

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105921	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Gardens Court		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide care and services to prevent accidents for 4 of 4 sampled residents, as evidenced by failure to ensure Resident #111 had adequate supervision during transfer, failure to ensure Resident #70 had padded side rails and floor mats near the bed, failure to ensure Resident #121 had padded side rails, and failure to investigate an accident reported on Resident #85. The findings included: 1) Record review revealed Resident #111 was admitted to the facility on [DATE]. Review of the annual assessment dated [DATE] documented Resident #111 required substantial assistance with going from sitting to lying position, going from lying to sitting and transferring from bed to chair. Review of the medical diagnosis documented Resident #111 had a history of falls, muscle weakness, cognitive communication deficit, displaced fracture of left femur, and abnormal posture. During an observation on 01/05/26 at 10:56 AM, Resident #111 was noted lying in bed with his head elevated, with facial grimacing. His knees were bent inward towards his body, and he was holding on to the right-side rail with his right hand. The resident was asked if he was in pain. He pointed at his legs and said yes, both of my legs. When asked are you able to straighten out your legs he attempted to unbend his leg but couldn't. When asked do you get out of bed, Resident #111 stated Sometimes. During an observation on 01/05/26 at 11:00AM, Staff B, Certified Nursing Assistant (CNA) entered the resident's room and brought in a sit-to-stand mechanical lift, left it and returned shortly, informed the resident that she was going to get him out of bed and proceeded to get him dressed. She brought the mechanical lift closer to the bed and assisted the resident to a sitting position on the side of the bed. She grabbed his hands to place them on the bar of the lift and as he was having a difficult time sitting up, she stated You have to sit up. The resident started to lean backward, and his hands were letting go of the bar. She stated, You have to help me; you have to sit up. I need to get help. She left the room while the resident was sitting on the side of the bed and as he was trying to hold on to the bar the mechanical lift began to move because it was not locked. Staff B, CNA and Staff C, CNA entered the room, Staff B sat the resident up straight and they put a green sling around his back and attached it to the mechanical lift. Resident #111 began to lean to the left and fall backward, Staff B, CNA pushed him back up to a sitting position and said what's going on you have to sit up. Staff C, CNA lifted the lift slightly and told the resident, you have to stand up. The resident stated I can't. Staff C, CNA attempted to straighten his legs, but the resident was unable to. Resident #111 noted to have facial grimacing and stated, I can't do it. Staff C, CNA stated We can't use this lift with him maybe the hooyer lift. He used to be able to do this. Staff C let the lift down and the resident was placed in a sitting position on the side of the bed. Staff B and Staff C, CNA unattached the sling from the lift and the resident fell backwards on the bed with the sling underneath him. They repositioned the resident in the bed and removed the sling from underneath him and the mechanical lift was removed from the room. (continued on next page)		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/05/26 at 11:42 AM, Staff B, CNA, was asked if Resident #111 is usually transferred using the sit-to-stand lift, Staff C, CNA said yes. When asked are you assigned to him often, she stated, Not often. I'm a floater. Review of the care plan dated for Resident #111 did not reveal any documentation regarding the use of the sit-to-stand mechanical lift for transfer. Review of the physician orders for Resident #111 did not reveal any orders to use the sit-to- stand mechanical lift for transfer. Review of Kardex revealed documentation that Resident #111 is to be transferred with a mechanical lift sit-to-stand lift with 2-person assistance. During an interview on 01/07/26 at 09:06 AM with Staff A, Registered Nurse (RN), when asked are you familiar with Resident #111 and how he transfers, she stated, Yes. She was asked if she was aware of the situation that happened on 01/05/26 when the aides were attempting to transfer him with the sit to stand lift, she stated, Yes, the aides should have come and got me. I am sorry. 2) Record review revealed Resident #70 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] revealed Resident #70 required supervision with rolling from left to right in bed and she was dependent on transferring from the bed to chair. Review of medical diagnosis revealed Resident #70 had a history of Seizures and Dementia (memory loss). During an observation 01/05/26 at 11:40 AM, Resident #70 was noted lying in bed on her right side. The bed was raised in a high position. Bilateral floor mats were noted folded on top of each other on the right side of the bed near the wall. Review of a physician order dated 07/24/25 instructed staff to ensure Resident #70 had bilateral floor mats at the bedside. Review of a physician order dated 07/24/25, instructed staff to ensure Resident #70 had padded sided rails every shift for Seizure precaution. During an observation on 01/06/26 Resident #70's bed was noted without padding on the side rails. During an observation on 01/07/2026 at 8:29 AM Resident #70 was noted sleeping in bed. The bed was raised in high position. There was no padding on the side rails. Bilateral floor mats noted folded against the wall on both sides of the bed. During an observation on 01/07/2026 at 11:36 AM, Resident #70 was noted lying in bed lying on her right-side with the