

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 93105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety Re-licensure survey was conducted on 04/30/2025 at Palm Garden of Vero Beach, a nursing home in Vero Beach, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C.) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K 000		
K 222 SS=D	NFPA 101 Egress Doors Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 18/19.2.2.2.5 shall be permitted. (2) Delayed-egress electrical locking systems complying with 7.2.1.6.1 shall be permitted. (3) Sensor-release of electrical locking systems complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.4 shall be permitted. (5) Approved existing door-locking installations shall be permitted. 18.2.2.2.4 through 18.2.2.2.7, 19.2.2.2.4 through 19.2.2.2.7 This Statute or Rule is not met as evidenced by:	K 222		5/24/25

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Electronically Signed

05/16/25

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K 222	<p>Continued From page 1</p> <p>Based on observations and staff interview, the facility failed to maintain egress doors equipped with special locking arrangements in accordance with NFPA 101, for 5 of 16 sampled special locking arrangement egress doors.</p> <p>The findings included:</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician, the following was observed:</p> <ol style="list-style-type: none"> At 11:36 AM, the Main Entrance electronic access-controlled double horizontal sliding exit doors, right leaf failed to break away when tested. At 11:40 AM, the Reception interior-egress door equipped with a delayed egress locking arrangement was missing the required signage. At 11:48 AM, the smoke doors equipped with a delayed egress locking arrangement, near Room 106, did not have the required signage. The delayed egress locks could not be tested at the time of the survey. At 3:05 PM, the corridor doors leading to laundry equipped with a delayed egress locking arrangement were missing the required signage and automatically reset when tested. At 4:16 PM, the Physical Therapy exit door, equipped with a delayed egress locking arrangement, required more than fifteen pounds of force to open the door. The threshold was rubbing on the bottom of the door. <p>An interview was conducted with the Plant Operations Technician concurrently with the</p>	K 222	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated on K222 on 05/16/2025 by the Executive Director.</p> <p>The maintenance director/designee completed the following corrections to the delayed egress doors:</p> <ol style="list-style-type: none"> The Main Entrance electronic access-controlled double horizontal sliding exit doors was inspected on 05/16/25 and the center obtained a quote to repair the lock on the door. The lock will be repaired by 05/24/2025. There is an existing fire exit on the left side of the door as of 05/16/2025. The Reception interior-egress door has signage added to include the egress time on 05/22/2025. The smoke doors equipped with a delayed egress locking arrangement, near Room 106 had the signage added to the doors on 05/22/2025. The maglock was inspected on 05/16/2025 by a vendor to re-engage the maglock and the egress door will be able to show functionality by 05/24/2025. The corridor doors leading to laundry equipped with a delayed egress locking arrangement had the correct signage installed on 05/22/2025 and the reset was inspected by a vendor on 05/16/2025 for proper functionality. 	
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K 222	Continued From page 2 observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 101 (2021 Edition) 7.1.9, 7.2.1.6.1.1(3)(a, d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.4(2) Photographic Evidence Obtained. Class III	K 222	5. The Physical Therapy exit door, equipped with a delayed egress locking arrangement was corrected to open with less than 15 pounds of pressure on 05/15/2025. Delayed egress doors will be audited for proper functioning related to signage, breakaway, pressure and resetting weekly x4 weeks and monthly x6 months. The repair reports and audits will be brought to QAPI on 05/21/2025 for review.	
K 223 SS=D	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure (except boiler rooms, heater rooms, and mechanical equipment rooms) shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 18.2.2.2.8, 19.2.2.2.8, 7.2.1.8.2 This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain doors with self-closing devices, in accordance with NFPA 101, for 8 of 29 sampled doors with self-closing devices. The findings included:	K 223	No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025. The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K223.	5/24/25

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K 223	<p>Continued From page 3</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician/ Director of Plant Operations, the following was observed:</p> <ol style="list-style-type: none"> At 1:22 PM, the Beauty Supply Room 45-minute fire door, open to the corridor, was missing the door closer. At 1:23 PM, the Culinary Director Office door, open to the corridor, was missing the door closer and was held open with a magnet that was not tied into the fire alarm system. At 4:01 PM, the Social Services Office door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:06 PM, the Director of Utilization Office door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:14 PM, the Physical Therapy door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:25 PM, the Seaway Wing Office 90-minute fire rated door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:27 PM, the Seaway Wing Clinical Services 45-minute fire rated door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 5:00 PM, the Life Enrichment Dining Room door, open to the corridor, was missing the door 	K 223	<ol style="list-style-type: none"> The Beauty Supply Room 45- minute fire door, open to the corridor was repaired and a closer was added on 05/16/2025. The Culinary Director Office door, open to the corridor, had a closer added and the magnet was removed from the door frame on 05/16/2025. The Social Services Office door, open to the corridor, had the magnet removed on 05/16/2025. The Director of Utilization Office door, open to the corridor, had the magnet removed on 05/16/2025. The Physical Therapy door, open to the corridor, had the magnet removed on 05/16/2025. The Seaway Wing Office 90- minute fire rated door, open to the corridor, the magnet was removed on 05/16/2025. The Seaway Wing Clinical Services 45-minute fire rated door, open to the corridor, the magnet was removed on 05/16/2025. The Life Enrichment Dining Room door, open to the corridor, had a door closer installed on 05/16/2025. <p>Doors with self closing devices will be audited weekly x4 weeks and monthly x6 months.</p> <p>The repair reports and audits will be</p>	

