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	09/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one resident (#10) out of three sampled residents.Findings included:Review of Resident #10's concern/grievance form dated 7/29/25, with a date of occurrence on 7/29/25 and a time of occurrence 3:00 p.m.-11:00p.m. revealed a grievance with the following documentation, . 7/29/25 [Resident #10] detail of complaint/grievance: Resident complaint that nurse is constantly mocking her when in room. Resident asked for inhaler and nurse stated she had to wait another 20 mins now that she is already in room, even though med [medication] cart is right outside room. Stating nurse called her crazy with finger mocking in her face to hers and [family member]. by twirl finger like we were crazy, and reported nurse is condescending and not helpful.,. Further review of the grievance revealed a follow up dated 8/5/25 revealed, [Resident #10] reports nurse is rude and not what she considers abusive in anyway. Nurse will not provide services moving forward and DON [Director of Nursing] to address nurse behaviors. Documentation of the resolution of the grievance revealed the following, . Nurse was reassigned on 8/5/25 and [Resident #10] signed the grievance form on 8/6/25. A review of the education attached to the grievance revealed the following . Resident also stated nurse constantly mocking resident. Education counseling instructions given to employee to correct action & performance improvement: Platinum service approach, reviewed. Customer service, reviewed. Staff Verbalized understanding. Employee performance improvement and progress results: No complaints concern since education. Signed by Department Director on 7/30/25 and Executive Director on 7/30/25.On 9/23/25 at 3:00 p.m., an interview was conducted with Resident #10. She said she remembered the grievance. Resident #10 stated, The nurse wouldn't give me my medication and when she came in the room and I was talking with her, and my [family member] was here as well, she called me crazy with the motion you make when you put your finger up to your ear and twirl it around. She thought we were crazy. I got very upset and was disgusted. She mocked me and my [family member]. The nurse made me feel angry. It's just so petty; she acted like we were stupid. It's very unprofessional and just uncaring. We need to be treated right and with dignity. She said no facility staff completed a follow-up with her after the incident. Resident #10 said the social worker came by a day or so later but didn't say anything about it.Review of Resident #10's admission record revealed an admission date of 03/07/2019. Further review of the admission record revealed diagnoses to include chronic atrial fibrillation, angina pectoris, hypertension, chronic obstructive pulmonary disease, diabetes, generalized anxiety, atherosclerotic heart disease of native coronary artery, atrial fibrillation, chronic kidney disease stage 3, heart failure.Review of Resident #10's quarterly Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact.Review of Resident #10's progress notes revealed the following:On 7/30/25, Quarterly assessment completed for [Resident#10]. Speech and communication skills remain stable. Cognitive status is stable. No report on changes in social interactions. No changes in mood noted. Residents' ability to make adjustments to situations remain stable. No new behaviors report. Resident is compliant with care. Resident is agreeable to current plan of care. No psychological/psychiatric services indicated at this time.Review of the facility's REPORT TRACKING LOG, dated 6/1/25 to 8/31/25, revealed there was no allegation of abuse, neglect, exploitation reported to state agencies for Resident #10.An interview was conducted on 9/23/25 at 12:48 p.m. with the Risk manager (RM) who stated, My expectations are they would report it to me; abuse; physical and verbal abuse and mental abuse. Mental abuse could be anything like making a resident feel bad by their actions. if you make a resident feel bad, I guess it would be the response that the resident had to determine if they were affected by it. She was asked if Resident #10's grievance would be a reportable event, and the RM stated, If it was a change in the psychosocial. Did the residents wellbeing change due to the event? Did it affect the resident? If yes, then we would report it. The RM stated, in reviewing it [Resident #10's grievance] now I should have reported it. The RM said the facility completed a thorough investigation and education with the staff. The RM said they interviewed the resident, received statements from the nurses, interviewed staff, and completed abuse training and education. The RM said the grievance was looked at in terms of lack of good customer service and not abuse.An interview was conducted with the DON and the RM on 9/23/25 at 1:30 p.m. They DON and the RM said Resident #10 had behavioral issues before and there was a care plan in place for confabulation as well as her behaviors