bed raised in high position. No padding was noted on the side rails. Bilateral floor mats were observed folded against the wall. During an interview on 01/07/2026 at 11:50 AM, Staff A, RN was asked do you have any residents with padded side rails, she stated Let me check. She proceeded to go up and down the hall checking the resident's room on the 323-334 hall. Staff A and the surveyor entered Resident #70's room. Bilateral floor mats were folded against the wall, bed was in high position, no padding was on the side rails. Staff A, RN was asked if the floor mats were supposed to be near the bed, she stated, That was needed for her in the past, because she used to move around a lot, but she doesn't move around as (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	much anymore. At that time, Staff A, RN was made aware that the residents still had an order to have the floor mats. She then placed the mats down on the floor near the resident's bed and left the room. She went to the UM (Unit Manger) and asked, Do you know where the padding for the side rails is kept, the surveyor needs to see them. Staff, D, the UM, went to the storage closet and showed a light blue rectangle shaped pad. She stated, this is the one and there is another kind as well, that I use for the residents on my unit. When asked if a resident had an order for them does the padding stay on the bed, she stated Yes, they shouldn't take them off unless they are transferring the resident, but then they should be put back on. 3) Record review revealed Resident #121 was readmitted to the facility on [DATE]. Review of medical diagnosis revealed Resident #121 had a documented history of muscle weakness and Dementia (memory loss). Review of a physician order dated 07/08/25, staff were instructed to ensure Resident #121 had padded side rails every shift for preventative treatment. Review of a progress noted dated 07/04/25, revealed documentation that Resident #121 sustained a skin tear to his left lateral wrist. The resident said he thinks he hit his arm on the side rail on the bed. During an observation on 01/06/26 at 9:52 AM, Resident #121's bed was noted without padding on the side rails. Review of the January Treatment Administration Record (TAR) for Resident #121 revealed staff signed to acknowledge that the side rails were padded. During an observation on 01/07/26 at 08:32 AM, Resident #121s bed noted without padding on the side rails. During an interview on 01/07/2026 at 09:20 AM, when asked if there were any special safety precautions used for Resident #121 while in bed, Staff D, Certified Nursing Assistant (CNA) asked, Do you mean as far as side rail? Yes, I make sure they are up and I put the bedside table in front of him. 4) Review of the facility policy titled, Incident and Reportable Event Management revised 09/23/25, documented in part, Definitions: Event Management includes, but is not limited to, the following types of events: . Transfer Injury . The Five I's to Event Management: . If an event occurs, the facility will follow the 5 I's in an effort to minimize the potential for recurrence. 1. Incident (what happened or was reported as happening) 2. Injury (provide care and document the injury) 3. Interview (who saw the resident last or at the time of the event) 4. Investigate (why did it happen) 5. Intervention (what mitigation effort are we using). This policy further describes the process to investigate an event to include interview by the licensed nurse to obtain as much information as possible, and an investigation by the nurse and interdisciplinary team (IDT). Review of the record revealed Resident #85 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], the assessment prior to the event of 10/05/25, documented Resident #85 was totally dependent upon staff for bed mobility and transfers. A progress note dated Tuesday 10/07/25 at 3:06 PM written by the direct care nurse, documented the daughter of Resident #85 told the nurse that while being transferred on Sunday (10/05/25), the resident hit her left leg and was now complaining of pain. This note documented the physician was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified and an order for an x-ray of the left leg was received. Further review of the record revealed the order for the left leg x-ray was entered into the electronic medical record (EMR) on 10/07/25 at 7:15 PM by the Evening Supervisor. Review of this x-ray revealed Resident #85 had acute nondisplaced fractures of the proximal tibia and fibula. During an interview on 01/08/26 at 1:52 PM, when asked about the fracture sustained by Resident #85, the Director of Nursing (DON) explained that she spoke with the daughter after the identification of the fracture, and she confirmed her mother did not sustain a fall and reported that her mother felt the pain when her legs were placed on the air mattress. The DON stated they had determined the fractures were pathological in nature due to the presence of osteopenia. During a side-by-side review of the record, when shown the progress note that documented the daughter had reported to the direct care nurse that her mother had pain after a transfer, the DON stated she was not aware of that note or event, that the direct care nurse should have reported that event, and that there should have been an incident report. During an interview on 01/08/26 at 3:15 PM when asked if she was told the daughter of Resident #85 reported on 10/07/25 that the resident had pain after a transfer on 10/05/25, the Second Floor Unit Manager stated she had not been notified. When asked if they should have completed an incident report to look into the transfer, the Unit Manager stated she thought so, but that it may not have been done as there was no fall or injury at that time. When asked if an incident report had been completed for Resident #85 around or after the time of the event, the