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K 223	Continued From page 4 closer. An interview was conducted with the Plant Operations Technician/ Director of Plant Operations concurrently with the observations and they acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 1 (2021 Edition) 14.5.4.1 NFPA 101 (2021 Edition) 2.1, 4.6.12.1, 19.1.1.1.3, 19.2.2.2.8 Photographic Evidence Obtained. Class III	K 223	brought to QAPI on 05/21/2025 for review.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. 19.7.6, 4.6.12, 4.6.12.1, 9.11 through 9.11.3.2, and NFPA 25 This Statute or Rule is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to maintain their Automatic Fire Sprinkler System (AFSS) in accordance with NFPA 101, for 1 of 1 sampled AFSSs.	K 353	No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025. The maintenance director and assistants	5/24/25

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K 353	<p>Continued From page 5</p> <p>The findings included:</p> <p>On 04/30/2025, between 10:30 AM and 4:00 PM, during record with the Director of Plant Operations, it was revealed that the annual AFSS inspection, dated 02/17/2025, had deficiencies for the water flow not reporting to the fire panel. No documentation was provided showing that the deficiency was repaired.</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician/ Director of Plant Operations, the following was observed:</p> <ol style="list-style-type: none"> At 12:53 PM, above the ceiling of the Reflections Nurses Station, there was a white wire laying on top of the AFSS piping. At 12:57 PM, the Reflections Television Cable Room had 1 of 1 loaded fire sprinkler heads. Paint was visible on the deflector. Between 1:10 PM and 1:15 PM, the Kitchen had 2 of 3 loaded dry sprinkler heads in the walk-in coolers. At 1:20 PM, the Beauty Supply Room had 1 of 2 loaded fire sprinkler heads. At 3:13 PM, the Phone Room, in the Laundry corridor, had a sprinkler inside which was surrounded by a ceiling that was not maintained. The ceiling had multiple seams which were open to the interstitial space above. Between 3:20 PM and 3:25 PM, the Fire Riser Room, in the Laundry corridor, had a red tag attached to the riser which stated that the water 	K 353	<p>were educated by the Executive Director on 05/16/2025 on K353.</p> <ol style="list-style-type: none"> Above the ceiling of the Reflections Nurses Station, the wire was removed on 05/16/2025 maintenance director/designee. Dynafire was notified to replace the Reflections Television Cable Room had 1 of 1 loaded fire sprinkler heads on 05/16/2025 maintenance director/designee. Kitchen 2 of 3 loaded dry sprinkler heads in the walk-in coolers were cleaned on 05/15/2025 by the maintenance director/designee. Dynafire was notified to replace the Beauty Supply Room loaded sprinkler head on 05/16/2025 maintenance director/designee. The Phone Room, in the Laundry corridor will have the ceiling repaired by 05/24/2025 by the maintenance director/designee. The Fire Riser Room, in the Laundry corridor, was inspected by Dynafire before 05/24/2025 and the red tag was removed by Dynafire. The sprinkler wrench was ordered from Dynafire on 05/15/2025. The hydraulic sign on will have a repair estimate by 05/24/25 to make the sign legible. The Seaway Wing, near Room 206, had the insulation removed from the on 	

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K 353	<p>Continued From page 6</p> <p>flow was not reporting to the fire panel. The hydraulic design calculation sign was illegible. Also, the spare sprinkler box was missing a spare concealed sprinkler wrench.</p> <p>7. At 3:56 PM, the Seaway Wing, near Room 206, had insulation on top of the sprinkler piping.</p> <p>8. At 4:20 PM, the Physical Therapy Riser Room spare sprinkler head box was missing a list of the spare fire sprinkler heads with the following: description of spare heads, number of spare heads in the box, manufacturer, model, orifice, deflector type, thermal sensitivity, and pressure rating, and issue or revision date of the list.</p> <p>9. At 4:56 PM, the Independent Wing Riser Room had a hydraulic design sign that was illegible.</p> <p>An interview was conducted with the Director of Plant Operations concurrently with the record review and the Plant Operations Technician/ Director of Plant Operations concurrently with the observations and they acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM.</p> <p>NFPA 1 (2021 Edition) 13.3.1.2, 13.3.3.3 NFPA 13 (2019 Edition) 17.1.3.1, 31.1 NFPA 25 (2020 Edition) 4.3.1, 5.1.1.2, 5.2.1.1.1, 5.2.8, 5.4.1.5.1, 5.4.1.5.5, 5.4.1.5.6, 5.4.1.5.6.1, 13.1.1.2, 13.2.4, 13.2.5.2, 14.2, 14.2.1.1 NFPA 101 (2021 Edition) 2.1, 4.6.12, 9.7.1.1, 19.3.5, 19.7.6</p> <p>Photographic Evidence Obtained.</p> <p>Class III</p>	K 353	<p>top of the sprinkler pipe by the maintenance director/designee.</p> <p>8. The Physical Therapy Riser Room spare sprinkler head box had a list of all of the required items posted on the wall next to the box at the time of survey. The list is posted as it does not fit inside the box.</p> <p>9. The Independent Wing Riser Room hydraulic sign was inspected by Dynafire and the center has contacted the original manufacturer Brown, on 05/13/25. The original data is unable to be retrieved. Dynafire is unable to update the data as of 05/13/25. The center will have the repair estimates to replace the signage by 05/24/25 for the Independence and Laundry corridor signs. This was completed by the maintenance director/designee.</p> <p>Sprinkler heads, ceilings surrounding sprinkler heads, fire riser rooms and sprinkler piping and hydraulic signs will be audited weekly x4 weeks and monthly x6 months for compliance with K353 maintenance director/designee.</p> <p>The results of these audits and any necessary repairs be brought to QAPI for review.</p>	