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure the identified needs for residents at high risk for fall interventions was effective and prevented falls with major injuries for two vulnerable residents (#7 and #8) out of eight residents sampled.Findings included:Review of the facility's Daily Census report provided on 9/22/25 at 6:12 a.m. showed 700 Unit had a census of 26.Review of the facility's Minimum Data Set (MDS) Resident Matrix dated 9/23/25 at 8:59 AM showed the 700 Unit 50% (13) of the residents had a fall and 34% (9) experience fall related injuries including fractures. 1. Review of Resident #8's admission record showed an admission to the facility on 7/1/2025 with diagnoses including dementia, fracture of left pubis, insomnia and displaced fracture of the olecranon process.Review of Resident #8's nursing admission evaluation, dated 7/1/25 showed a fall prevention interventions was started of Hi/low bed, anticipate needs as able and call light within reach when in room.Review of Resident #8's MDS dated [DATE], Section C, Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) summary score of 0, indicating severe cognitive impairment. Section GG, Functional Abilities shows the resident needs a helper to complete all self-care activities and when transferring from bed to chair.Review of Resident #8's care plan showed a focus on the resident had an actual fall and a pubis ramus fracture, initiated on 7/2/25 interventions included adequate lighting, anticipate needs, call light and frequently used items within reach, wearing nonskid footwear and glasses, fall risk assessments, 4p's rounding (check resident for any pain concerns, positioning needs, personal items are within reach and personal needs are being met), keep bed in low position. Floor mats x2, scoop air mattress, medication and laboratory review and started medication for sleep aid initiate on 7/31/25. Psychology/Psychiatry evaluation and therapy screening and evaluation on 9/1/25. Encourage resident to remain in a common area if restless/agitated, start antianxiety medications and the use of a pommel cushion on 9/1/25. Anti-tippers to wheelchair and hip protector's interventions added on 9/11/25. A care plan for left elbow fracture was initiated on 9/10/25. Review of Resident #8's Order summery report, dated 9/22/25 included the following orders neuro checks after a fall - 7/31/25, 9/1/25 and 9/7/25, left elbow skin tear wound care- 9/1/25, buspirone HCL 5mg two times daily for anxiety- 9/6/25, send to the emergency department for evaluation and possible treatment after a fall- 9/7/25, Naproxen 500 mg every 12 hours for left elbow fracture - 9/7/25, Tylenol extended release (ER) 650 mg every six hours for left elbow fracture- 9/7/25, lorazepam 0.5mg every 8 hours for anxiety 9/8/25, ice pack to left elbow status post (s/p) open reduction and internal fixation (ORIF) - 9/16/25 and lorazepam 0.5mg every 6 hours for anxiety and agitation - 9/17/25.Review of Resident #8's emergency department discharge instructions dated 9/7/25 showed acute displaced fracture of the olecranon with intra-articular involvement. The discharge instructions include ice to affected area, maintain splint and arm immobilizer, and elevate affected area for 24 hours and follow-up with orthopedic surgeon in 3-5 days. Review of Resident #8's progress notesOn 7/31/25 at 11:10 p.m., a post fall progress note showed injury was noted at the time of the fall right elbow and right knee bruise . Current .measures in place include call light education, 4P's, Hi/Lo bed, room close to the nurses' station, therapy evaluation, frequent checks On 9/6/25 at 11:49 a.m. a system note showed current preventative safety measures in place: call light education, 4P's, Hi/Lo bed, room close to the nurses' station, mat next to bed, activities/exercise, frequent checks; scoop mattress.On 9/6/25 at 12:11 p.m. an order note showed buspirone 5mg tab one tablet two times daily for anxiety, monitor for .dizziness, .insomnia, . anxiety . On 9/7/25 at 1:42 p.m., an incident SBAR note showed CNA (Certified Nursing Assistant) found resident sitting up on bedside mat with back against the bed in lowest position. [wearing] only brief and non-skid socks . No apparent injuries.On 9/7/25 at 1:48 p.m. an incident SBAR note showed .alerted by CNA that resident was on the floor near nurses' station. Patient was noted to be on her back on the floor holding her left wrist. Resident left in place supervised while 911 called.left at approximately 10:45 a.m.On 9/7/25 at 7:11 p.m. a clinical note showed Resident #8 returned to the facility, . acute displaced fracture of olecranon w/intra-articular involvement. Left elbow fiberglass splint .On 9/14/25 a system note showed the Interdisciplinary Team (IDT) met regarding falls from 8/31/25, and 9/7/25, laboratory results reviewed, melatonin started, therapy to screen, psych visit started with anti-anxiety medications, encourage resident to be placed in the common area if seem restless/ agitation and pommel cushion .On 9/16/25 at 8:41 PM a clinical note showed Resident #8 returned from the hospital after ORIF procedure.On 9/18/25 Primary Care Physician (PCP) note showed Resident #8 's history included an unwitnessed ground level fall with left