Unit Manager looked in the EMR and stated there was none. During an interview on 01/08/26 at 3:40 PM, when asked if she was informed the daughter of Resident #85 reported on 10/07/25 pain after staff transferred her mother the previous Sunday, the Evening Supervisor stated she did not. When asked if she would expect to be told and or expect the direct care nurse to do an incident report the Evening Supervisor stated she would. Upon review of the record, the Evening Supervisor noted she herself had entered the x-ray for Resident #85 into the EMR. The Evening Supervisor stated she only recalled a concern with the resident's feet being swollen and she ended up in the hospital. During an interview on 01/08/26 at 4:13 PM, when asked if a family member tells a nurse her mother hit her legs while being transferred and was now in pain, would you expect an incident report be completed, the Risk Manager stated, Of course. The Risk Manager agreed the incident with the transfer should have been investigated. The Risk Manager stated she would have investigated had she known. The Risk Manager stated she recalled asking staff if Resident #85 fell or something, and the staff stated she hadn't hurt herself. The Risk Manager stated she was unaware of the progress note for Resident #85 dated 10/07/25 or she would have completed an incident report and investigation herself.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide care and services to prevent electrolyte imbalance as evidenced by ensuring Resident #14 had adequate hydration, for 1 of 1 sampled resident reviewed for hydration. The findings included: Record review revealed Resident #14 was readmitted to the facility on [DATE]. Review of medical diagnosis revealed Resident #14 had a history of dysphagia (difficulty swallowing) following cerebral infarction (stroke), gastrostomy (feeding tube), dementia (memory loss). Review of the care plan dated 11/29/25 documented a focus that Resident #14 required tube feeding related to dysphagia with a goal that she will remain free of side effects or complications related to tube feeding with the interventions that Resident #14 is dependent on staff for tube feeding and water flushes. A second focus documented Resident #14 was at risk for dehydration or potential fluid deficit related to the resident readmitted with feeding tube with a goal that the resident will be free of symptoms of dehydration. During an observation on 01/06/26 at 9:10AM, Resident #14 noted lying in bed on her right side with her head elevated. There was a pole with a feeding pump attached, which had a bottle of light brown formula that had approximately 260 ml (milliliters) remaining with a label dated 01/05/26 at 2:00 PM and a clear bag with clear liquid with approximately 1200 ml in it, with a label dated 01/05/26 at 2:00 PM, hanging on the pole. The tubing connected to both were connected to the resident. The settings on the pump read the feeding was at a continuous rate of 50 ml per hour and the total feed infused was 809 ml. During an interview on 01/06/26 at 9:20 AM, Staff A, Registered Nurse (RN) was called into Resident #14's room and was asked what is the flush setting. Staff A pushed the show flush button on the pump, and the setting was noted to be at 15 ml every hour. She stated, it says 15 ml an hour, but it should be 150 ml every shift. At that time, Staff A, RN reset the pump to 150 ml every 8hours with next flush to be administered in 448 mins.Review of a physician order dated 12/08/25, stated the staff was instructed to provide 150 ml water every 8 hours via pump.During an interview on 01/06/26 at 9:32 AM, the Director of Nursing (DON) was made aware that the settings on the feeding pump were not set properly and there was concern that the resident had not received any flush. At that time, she called the Dietitian to come to the third floor. The Dietician arrived and the DON told her that there was an issue with Resident #14's flush settings. The Dietitian, DON and surveyor went to the resident's room and Staff A, RN went into the room as well. The bag of the liquid in the clear bag was still hanging with approximately 1200 mls in it. The DON stated this is a newer pump and she was not sure how to see the history. The Surveyor pressed on the menu and chose view history. The history was reviewed by the surveyor, Dietitian, DON, and Staff A, RN, and it was noted that, according to the pump, 0 flush was received by the resident for the past 3 days. The DON stated she will get an order for STAT labs to make sure the resident is not dehydrated. Review of January's Medication Administration Record (MAR) for Resident #14 revealed staff signed acknowledging that 150 ml of water was administered via pump every shift.Review of a physician order dated 01/06/26 revealed blood work was ordered (STAT CBC CMP) for Resident #14.Review of the CBC CMP lab results dated 01/06/25 revealed Resident #14 had an electrolyte imbalance and elevated liver enzymes. Lab results from 01/06/2026 were: Sodium 155 (137-145); Potassium 3.3 (3.5-5.1); Chloride 118 (98-107); BUN 38 (9.0-20.0); BUN/Creat 57 (10-20); ALT 168 (<=150); and AST 119 (17-59). During an interview on 01/07/26 at 8:27AM, Staff A, RN stated she made sure the flush is still set correctly on Resident #14 pump.During an observation on 01/07/26 at 8:35 AM, it was noted that 480 ml of flush had been infused since 01/06/26. Review of physician orders dated 01/07/25 instructed staff to administer Resident #14 bolus 250 ml of purified water via peg tube (feeding tube) every shift until 01/08/2026 23:59; and instructed state to administer Resident #14, potassium chloride Liquid 20 MEQ/15ML (10%) give 20 mEq via g-tube one time a day for hypokalemia (low potassium).Review of another physician order dated 01/08/26, revealed a portable upper abdominal liver ultrasound was ordered for Resident #14.		