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K 355	Continued From page 7	K 355		
K 355 SS=F	<p>NFPA 101 Portable Fire Extinguishers</p> <p>Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, 9.9, and NFPA 10</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to install and maintain portable fire extinguishers in accordance with NFPA 101, for 1 of 1 telecommunication equipment rooms.</p> <p>The findings included:</p> <p>On 04/30/2025, at 1:18 PM, during the fire safety tour of the facility with Plant Operations Technician, it was observed that the Telecommunication Equipment Room, located next to the Culinary Director's Office, did not have a clean agent fire extinguisher.</p> <p>An interview was conducted with the Plant Operations Technician concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM.</p> <p>NFPA 10 (2018 Edition) 5.3.2.6, 5.5.6, 5.5.6.1 NFPA 99 (2021 Edition) 16.10.1, 16.10.1.5 NFPA 101 (2021 Edition) 9.9, 19.3.5.12</p> <p>Class III</p>	K 355	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K355.</p> <p>The telecommunication Equipment Room, located next to the Culinary Director's Office, had a clean agent fire extinguisher ordered on 05/16/2025 by the maintenance director/designee.</p> <p>Fire extinguishers will be audited weekly x4 weeks and monthly x6 months for compliance with K355 by the maintenance director/designee by the maintenance director/designee.</p>	5/24/25
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 372		5/24/25

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K 372	<p>Continued From page 8</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction</p> <p>2021 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3 through 19.3.7.5.2, 8.5</p> <p>2021 NEW Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, in which case both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2) Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems. (3) The provisions of 8.5.6.5 and 8.5.7.2 shall not apply. 18.3.7.3 through 18.8.7.5.2, 8.5</p> <p>For other than existing assemblies, where there is an accessible concealed floor, floor/ceiling, or attic space, fire barriers, smoke barriers, and</p>	K 372		

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K 372	<p>Continued From page 9</p> <p>smoke partitions shall be permanently identified with signs or stenciling in the concealed space and shall comply with all of the following:</p> <ul style="list-style-type: none"> " (1) Be located in accessible concealed floor, floor/ceiling, or attic spaces. " (2) Be located within 15 ft (4572 mm) of the end of each wall and at intervals not exceeding 30 ft (9144 mm) measured horizontally along the wall or partition. " (3) Include lettering not less than 3 in. (76 mm) in height with a minimum 3/8 in. (9.5 mm) stroke in a contrasting color. " (4) Identify the wall type and its fire resistance rating, as applicable. <p>8.2.2.5</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain their fire/smoke barrier construction in accordance with NFPA 101, for 3 of 3 sampled fire/smoke barriers.</p> <p>The findings included:</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician, the following was observed:</p> <ol style="list-style-type: none"> 1. At 12:03 PM, the Reflection Wing 1-hour smoke wall, near Room 106, had five penetrations above the ceiling. 2. At 12:10 PM, the Reflection Wing 1-hour smoke wall, near Room 104, had three penetrations above the ceiling. 3. At 3:47 PM, the Seaway Wing 2-hour fire rated wall, near Room 206, had four penetrations 	K 372	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K372.</p> <p>The center smoke walls were inspected above the ceilings throughout the center on 05/16/2025 to identify any other penetrations needing to be sealed by the maintenance director/designee.</p> <ol style="list-style-type: none"> 1. The Reflection Wing 1-hour smoke wall, near Room 106, had the five penetrations above the ceiling repaired on 05/20/25 by the maintenance director/designee. 2. The Reflection Wing 1-hour smoke wall, near Room 104, had the three penetrations above the ceiling repaired 	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 93105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 05 - MAIN LIC B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 372	Continued From page 10 above the ceiling. An interview was conducted with the Plant Operations Technician concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NOTE: These examples are not to be considered as the only unprotected penetration of the facility's fire/smoke barriers. A thorough inspection of each barrier shall be made along its full length and height to ensure that all penetrations are found and properly sealed. It is required that every breach (penetration) of a fire barrier be appropriately repaired and the wall, ceiling, floor above or below brought back to its original fire or smoke rated integrity. This is essential to restrict the movement of fire and smoke and to ensure the safety of occupants within the facility in a fire emergency. The penetrations in fire rated barriers shall be sealed with a UL (Underwriters Laboratories) listed approved system. NFPA 101 (2021 Edition) 4.6.12.1, 8.3.4, 8.3.4.2.1, 8.4.4, 8.4.6.2, 8.5.5.2, 8.5.5.4.1, 8.5.5.4.2, 8.5.6.2, 19.1.1.1.3, 19.3.7.5, 19.7.6 Photographic Evidence Obtained. Class III	K 372	05/20/25 by the maintenance director/designee. 3. The Seaway Wing 2-hour fire rated wall, near Room 206, had the four penetrations above the ceiling repaired 05/20/25 by the maintenance director/designee. Fire penetrations above the ceiling will audited for compliance with K372 by the maintenance director/designee weekly x4 weeks, monthly x6 months and the results of these audits will be brought to QAPI for review.	
K 741 SS=F	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:	K 741		5/24/25

