, indicating on 07/09/24. When asked about the gauze wrap to the left arm of Resident #103 on 07/11/24 at 2:50 PM, the WCN was unaware of any issues or dressings. She reviewed the electronic record and found no documentation related to the elbow and or dressing. Upon observation of the resident at this time, there was no dressing noted and there appeared to be a small round area to the left elbow that had been open or draining but was closed and dry at that time. 3) Review of the record revealed Resident #159 was admitted to the facility on [DATE] with a diagnosis to include aftercare following joint replacement surgery. A current order dated 07/05/24 documented to monitor the left hip surgical site for signs and symptoms of infection. The record lacked any other current orders related to the hip surgery. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/08/24 at 3:02 PM, a wound VAC (machine attached to a wound that provides light suctioning to collect drainage) was noted disconnected from Resident #159 and had been set on the corner of the dresser. When asked why the VAC was not on the wound and or running, Resident #159 stated explained it had been placed by the surgeon during his hip replacement surgery, and he noticed it had stopped this past weekend, on Saturday. Resident #159 stated none of the staff knew what to do, so he called the phone number on the back of the machine. Resident #159 stated the VAC company explained it was scheduled to run for a certain amount of time and then turn off. The VAC company stated it was okay and ensured he had a scheduled follow up appointment with the surgeon. Resident #159 stated he was scheduled to see the surgeon on 07/09/24, the next day. Review of the record revealed a progress noted dated Sunday 07/07/24 at 12:47 PM by the direct care nurse that documented a lack of suctioning noted to the wound VAC. This note documented the wound VAC technical support was called and the nurse was informed the wound VAC was operating as per the intent. The note documented MD notified and made aware. MD stated, 'will see patient.' The note lacked which physician was notified and what care was to be provided regarding the VAC. The record lacked any additional orders at that time. The record lacked any notification to the surgeon. Further review of the record lacked any MD note from 07/07/24. A progress note dated 07/08/24 at 7:19 PM documented notification to the surgeon with interventions that it was OK to disconnect and additional wound dressing instructions. The record lacked any orders for the changes in care as per this MD notification. A progress note dated 07/09/24 at 8:16 AM documented, in part that as per Resident #159, the wound VAC stopped on Saturday 07/06/24, and that the resident had called the wound VAC company. The record lacked any interventions on Saturday. During an interview on 07/11/24 at 3:13 PM, the Weekend Supervisor stated to her knowledge, the VAC stopped on Sunday 07/07/24. The Supervisor agreed the resident had called the wound VAC company (unsure when) and the direct care nurse had also called the company. The Supervisor stated they had called both the attending physician who stated she would see the resident and also the answering service for the surgeon. The Supervisor stated the surgeon's office had told them it was OK that the VAC had stopped running and that they could either replace the wound VAC dressing with an OPT site dressing or leave the wound VAC dressing in place. This information was not documented in the progress notes of 07/07/24 nor was there an order for these interventions.