STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965159	09/22/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sabal House	150 Crossville Street Cantonment, FL 32533	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0000-Initial Comments
A biennial and Limited Nursing Service survey was conducted at Sabal House Assisted Living Facility. At the time of survey deficiencies were found.

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on observation, record review, staff and resident interview the facility failed to assist 2 residents with their meal during lunch on in the main dining . (#4, #12)

The findings are:

Residents #4 and #12 were observed during the lunch meal in the main dining at 12:30 pm. Neither resident had a knife to use during the meal. They were served sliced ham which was not cut up for them. A visitor sitting at the table indicated resident #12 doesn't get a knife for meals and staff doesn't assist him. She indicated his ham was not cut for him today and he uses his fork to cut it up or uses his mouth.

Resident #4 was trying to cut the ham with her fork.

Interview with resident #12 during lunch said he never gets a knife, they don't have any. I do what I can to eat.

Interview with aide D who was serving the residents during lunch indicated they (residents #4 and #12) don't get a knife. Resident #12 has difficulty using a knife and has swallowing difficulties. Resident #4 has a hard time using a knife to cut up meat.

Aide D gave resident #4 a knife but did not offer to assist to cut up the ham. She did not offer a knife to resident #12 or ask if he needed assistance.

Interview with director of nursing at 3:00 pm indicated resident #4 was moved to that table where resident's need assistance with eating and we don't put knives at that table.

Record review of resident #12 indicated a diagnosis of , Parkinson and with precautions for . He needs assistance with eating.

Interview with Licensed Practical Nurse (LPN) on at 2:30 pm indicated he has difficulty chewing and swallowing due to Parkinson's.

Record review for resident #4 indicated a diagnosis of memory loss and on regular diet. She is independent with eating. No indication for not using a knife.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965159	**09/22/2014**
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on resident and staff interview and record review the facility failed to follow elopement policy for 1 of 1 sampled resident's. (#11)

The findings are:

Interview with staff C on at 1:52 am indicated resident #11 eloped from the facility. A family member thought he was a visitor and he left the premises and they found him on the highway. The resident flagged down a policeman who returned him to the facility.

The facility lacked documentation in the resident's record, incident log and in the facility any record or investigation of the 2 elopements.

Observation of all residents were conducted on at 3:30 pm and were all accounted for.

Interview with director of nursing (DON) on at 3:39 pm indicated he did elope two times right after his admission prior to her employment with the company. She said they did not follow their policy by not completing a thorough assessment, contacting the physician, completing an adverse incident and submitting to AHCA.

Observation of resident on at 3:30 pm found no identification (arm) on his person. Interview with DON at that time confirmed the findings. She placed an wrist on him at that time.

Record review found he was admitted with a diagnosis of with and behavioral problems and at risk for elopement. He is independent with activities of daily living.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, record review and staff interview unlicensed staff were observed administering medications to 2 of 3 sampled residents who needed assistance with self administration of medications. (#1, 2)

The findings are:

Medical technician (MT) A was observed administering medications to resident #1 who was assessed to need assistance with self medication on at 9:40 am. She poured the medications into a med cup while out in hall at med cart. The resident was in his door closed. She gave the medications to him without explaining medications.

Medical technician A administered medication to resident #2 who was assessed to need assistance with self medications on at approximately 9:50 am. She poured up the med's into the med cup at the cart in the hallway. The resident was in his the door closed. She gave the medications to him without explaining medications.

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Interview with MT on at same time indicated she messed up and should have taken the medications inside original bottles into the residents and assisted them with their medications.

Interview DON on at 12:45 pm indicated policy is for MT to assist with self administration of medications.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review, staff and resident interview the facility failed to make available eating utensils for 2 residents observed during lunch. (#4, #12)

The findings are:

Residents #4 and #12 were observed during lunch in the main dining at 12:30 pm. Neither resident had a knife to use during the meal. Their were served sliced ham which was not cut up for them. A visitor sitting at the table indicated resident #12 doesn't get a knife for meals and staff doesn't assist him. She indicated his ham was not cut for him today and he uses his fork to cut it up or uses his mouth.

Resident #4 was trying to cut her ham with her fork.

Interview with resident #12 during lunch said he never gets a knife, they don't have any. I do what I can to eat.

Interview with aide D who was serving the residents during lunch indicated they (residents #4 and #12) don't get a knife. Resident #12 has difficulty using a knife and has swallowing difficulties. Resident #4 has a hard time using a knife to cut up meat.

Aide D gave resident #4 a knife but did not offer to assist to cut up the ham. She did not offer a knife to resident #12 or ask if he needed assistance.

Interview with director of nursing at 3:00 pm indicated resident #4 was moved to that table where resident's need assistance with feeding and we don't put knives at that table.

Record review of resident #12 indicated a diagnosis of , Parkinson and with precautions for . He needs assistance with eating.

Interview with Licensed Practical Nurse (LPN) on at 2:30 pm indicated he has difficulty chewing and swallowing due to Parkinson's.

Record review for resident #4 indicated a diagnosis of memory loss and on regular diet. She is independent with eating. No indication for not using a knife.

Class III

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00165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on resident and staff interview and record review the facility failed to complete an adverse incident report, failed to investigate and failed to submit report to the Agency for Health Care Association (AHCA) for 1 of 1 sampled resident's. (#11) who eloped from the facility.

The findings are:

Interview with staff C on at 1:52 am indicated resident #11 eloped from the facility. A family member thought he was a visitor and he left the premises and they found him on the highway. The resident flagged down a policeman who returned him to the facility.

The facility lacked documentation in the resident's record, incident log and in the facility any record or investigation of the 2 elopements.

Observation of all residents were conducted on at 3:30 pm and were all accounted for.

Interview with director of nursing (DON) on at 3:39 pm indicated he did elope two times right after his admission prior to her employment with the company. She said they did not follow their policy by not completing a thorough assessment, contacting the physician, completing an adverse incident and submitting to AHCA.

Observation of resident on at 3:30 pm found no identification (arm) on his person. Interview with DON at that time confirmed the findings. She placed an wrist on him at that time.

Record review found he was admitted with a diagnosis of with and behavioral problems and at risk for elopement. He is independent with activities of daily living.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Sabal House
150 Crossville Street
Cantonment, FL 32533

Dear Administrator:

This letter reports the findings of a state licensure and limited nursing services monitoring survey that was conducted on , 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Patricia M Gatti, RN

Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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