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K 741	<p>Continued From page 11</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18/19.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 (Note smoking tower disposal receptacles are not ashtrays)</p> <p>This Statute or Rule is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain their smoking area in accordance with NFPA 101, for 1 of 1 smoking area.</p> <p>The findings included:</p> <p>On 04/30/2025, at 4:43 PM, during the fire safety tour of the facility with the Director of Plant Operations, it was observed that the Smoking Area, near Room 349, did not have a metal container with a self-closing lid, for ashtrays to be</p>	K 741	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K741.</p> <p>The smoking equipment was removed on 05/16/2025 by the maintenance director/designee as the center is a smoke free facility with no residents who smoke</p>	

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NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960		
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K 741	Continued From page 12 emptied, and there was no ashtray of a safe, noncombustible design. An interview was conducted with the Director of Plant Operations concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 101 (2021 Edition) 19.7.4 (5-6) Class III	K 741	living in it. The center will maintain the smoke free policy. Any changes in this policy would be brought to the QAPI committee for review.	
K 761 SS=F	NFPA 101 Maintenance Inspection & Testing - Doors Fire door assemblies shall be installed, inspected, tested, and maintained in accordance with NFPA 80. All fire door assemblies shall be labeled. Labels on fire door assemblies shall be maintained in a legible condition. In existing installations, steel door frames without a label shall be permitted where approved by the authority having jurisdiction. Unless otherwise specified, fire doors shall be self-closing or automatic-closing. Doors, other than those listed in 8.2.2.4 and 8.3.3.1, that are required to be self-closing or automatic closing shall comply with all of the following: (1) Door assemblies shall be inspected annually. (2) Doors shall be operated to confirm full closure. (3) Parts found to be damaged or inoperative shall be replaced. (4) Door openings and the surrounding areas shall be kept clear of anything that could obstruct	K 761		5/24/25

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K 761	<p>Continued From page 13</p> <p>or interfere with the free operation of the door.</p> <p>(5) Blocking or wedging of doors in the open position shall be prohibited.</p> <p>(6) Self-closing and automatic-closing devices shall be kept in working condition at all times.</p> <p>Written records of inspection and testing are maintained and are available for review. 19.7.6, 4.6.12.1, 8.3.3.3 through 8.3.3.3.5, 8.5.4.3, 8.5.4, 8.7.1.3, 8.8 (NFPA 101) 5.2, 5.2.3 (NFPA 80)</p> <p>This Statute or Rule is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to inspect and maintain its fire doors in accordance with NFPA 101, for 7 of 7 sampled fire rated attic access doors.</p> <p>The findings included:</p> <p>On 04/30/2025, at 12:22 PM, during the fire safety tour of the facility with the Plant Operations Technician, it was observed that the facility had fire rated attic access doors. The Plant Operations Technician was not sure if these doors were being inspected and tested as part of the annual fire door inspection.</p> <p>On 04/30/2025, between 10:30 AM and 4:00 PM, during record with the Director of Plant Operations, it was revealed that the facility's annual fire door inspection, dated 04/10/2025, did not include their fire rated attic access doors.</p> <p>An interview was conducted with the Plant Operations Technician concurrently with the observations and the Director of Plant Operations concurrently with the record review and they acknowledged the findings. The findings were</p>	K 761	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K761.</p> <p>The attic fire doors were inspected by the maintenance director/designee on 05/20/2025. No concerns were identified. The result of the inspection was brought to QAPI on 05/21/2025.</p> <p>Attic fire doors will be inspected annually per K761 by the maintenance director/designee and the results of the inspection will be brought to QAPI for review.</p>	

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K 761	Continued From page 14 explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 1 (2021 Edition) 12.4.1, 12.4.2.8.4.1, 12.4.2.11.1 NFPA 80 (2019 Edition) 5.2, 5.2.3, 5.2.3.5.1, 5.2.3.7.1, 5.2.4, 5.2.4.1, 5.2.4.2 NFPA 101 (2021 Edition) 4.6.12, 8.3.3.1, 19.1.1.1.3, 19.7.6 NFPA 105 (2019 Edition) 4.1, 4.53, 5.2, 5.2.1(1), 5.2.2.4, 5.2.4, 5.2.4.4.2, 5.2.5.1 Photographic Evidence Obtained. Class III	K 761		
K1150 SS=F	NFPA 99 (2021 Edition) Security Management This chapter shall apply to new and existing health care facilities. A health care facility shall have a security management plan. The scope, objectives, performance, and effectiveness of the security plan shall be tested at a frequency shown to be necessary by review of the security vulnerability assessment (SVA) in accordance with Section 13.3. NFPA 99 This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain their security management plan in accordance with NFPA 99, for 1 of 1 security vulnerability assessment. The findings included: On 04/30/2025, between 10:30 AM and 4:00 PM,	K1150	No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025. The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K1150.	5/24/25

