STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105694	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sabal Palms Health & Rehabilitation	499 Alternate Keene Rd NE Largo, FL 33771

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interviews and record review, the facility failed to identify, assess, and respond in a timely manner to a resident's change in condition related to a wound for one (Resident #1) of four residents reviewed. Findings included: Resident #1 was admitted to the facility on [DATE] with a primary diagnosis of nondisplaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing. Review of a care plan dated 03/15/24 showed Resident #1 had alteration in skin integrity related to incontinence, impaired mobility, a sacrum pressure ulcer, and a left heel skin tear posterior right lower leg. Interventions included to assist with transfers and positioning during rounds as resident allows cushion in wheelchair, dermatology consult, dietary consult as ordered, educate resident on the importance of offloading and pressure reduction as appropriate, encourage fluid intake with and between meals and increase protein in diet, and float heels while in bed as resident will allow. Observe and assess skin for signs/symptoms of redness, drainage, blisters, or evidence of skin breakdown. Observe and assess wound/ulcer for signs/symptoms of increased redness, swelling, warmth or purulent drainage. Apply skin prep heels x 21 days. Follow treatment per MD (Medical Doctor) orders and weekly skin checks. A focus in the care plan dated 10/13/23 showed Resident #1 was receiving an anti-coagulant with interventions to evaluate for bruising. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105694	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Sabal Palms Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 499 Alternate Keene Rd NE Largo, FL 33771	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/24 at 11:59 p.m., an interview was conducted with Resident #1's family member/ POA (Power of Attorney). He stated on 03/12/24 he was at the facility visiting Resident #1. He stated while visiting with the resident in the dining room, he had noticed the resident had a wound that was weeping at the back of her right leg. He stated he reported his concerns to the nurses, and they did not respond. He said, they were not aware, they did nothing. They did not even attempt to come and see what the issue was. The wound on the back of her leg was filled with puss and was draining to her socks. Her socks were soaking wet. The family member said, We are not trying to be adversarial. It was neglectful. The draining fluid was running down to her socks. This didn't occur overnight. They said this was happening because of the Velcro on her left boot. They don't analyze or accept anything. It's systemic. We notified Staff A, Registered Nurse (RN)/ Unit Manager. My partner went to the desk and notified her. The family member stated Staff B, RN was also at the desk. He stated they never came to look at the resident's leg. The family member stated they were at the facility until after 6 p.m. and the nurses never came to assess the resident. The family stated this was not the first time they failed to identify a concern. He stated sometime in February he had notified the facility of an infection to the resident's right thumb. He stated no one was aware and no one had done anything about it. On 04/23/24 at 11:47 a.m., an interview was conducted with Staff B, RN. She stated she remembered the family coming up to the desk. She said, it must have been a Tuesday night I believe the 12th between 3 p.m. and 4 p.m. The family brought her [Resident #1] to the desk. She was in her wheelchair and reported there was some drainage on her leg. At the time [Staff A, RN] was going to be coming on shift. She said she would look at the leg when she got the resident in bed or as soon as possible . The family was still visiting when I left. Staff B stated the next day [03/13/24], she did rounds and noticed the resident had redness, serious drainage and weeping from the back of her leg. She stated she discussed this with Staff A. She stated Staff A was not going to pick up the resident for wound care, but she was going to put her on antibiotics. Staff B confirmed there were no notes indicating this conversation and course of treatment. She said, I do not see it under progress notes, we discussed it with the wound care nurse who no longer works at the facility.[Staff A] was to obtain orders. On 04/23/24 at 1:02 p.m., an interview was conducted with Staff A, RN/UM. She stated early in March the family was visiting. She stated they had reported Resident #1 had a skin tear to the right calf, and it was weeping. She stated the resident caused the injury. Staff A said, I was walking down the hall, there was another person with the family member. They said, [Resident #1] had something on her foot. I went and looked at her leg, she was in a wheelchair, she was wet. I asked the CNA [Certified Nursing Assistant] to change her and put her in bed. [Staff B, RN] was with me, we both looked at her. Staff A stated the resident crossed her foot with the boot she was wearing at that time and caused the injury. Staff A stated she obtained an order for wound care and doxycycline for 10 days. