STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105694	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review and policy review facility failed to report in 24 hours the event that caused the allegation neglect that did not result in serious bodily injury to the State Survey Agency and the Department of Children and Families for one (#1) of three sampled residents. Findings included: Review of resident record revealed Resident #1 was admitted on [DATE] with pertinent [DIAGNOSES REDACTED]. Review of Clinical Notes Report dated [DATE]9/20 revealed at Approximately 3:30 pm Resident #1 walked through front door of the facility and stated can you help me back to my room. The writer assisted her to a chair and assessed her, skin was cool, (warm day outside) Vitals were taken. Writer asked Resident how she got outside, if she enjoyed the elevator ride? Resident stated I did not go in the elevator, I went down the stairs, I was tired afterwards I sat down Nurse asked Where did you sit? Resident sated by the water. After further investigation nurse noted, resident went down stairwell and exited out by pediatric exit, walked around facility and came to front door. Resident able to describe briefly, stated I did not sit long then I got up and walked down the sidewalk and kept going right until I got to the door to let me back in my home. No signs of any distress. MD aware, Spouse aware, NHA/DON (Nursing Home Administrator/Director of Nurses) aware Resident placed on 15 min checks, wander guard placement to Lower Extremity, Vitals and symptoms observations are ongoing. Last observed during shift change at approximately 3:15 pm per assigned nurse. Resident found at approximately 3:30 pm. Review of Immediate Report # dated 4/22/2020 revealed date of incident [DATE]9/2020 and time of incident at 3:30 pm. Resident Representative was notified on [DATE]9/2020 and Abuse registry was notified on 4/22/2020. On Sunday [DATE]9/20 at 3:30 PM the resident came walking in the front door of the building. Last seen by staff members on the locked unit during shift change at 3:15pm. Resident has been noted by all staff members on the unit to be exit seeking and trying to pull on doors. The Facility's immediate response: Investigation started, Maintenance notified, all the codes to the doors were changed, and not given to any staff members. DON, Administrator, MD, and family notified. DCF (Division of Children and Families) notified on 4/22/2020. On 4/22/2020 at 5:13 pm an Interview was conducted with the Risk Manager (RM) who stated we pulled cameras today and were able to identify the staff members, Certified Nursing Assistants, who used the stairwell the resident used to get out of the building. The footage showed us that at 3:15 pm they used the back stairwell to go on break. There is an elevator on that side of the 700-hall, a key is needed to unlock the elevator. When we looked at the footage, we were able to see the resident go out back and stay there for a while then walked around to the front entrance. The Resident was quick and caught the door before it shut. The Maintenance Director and I went up last night 4/21/20 to reenact the scenario and check the doors. Our conclusion was that she either walked through right behind them or she knew the code to the get out. On 4/22/2020 at 5:52 pm an additional Interview was conducted with the Risk Manager. The day of the event the Nursing Home Administrator, the Director of Nursing, the MD and the spouse were made aware of the event. I understand that a 24-hour report should be submitted for neglect. A report was not done Monday, but our investigation continued. The Agency of Health Care Administration and the Department of Children and Families were notified today 4/22/20 at the same time. On 4/22/2020 at 6:58 pm an interview with Administrator was conducted. The Administrator stated I told the Risk Manager not to report immediately because we wanted to confirm the findings with our own investigation. The reporting was completed on 4/22/20. In hindsight I would have wished we would have reported immediately, but I wanted to wait confirm what happened. Our risk manager is like a bulldog and she asked if it should be reported that night. I wanted to further investigate, and I told her we would wait. From here on out I will be reporting within the 2 to 24-hour timeframe. Review of Sabal Palms Health Care Center Policy/Procedure titled Abuse, Neglect and Exploitation dated November 2017 Revised January 2020 stated, Policy: Each Resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's medical symptoms. Policy Explanation and Compliance Guidelines 1. .Report allegations or suspected abuse, neglect or exploitation immediately to: Administrator Other Officials in accordance with State Law State Survey and Certification agency following state protocols 9. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Sections V and VII state that: V. Investigation of Alleged Abuse, Neglect, Exploitation and Misappropriation When suspicion of abuse, neglect, exploitation, or an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation shall be conducted. VII. Response and Reporting of Abuse, Neglect, Exploitation and Misappropriation Anyone with knowledge or concerns about the care of a resident in the facility must report suspected abuse to the Facility Administrator, abuse agency hotline or file complaint with the State Survey agency immediately. or no later than 24 hours if the events that lead the allegation do not involve abuse and do not result in serious bodily injury.

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