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K1150	<p>Continued From page 15</p> <p>during record review with the Director of Plant Operations, the facility failed to provide documentation that it conducted an annual security vulnerability assessment. The last security vulnerability assessment that was provided was dated 01/25/2023.</p> <p>An interview was conducted with the Director of Plant Operations concurrently with the record review and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM.</p> <p>NFPA 99 (2021 Edition) 13.3</p> <p>Class III</p>	K1150	<p>The annual security vulnerability assessment was completed on 05/15/25 by the Executive Director. The assessment was brought to QAPI on 05/21/25 for review.</p> <p>The security vulnerability assessment will be reviewed annually per K1150 by the Executive Director and QAPI Committee.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960	
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K 000	<p>INITIAL COMMENTS</p> <p>An unannounced Fire & Life Safety Recertification survey was conducted on 04/30/2025 at Palm Garden of Vero Beach, a nursing home in Vero Beach, Florida. Palm Garden of Vero Beach is not in compliance with 42 CFR 483 Subpart B, 42 CFR 488.307, and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes.</p> <p>Initial Plan Review: 1987 Existing NFPA 220 Construction Type: III (211) Number of beds: 189 Census: 162</p> <p>The following is a description of the noncompliance.</p>	K 000		
K 222 SS=D	<p>Egress Doors CFR(s): NFPA 101</p> <p>Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p>	K 222		5/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/16/2025

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.

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K 222	<p>Continued From page 1</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire</p>	K 222		

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K 222	<p>Continued From page 2</p> <p>detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain egress doors equipped with special locking arrangements in accordance with NFPA 101, for 5 of 16 sampled special locking arrangement egress doors.</p> <p>The findings included:</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician, the following was observed:</p> <ol style="list-style-type: none"> At 11:36 AM, the Main Entrance electronic access-controlled double horizontal sliding exit doors' right leaf failed to break away when tested. At 11:40 AM, the Reception interior-egress door equipped with a delayed egress locking arrangement was missing the required signage. At 11:48 AM, the smoke doors equipped with a delayed egress locking arrangement, near Room 106, did not have the required signage. The delayed egress locks could not be tested at the time of the survey. At 3:05 PM, the corridor doors leading to laundry equipped with a delayed egress locking arrangement were missing the required signage and automatically reset when tested. At 4:16 PM, the Physical Therapy exit door, equipped with a delayed egress locking 	K 222	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated on K222 on 05/16/2025 by the Executive Director.</p> <p>The maintenance director/designee completed the following corrections to the delayed egress doors:</p> <ol style="list-style-type: none"> The Main Entrance electronic access-controlled double horizontal sliding exit doors was inspected on 05/16/25 and the center obtained a quote to repair the lock on the door. The lock will be repaired by 05/24/2025. There is an existing fire exit on the left side of the door as of 05/16/2025. The Reception interior-egress door has signage added to include the egress time on 05/22/2025. The smoke doors equipped with a delayed egress locking arrangement, near Room 106 had the signage added to the doors on 05/22/2025. The maglock was inspected on 05/16/2025 by a vendor to re-engage the maglock and the egress door will be able to show functionality by 05/24/2025. 	

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K 222	Continued From page 3 arrangement, required more than fifteen pounds of force to open the door. The threshold was rubbing on the bottom of the door. An interview was conducted with the Plant Operations Technician concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 101 (2012 Edition) 7.1.9, 7.2.1.6.1.1(3)(a, d), 7.2.1.6.1.1(4)(a), 19.2.1, 19.2.2.2.4(2) Photographic Evidence Obtained.	K 222	4. The corridor doors leading to laundry equipped with a delayed egress locking arrangement had the correct signage installed on 05/22/2025 and the reset was inspected by a vendor on 05/16/2025 for proper functionality. 5. The Physical Therapy exit door, equipped with a delayed egress locking arrangement was corrected to open with less than 15 pounds of pressure on 05/15/2025. Delayed egress doors will be audited for proper functioning related to signage, breakaway, pressure and resetting weekly x4 weeks and monthly x6 months. The repair reports and audits will be brought to QAPI on 05/21/2025 for review.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power.	K 223		5/24/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	<p>Continued From page 4</p> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interview, the facility failed to maintain doors with self-closing devices, in accordance with NFPA 101, for 8 of 29 sampled doors with self-closing devices.</p> <p>The findings included:</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician / Director of Plant Operations, the following was observed:</p> <ol style="list-style-type: none"> At 1:22 PM, the Beauty Supply Room 45-minute fire door, open to the corridor, was missing the door closer. At 1:23 PM, the Culinary Director Office door, open to the corridor, was missing the door closer and was held open with a magnet that was not tied into the fire alarm system. At 4:01 PM, the Social Services Office door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:06 PM, the Director of Utilization Office door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:14 PM, the Physical Therapy door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. At 4:25 PM, the Seaway Wing Office 90-minute 	K 223	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K223.</p> <ol style="list-style-type: none"> The Beauty Supply Room 45- minute fire door, open to the corridor was repaired and a closer was added on 05/16/2025. The Culinary Director Office door, open to the corridor, had a closer added and the magnet was removed from the door frame on 05/16/2025. The Social Services Office door, open to the corridor, had the magnet removed on 05/16/2025. The Director of Utilization Office door, open to the corridor, had the magnet removed on 05/16/2025. The Physical Therapy door, open to the corridor, had the magnet removed on 05/16/2025. The Seaway Wing Office 90- minute fire rated door, open to the corridor, the magnet was removed on 05/16/2025. The Seaway Wing Clinical Services 	