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sabal Palms Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 499 Alternate Keene Rd NE Largo, FL 33771	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note documented by Staff A, RN on 03/14/24, showed Nurse's Description: CNA on duty notified writer that resident has an area that it look little red and is moist, writer went into the resident's room and skin tear is observed in the posterior part of the right lower leg, area looks little red, moist, mild clear drainage with no odor noted. MD [Medical Doctor] made aware about the new skin area and order to clean are with NS (Normal Saline) pad and dry, apply xeroform and cover with bordered gauze was given. Also, to monitor site for s/s (signs or symptoms) of infection and ABT (antibiotic) BID (two times daily) x 10 days was given due to the little redness and the clear drainage. All the orders are placed in [a software documentation program]. Wound care performed and well tolerated. Resident observed on daily basis to try to cross the right leg over the left leg. Resident uses a Podus boot on the left foot and the Velcro part touches and rubs the same area that was reported as per CNA on duty. POA made aware and no questions or concerns were expressed at this time. Staff will continue to monitor. Resident's description of what happened: None. Witnesses? Yes/No: None. Injuries: Skin tear posterior right lower leg. Immediate Actions taken: Assessment performed. MD made aware, new orders obtained and placed in PCC. Wound care performed. POA made aware. Predisposing factors: Resident has active wounds. Resident is on diuretics, cardiac meds, and anticoagulants. Assist x 1 for transfers and ADLs (Activities of Daily Living). Resident seen by therapy for wheelchair positioning. Resident observed in daily basis to try to cross the right leg over the left leg. Resident uses a Podus boot on the left foot and the Velcro part touches and rubs the same area that was reported as per CNA on duty. Notifications: MD made aware and POA notified. This documentation confirmed Staff A,RN responded to the change in condition on 03/14/24 and not 03/12/24 when she was first notified. Review of Resident #1's skin assessment dated [DATE] revealed there were no concerns documented related to the right foot infection. Review of a progress note documented by Staff A, RN, dated 02/01/24 showed, Clinical Note Text: Resident's son approached writer regarding his mom right thumb being red close the nail. Area looks little red, no open area, no drainage or bleeding. Resident denied pain and stated it just bothered when it's being touch. Finger nail observed to start having slight change in color and texture. MD made aware and new orders were given to start ABT and Dermatology consult. New orders placed in [a software documentation program]. POA made aware and no questions or concerns were expressed at this time. Staff will continue to monitor. A progress note dated 02/01/24 showed, Infection note: Note Text: Abt/Rt thumb in progress. First dose pulled via EDK (Emergency Drug Kit). No adverse effects noted. C/o (complaint of) pain this shift, Tramadol given + effect. VS WNL (vitals within normal limits). All safety measures in place with call light within reach. On 04/23/24 at 2:10 p.m. an interview was conducted with Staff A, RN, The Director of Nursing (DON) and the Regional Nurse Consultant (RNC). The DON stated when the thumb incident was reported they educated all staff about monitoring and assessing residents. She stated if the CNAs found any concerns with the skin, they should document in the task log. She stated the task log asks the question if there are new changes. This would mean a new change to the staff documenting. If they answer Yes, the system will send a notification to some key staff members such as the DON and the Unit Managers. She confirmed the family had notified them of the two incidents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 2:15 p.m., The DON reviewed a document titled, Follow -up Question Report, dated 02/01/24 to 02/07/24 and 03/10/24 to 03/15/24. The DON confirmed the CNA's had not reported any changes to the resident's skin. She confirmed they had not received any alerts on changes to the resident. On 4/23/24 at 10:02 a.m., an interview was conducted with Staff C, RN QIC (Quality Infection Control) nurse. She stated she had started education for the nursing staff on identifying change in condition, addressing family concerns in a timely manner. She stated she understood the family's concern. She said, What might have appeared normal to a nurse would be perceived differently by a family member. I understand. The nurse should have taken the time to go see the resident. An interview was conducted with the Nursing Home Administrator (NHA) on 04/23/24 at 11:02 a.m. She stated they will address the change in condition concerns. The nurse should have contacted the family. The nurse should have responded to the family in a timely manner. We will educate about assessing resident's needs. Review if a facility policy titled, Change in a resident's condition, dated 10/22/23, showed a change noted in a resident's condition is reported as soon as practical to charge nurse. The procedure showed A. notify the charge nurse when any condition occurs in the resident including but not limited to (1.) anything that seems different than usual. (11.) change in skin color or condition; red areas on skin, skin tears, bruises. C. Evaluate reported changes in resident condition performed by a licensed nurse. D. Report findings to Health Care Provider and resident representative, as indicated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and policy review, the facility failed to ensure clean and sanitary equipment and floors for two of two units and eleven of seventeen rooms where tracheostomy residents reside. Findings included: An observation was conducted on 4/22/24 at 1:14 p.m. in room [ROOM NUMBER] of an oxygen concentrator that had dried liquid splatter on it as well as dust. The suction canister base and motor had debris and dust. There was a fan clipped to a pole at the bedside that was covered in dust. (Photographic evidence obtained.) An observation was