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K 223	Continued From page 5 fire rated door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. 7. At 4:27 PM, the Seaway Wing Clinical Services 45-minute fire rated door, open to the corridor, had a magnet holding it open which was not connected to the fire alarm panel. 8. At 5:00 PM, the Life Enrichment Dining Room door, open to the corridor, was missing the door closer. An interview was conducted with the Plant Operations Technician / Director of Plant Operations concurrently with the observations and they acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 101 (2012 Edition) 2.1, 4.6.12.1, 19.1.1.1.3, 19.2.2.2.7, 19.2.2.2.8 Photographic Evidence Obtained.	K 223	45-minute fire rated door, open to the corridor, the magnet was removed on 05/16/2025. 8. The Life Enrichment Dining Room door, open to the corridor, had a door closer installed on 05/16/2025. Doors with self closing devices will be audited weekly x4 weeks and monthly x6 months. The repair reports and audits will be brought to QAPI on 05/21/2025 for review.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		5/24/25

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K 353	<p>Continued From page 6</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to maintain their Automatic Fire Sprinkler System (AFSS) in accordance with NFPA 101, for 1 of 1 sampled AFSSs.</p> <p>The findings included:</p> <p>On 04/30/2025, between 10:30 AM and 4:00 PM, during record with the Director of Plant Operations, it was revealed that the annual AFSS inspection, dated 02/17/2025, had deficiencies for the water flow not reporting to the fire panel. No documentation was provided showing that the deficiency was repaired.</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician / Director of Plant Operations, the following was observed:</p> <ol style="list-style-type: none"> At 12:53 PM, above the ceiling of the Reflections Nurses Station, there was a white wire laying on top of the AFSS piping. At 12:57 PM, the Reflections Television Cable Room had 1 of 1 loaded fire sprinkler heads. Paint was visible on the deflector. 	K 353	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K353.</p> <ol style="list-style-type: none"> Above the ceiling of the Reflections Nurses Station, the wire was removed on 05/16/2025 maintenance director/designee. Dynafire was notified to replace the Reflections Television Cable Room had 1 of 1 loaded fire sprinkler heads on 05/16/2025 maintenance director/designee. Kitchen 2 of 3 loaded dry sprinkler heads in the walk-in coolers were cleaned on 05/16/2025 by the maintenance director/designee. Dynafire was notified to replace the Beauty Supply Room loaded sprinkler head on 05/16/2025 maintenance 	

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K 353	<p>Continued From page 7</p> <p>3. Between 1:10 PM and 1:15 PM, the Kitchen had 2 of 3 loaded dry sprinkler heads in the walk-in coolers.</p> <p>4. At 1:20 PM, the Beauty Supply Room had 1 of 2 loaded fire sprinkler heads.</p> <p>5. At 3:13 PM, the Phone Room, in the Laundry corridor, had a sprinkler inside which was surrounded by a ceiling that was not maintained. The ceiling had multiple seams which were open to the interstitial space above.</p> <p>6. Between 3:20 PM and 3:25 PM, the Fire Riser Room, in the Laundry corridor, had a red tag attached to the riser which stated that the water flow was not reporting to the fire panel. The hydraulic design calculation sign was illegible. Also, the spare sprinkler box was missing a spare concealed sprinkler wrench.</p> <p>7. At 3:56 PM, the Seaway Wing, near Room 206, had insulation on top of the sprinkler piping.</p> <p>8. At 4:20 PM, the Physical Therapy Riser Room spare sprinkler head box was missing a list of the spare fire sprinkler heads with the following: description of spare heads, number of spare heads in the box, manufacturer, model, orifice, deflector type, thermal sensitivity, and pressure rating, and issue or revision date of the list.</p> <p>9. At 4:56 PM, the Independent Wing Riser Room had a hydraulic design sign that was illegible.</p> <p>An interview was conducted with the Director of Plant Operations concurrently with the record review and the Plant Operations Technician /</p>	K 353	<p>director/designee.</p> <p>5. The Phone Room, in the Laundry corridor will have the ceiling repaired by 05/24/2025 by the maintenance director/designee.</p> <p>6. The Fire Riser Room, in the Laundry corridor, was inspected by Dynafire before 05/24/2025 and the red tag was removed by Dynafire. The sprinkler wrench was ordered from Dynafire on 05/15/2025. The hydraulic sign on will have a repair estimate by 05/24/25 to make the sign legible.</p> <p>7. The Seaway Wing, near Room 206, had the insulation removed from the on top of the sprinkler pipe by the maintenance director/designee.</p> <p>8. The Physical Therapy Riser Room spare sprinkler head box had a list of all the required items posted on the wall next to the box at the time of survey. The list is posted as it does not fit inside the box.</p> <p>9. The Independent Wing Riser Room hydraulic sign was inspected by Dynafire and the center has contacted the original manufacturer Brown, on 05/13/25. The original data is unable to be retrieved. Dynafire is unable to update the data as of 05/13/25. The center will have the repair estimates to replace the signage by 05/24/25 for the Independence and Laundry corridor signs. This was completed by the maintenance director/designee.</p>	

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K 353	Continued From page 8 Director of Plant Operations concurrently with the observations and they acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 13 (2010 Edition) 9.1.1.7, 26.1 NFPA 25 (2011 Edition) 4.3.1, 5.1.1.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.8, 5.4.1.5.1, 5.4.1.5.5, 5.4.1.5.6, 5.4.1.5.6.1, 13.1.1.2, 13.2.4, 13.2.5.2, 14.2, 14.2.1.1 NFPA 101 (2012 Edition) 2.1, 4.6.12, 9.7.1.1, 19.3.5, 19.7.6 Photographic Evidence Obtained.	K 353	Sprinkler heads, ceilings surrounding sprinkler heads, fire riser rooms and sprinkler piping and hydraulic signs will be audited weekly x4 weeks and monthly x6 months for compliance with K353 maintenance director/designee. The results of these audits and any necessary repairs be brought to QAPI for review.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to install and maintain portable fire extinguishers in accordance with NFPA 101, for 1 of 1 telecommunication equipment rooms. The findings included: On 04/30/2025, at 1:18 PM, during the fire safety tour of the facility with Plant Operations Technician, it was observed that the Telecommunication Equipment Room, located next to the Culinary Director's Office, did not have	K 355	No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025. The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K353. 1. Above the ceiling of the Reflections Nurses Station, the wire was removed on 05/16/2025 maintenance	5/24/25

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K 355	Continued From page 9 a clean agent fire extinguisher. An interview was conducted with the Plant Operations Technician concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. NFPA 10 (2010 Edition) 5.3.2.6, 5.5.6, 5.5.6.1 NFPA 99 (2012 Edition) 15.9.1 NFPA 101 (2012 Edition) 9.9, 19.3.5.12	K 355	director/designee. 2. Dynafire was notified to replace the the Reflections Television Cable Room had 1 of 1 loaded fire sprinkler heads on 05/16/2025 maintenance director/designee. 3. Kitchen 2 of 3 loaded dry sprinkler heads in the walk-in coolers were cleaned on 05/15/2025 by the maintenance director/designee. 4. Dynafire was notified to replace the Beauty Supply Room loaded sprinkler head on 05/16/2025 maintenance director/designee. 5. The Phone Room, in the Laundry corridor will have the ceiling repaired by 05/24/2025 by the maintenance director/designee. 6. The Fire Riser Room, in the Laundry corridor, was inspected by Dynafire before 05/24/2025 and the red tag was removed by Dynafire. The sprinkler wrench was ordered from Dynafire on 05/15/2025. The hydraulic sign on will have a repair estimate by 05/24/25 to make the sign legible. 7. The Seaway Wing, near Room 206, had the insulation removed from the on top of the sprinkler pipe by the maintenance director/designee. 8. The Physical Therapy Riser Room spare sprinkler head box had a list of all of	

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K 355	Continued From page 10	K 355	<p>the required items posted on the wall next to the box at the time of survey. The list is posted as it does not fit inside the box.</p> <p>9. The Independent Wing Riser Room hydraulic sign was inspected by Dynafire and the center has contacted the original manufacturer Brown, on 05/13/25. The original data is unable to be retrieved. Dynafire is unable to update the data as of 05/13/25. The center will have the repair estimates to replace the signage by 05/24/25 for the Independence and Laundry corridor signs. This was completed by the maintenance director/designee.</p> <p>Sprinkler heads, ceilings surrounding sprinkler heads, fire riser rooms and sprinkler piping and hydraulic signs will be audited weekly x4 weeks and monthly x6 months for compliance with K353 maintenance director/designee.</p> <p>The results of these audits and any necessary repairs be brought to QAPI for review.</p>	
K 372 SS=F	<p>Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where</p>	K 372		5/24/25

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K 372	<p>Continued From page 11</p> <p>an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to maintain their fire/smoke barrier construction in accordance with NFPA 101, for 3 of 3 sampled fire/smoke barriers.</p> <p>The findings included:</p> <p>On 04/30/2025, at the following times, during the fire safety tour of the facility with the Plant Operations Technician, the following was observed:</p> <ol style="list-style-type: none"> At 12:03 PM, the Reflection Wing 1-hour smoke wall, near Room 106, had five penetrations above the ceiling. At 12:10 PM, the Reflection Wing 1-hour smoke wall, near Room 104, had three penetrations above the ceiling. At 3:47 PM, the Seaway Wing 2-hour fire rated wall, near Room 206, had four penetrations above the ceiling. <p>An interview was conducted with the Plant Operations Technician concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM.</p>	K 372	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K372.</p> <p>The center smoke walls were inspected above the ceilings throughout the center on 05/16/2025 to identify any other penetrations needing to be sealed by the maintenance director/designee.</p> <ol style="list-style-type: none"> The Reflection Wing 1-hour smoke wall, near Room 106, had the five penetrations above the ceiling repaired on 05/20/25 by the maintenance director/designee. The Reflection Wing 1-hour smoke wall, near Room 104, had the three penetrations above the ceiling repaired 05/20/25 by the maintenance director/designee. The Seaway Wing 2-hour fire rated wall, near Room 206, had the four penetrations above the ceiling repaired 05/20/25 by the maintenance 	

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K 372	Continued From page 12 NOTE: These examples are not to be considered as the only unprotected penetration of the facility's fire/smoke barriers. A thorough inspection of each barrier shall be made along its full length and height to ensure that all penetrations are found and properly sealed. It is required that every breach (penetration) of a fire barrier be appropriately repaired and the wall, ceiling, floor above or below brought back to its original fire or smoke rated integrity. This is essential to restrict the movement of fire and smoke and to ensure the safety of occupants within the facility in a fire emergency. The penetrations in fire rated barriers shall be sealed with a UL (Underwriters Laboratories) listed approved system. NFPA 101 (2012 Edition) 4.6.12.1, 8.3.4, 8.3.4.2.1, 8.4.4, 8.4.6.2, 8.5.5.2, 8.5.5.4.1, 8.5.5.4.2, 8.5.6.2, 19.1.1.1.3, 19.3.7.5, 19.7.6	K 372	director/designee. Fire penetrations above the ceiling will audited for compliance with K372 by the maintenance director/designee weekly x4 weeks, monthly x6 months and the results of these audits will be brought to QAPI for review.	
K 741 SS=F	Photographic Evidence Obtained. Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741		5/24/25