conducted on 4/22/24 at 1:18 p.m. in room [ROOM NUMBER] of a IV (Intravenous) pole that had dried splatter on the base. The suction canister and motor set up had dust and debris on it. (Photographic evidence obtained.) An observation on 4/23/24 at 9:56 a.m. revealed the equipment in rooms [ROOM NUMBERS] remained in the same condition as they were on 4/22/24 at 1:14 p.m. Additional rooms of residents that had tracheostomies were toured on 4/23/24 from 11:30 a.m. to 12:00 p.m. with the following observations: -room [ROOM NUMBER] had an IV pole with dried splatter on the base. (Photographic evidence obtained.) -room [ROOM NUMBER] had a fan at the bedside with dust on it and black marks on the floors. (Photographic evidence obtained.) -room [ROOM NUMBER] had black spots and stains on the floor, a dirty IV pole, a crib bed with dust and debris on the railings, a plastic crib covering with dried liquid, brown splatter on the wall. (Photographic evidence obtained.) -The floor outside the 600 Unit nurses' station was dirty with black marks and spills. (Photographic evidence obtained.) -room [ROOM NUMBER] had a fan at the bedside with dust on it, a piece of tape attaching two pieces of flooring, dirty/stained floors, a dirty IV pole base, trash on the floor, a call light cord that had visible dirty, and a side table with spots/stains and a pink liquid spilled. (Photographic evidence obtained.) -room [ROOM NUMBER] had a dresser with broken drawers and a suction canister base and motor that had dust and debris. (Photographic evidence obtained.) (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER] had a tablet and black stand on wheels that was visibly soiled. (Photographic evidence obtained.) -room [ROOM NUMBER] had a black stand on wheels that was visibly soiled. (Photographic evidence obtained.) -room [ROOM NUMBER] had a basin with towel under a ventilator hose to catch dripping water. The towel had black dirt partially covering the top, an IV pump had dried splatter, and there was another basin catching water dripping from a ventilator hose. -room [ROOM NUMBER] had a cough assist machine that had dried splatter and debris on the top. An interview was conducted on 4/23/24 at 12:12 p.m. with Staff D, Licensed Practical Nurse (LPN). Staff D identified herself as a unit manager (UM) on the 300 unit. Staff D said housekeeping wiped down all the surfaces of equipment in resident rooms. She said nurses should also wipe equipment down if they see that it is dirty. Staff D said nurses also change ventilator tubing and suction canisters weekly and should clean soiled items. She said IV poles were swapped out when they were obviously soiled and the dirty ones were taken out back and sprayed down. She added that housekeeping wiped the poles down and nurses or certified nursing assistants (CNA) could also wipe the poles down if they were soiled. Staff D was observed going to room [ROOM NUMBER] and looking at the fan at the bedside and the suction canister set up. Staff D said, it is disgusting. She said it was not acceptable to have equipment in this condition in resident rooms. She removed the fan and said it needed to go in the trash it was so dirty. An interview was conducted on 4/23/24 at 12:19 p.m. with the interim Director of Nursing (DON.) She stated she did not know who was responsible for cleaning the equipment in resident rooms and she would look into it. She agreed the medical equipment in resident rooms should not have splatters and dust on it. At 12:46 p. m. the DON said nursing and respiratory should be cleaning the suction and IV equipment in the resident rooms. An interview was conducted on 4/23/24 at 12:59 p.m. with the Environmental Services (EVS) Director. She said when it came to medical equipment housekeeping was hesitant to touch it because they did not want to mess anything up, especially if it was being used by a resident. A follow-up interview was conducted on 4/23/24 at 1:01 p.m. with Staff D, LPN/UM. Staff D agreed with the EVS Director and said she believed housekeeping thought nursing cleaned the equipment and nursing thought housekeeping cleaned it. She said it fell through the cracks but was being cleaned now. A follow-up interview was conducted on 4/23/24 with the EVS Director. She said the facility did not have a policy on floor maintenance. She said they rotate doing deep cleaning on the floors in each room. She said the black marks on the floors were stains and she could not get them up. She agreed it did not look good and was not acceptable in resident areas. She was shown the area by the 600 unit nurses station, she said she would try to deep clean that area. Review of a facility policy titled Maintaining a Safe, Clean, Comfortable, and Homelike Environment, reviewed 3/20/24, showed the following: Policy (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This facility will accommodate, to the extent possible, a personalized, homelike environment that recognizes the individuality and autonomy of each resident. Policy Explanation and Compliance Guidelines . 6. Report any furniture disrepair to Maintenance promptly. 7. Maintain a clean, comfortable, and homelike environment (i.e. ceiling tiles, wallpaper, floor times.) 8. Report any unresolved environmental concerns to the Administrator. Review of a facility policy titled Cleaning and Disinfection of Resident-Care Equipment, reviewed 10/25/23, showed the following: Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Policy Explanation and Compliance Guidelines: 1. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. General guidelines include: . b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. c. Direct care staff are responsible for cleaning single-resident equipment when visibly soiled, and according to facility protocol.