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K 741	<p>Continued From page 13</p> <p>that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interview, the facility failed to maintain their smoking area in accordance with NFPA 101, for 1 of 1 smoking area.</p> <p>The findings included:</p> <p>On 04/30/2025, at 4:43 PM, during the fire safety tour of the facility with the Director of Plant Operations, it was observed that the Smoking Area, near Room 349, did not have a metal container with a self-closing lid, for ashtrays to be emptied, and there was no ashtray of a safe, noncombustible design.</p> <p>An interview was conducted with the Director of Plant Operations concurrently with the observations and he acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM.</p> <p>NFPA 101 (2012 Edition) 19.7.4 (5-6)</p>	K 741	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K741.</p> <p>The smoking equipment was removed on 05/16/2025 by the maintenance director/designee as the center is a smoke free facility with no residents who smoke living in it.</p> <p>The center will maintain the smoke free policy. Any changes in this policy would be brought to the QAPI committee for review.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105592	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN FED B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF VERO BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1755 37TH STREET VERO BEACH, FL 32960	
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K 761 SS=F	<p>Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101</p> <p>Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to inspect and maintain its fire doors in accordance with NFPA 101, for 7 of 7 sampled fire rated attic access doors.</p> <p>The findings included:</p> <p>On 04/30/2025, at 12:22 PM, during the fire safety tour of the facility with the Plant Operations Technician, it was observed that the facility had fire rated attic access doors. The Plant Operations Technician was not sure if these doors were being inspected and tested as part of the annual fire door inspection.</p> <p>On 04/30/2025, between 10:30 AM and 4:00 PM, during record with the Director of Plant Operations, it was revealed that the facility's annual fire door inspection, dated 04/10/2025, did</p>	K 761	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K761.</p> <p>The attic fire doors were inspected by the maintenance director/designee on 05/20/2025. No concerns were identified. The result of the inspection was brought to QAPI on 05/21/2025.</p> <p>Attic fire doors will be inspected annually per K761 by the maintenance director/designee and the results of the inspection will be brought to QAPI for review.</p>	5/24/25

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K 761	<p>Continued From page 15 not include their fire rated attic access doors.</p> <p>An interview was conducted with the Plant Operations Technician concurrently with the observations and the Director of Plant Operations concurrently with the record review and they acknowledged the findings. The findings were explained to the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM.</p> <p>NFPA 80 (2010 Edition) 5.2, 5.2.3, 5.2.3.5.1, 5.2.3.7.1, 5.2.4, 5.2.4.1, 5.2.4.2 NFPA 101 (2012 Edition) 4.6.12, 8.3.3.1, 19.1.1.1.3, 19.7.6 NFPA 105 (2010 Edition) 4.1, 4.53, 5.2, 5.2.1(1), 5.2.2.4, 5.2.4, 5.2.4.4.2, 5.2.5.1</p> <p>Photographic Evidence Obtained.</p>	K 761	<p>K1150</p> <p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The maintenance director and assistants were educated by the Executive Director on 05/16/2025 on K1150.</p> <p>The annual security vulnerability assessment was completed on 05/15/25 by the Executive Director. The assessment was brought to QAPI on 05/21/25 for review.</p> <p>The security vulnerability assessment will be reviewed annually per K1150 by the Executive Director and QAPI Committee.</p>	

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E 000	Initial Comments During the Fire & Life Safety Recertification survey, conducted on 04/30/2025 at Palm Garden of Vero Beach, a nursing home, Emergency Preparedness was reviewed.	E 000		
E 024 SS=F	Palm Garden of Vero Beach is not in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities. Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		5/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/16/2025

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.

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E 024	<p>Continued From page 1</p> <p>*[For RNHCs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.</p> <p>*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to demonstrate how they would incorporate the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for the integration of State and Federally designated health care professionals to address surge needs during an emergency in their Emergency Preparedness Program (EP), in accordance with Code of Federal Regulations (CFR).</p> <p>The findings included:</p> <p>On 04/30/2025, at 6:00 PM, during record review of the facility's EP with the Administrator, there was no policy and procedures which included the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.</p> <p>An interview was conducted with the Administrator concurrently with the record review and she acknowledged the findings. The findings</p>	E 024	<p>No residents were affected by this alleged deficient practice as of 05/16/2025 and none can be identified as of 05/16/2025.</p> <p>The Executive Director was educated by the Regional Director of Operations on 05/16/2025 regarding E024.</p> <p>The policy for E024 was updated by the Executive Director on 05/16/2025 to reflect the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.</p> <p>The policy was approved by the QAPI committee on 05/21/2025. The policy will be maintained in the Executive Director's office and reviewed</p>		

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E 024	Continued From page 2 were reviewed with the Administrator and the Director of Plant Operations at the exit conference on 04/30/2025 at 6:30 PM. 42 CFR 483.73(b)(6)	E 024	annually or as needed.		