STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969274	**11/20/2018**
NAME OF PROVIDER OR SUPPLIER **SABAL PALMS ASSISTED LIVING AND MEMORY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **2125 PALM HARBOR PKWY** **PALM COAST, FL 32137**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A complaint investigation (CCR #2018012528) was conducted in conjunction with an Emergency Power Plan monitoring visit at Sabal Palms Assisted Living and Memory Care (License Number: 13103) on to . Sabal Palms Assisted Living and Memory Care had deficiencies at the time of the investigation.

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observations, resident and staff interviews, and resident record reviews, the facility failed to ensure supervision and assistance with activities of daily living was provided as needed to 2 of 3 sampled residents (Residents 1 and 3) who required assistance.

The findings include:

During a tour of the facility at 9:20 am on , the housekeeper was briefly interviewed. She stated there were 3 housekeepers on duty in the facility, but they did not do laundry or change resident's bedding. The aides performed those tasks.

An interview was conducted with Medication Technician (MT) at 9:40 am on . She stated she stated she typically worked on the first floor. She had not worked in the facility for long, and did not intend to stay. This was because she felt there was not enough staff to provide adequate supervision or care to the residents, and some residents were not being showered per their schedule. The MT explained the staff reported their concerns to management but they did not seem willing to address the issue. The MT stated the couple in apartment 108, Resident 3 and her spouse, required a lot of care. Both required assistance with bathing, and Resident 3 required total care. The shower schedule typically provided for 2 showers a week for each resident, and was posted by the nursing station. The current staffing did not provide enough personnel to provide all of the showers per the schedule. Medication Technicians and Resident Care Aides (RCAs) were also responsible for changing resident's bed linens as needed, and doing resident laundry. She requested this surveyor please go look at the hygiene of the residents in 108, stating "You will see."

An observation and attempted interview with Resident 3 was conducted at 10:25 am on in her apartment. She was up in her wheelchair, dressed and groomed for the day. Her hair was combed but

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appeared to be greasy at the crown, and was matted close to her , . The MT passed by in the hallway just outside the apartment, stopped, and quietly announced "They look pretty good today!" Resident 3 was unable to state how long she resided in the facility, how often she was showered, or if she received them as scheduled. Her spouse, who was in a leisure chair next to her, was observed with some crusting around both , .

An observation and attempted interview was conducted with Resident 1 at 10:35 am on . She appeared to be pleasantly at the time, unable to answer questions. Her spouse, Resident 6, had to answer for her. He stated he was Resident 1's power of attorney (POA). Resident 6 stated staff sometimes took 15 to 45 minutes for staff to answer the call lights. Most of his calls were for staff to come dress Resident 1. Showers were scheduled 2 times a week, but Resident 1 received an average of one or fewer showers per week. He pointed to a shower schedule on the wall, which confirmed his statement. He continued, there was no explanation for this provided by the staff. It was just that no one would arrive to shower her. When he questioned it, the aides would tell him they were doing paperwork. Resident 6 stated he had gone to the Administrator with his concerns, but nothing had changed. After voicing some additional unrelated concerns, he concluded by stating there was no end to this. There was no way of combating any of the issues, they just keep doing the same thing.

An interview was conducted with the Resident Service Associate (RSA) at 11:30 am on . She stated she typically had 13 to 14 residents assigned to her each day. Most of those residents required assistance with activities of daily living. She explained, "we just have to do our best." When asked if there was enough staff to provide showers and assistance with ADLs to the residents, she did not want to answer. The RCA stated there was a schedule for showers, laundry, and linen changes for each resident. She said some resident were "heavy wetters", and had to have their bedding changed 2 to 3 times a week. She confirmed the RCAs were responsible for assisting residents with linen changes and laundry. There was a shower schedule for each resident, and staff document the showers. The RCA took me to the office and showed me the schedules for each resident, the shower log, and a staff communication book for reporting unusual issues on each shift.

A review of the shower schedules, logs, and communication notes for Residents 1 and 3 was conducted with the RSA at this time. She explained Resident 1 had and was very . She also had extreme behaviors, would get too upset to shower, and would act out in refusal. Resident 3 was dependent on staff for assistance with her showers.

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The shower documentation book contained a sheet for each resident. The instructions on the shower sheet stated "Please sign below when given, if refused, write "refused" and notify nurse on duty." The log for Resident 1 indicated she received showers on , , , 17, , 6, 16, and , ; 7 times since the beginning of , . Refusals were documented on , , , 24, , 8, 18, 22, and and 15, 2018. Review of the shower and communication logs found no indication staff went at a later time to offer showers after refusals were noted.

Review of the shower and communication log for Resident 3 found she received showers on , , (two showers noted on this day), 30, , and 14, 2018; 6 times since the beginning of , . None had been documented since. Refusals were noted on and , . There was no documentation in the shower or communication logs that staff went at a later time to offer showers after refusals were noted. The RSA reviewed the data for Residents 1 and 3, and had no explanation.

Record review for Resident 1 revealed a Needs And Service Plan dated which noted she required total assist with bathing twice weekly. The AHCA 1823 dated noted Resident 1 followed directions with difficulty. Bathing assistance required was noted as total dependence.

Record review for Resident 3 revealed a Needs and Service Plan dated which revealed she required total assistance with bathing. The AHCA 1823 (Resident Health Assessment) for Resident 3 also indicated she required total assist from staff with bathing.

Review of the facility's grievance policy and log revealed there had been no written grievances filed on behalf of Resident 1 or 3 regarding showers. An interview was conducted with the Administrator at 2:10 pm on . She explained the facility's grievance procedure, and stated the typical complaints she might receive were about the food, or someone missing a shower; things she would not consider major grievance. Resident 6 once complained Resident 1 did not get a shower, but she refused according to the staff. The Administrator said she developed a shower schedule and documentation form. Staff were to document all showers and refusals, and report refusals to the nurse. The Administrator reviewed the shower records for Residents 1 and 3. She confirmed only 7 showers had been documented as given to Resident 1, and 6 showers were documented as provided to Resident 3 since the beginning of

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, . The Administrator stated her instructions and expectations were for staff to document all showers and refusals. She acknowledged there was no indication in the records that staff returned later in the shift to offer a shower after resident refusals.

Class III

Based on a review of facility records and interview with the Administrator, the facility failed to develop written policies and procedures to ensure the activation, operation and maintenance of the alternate power source during a state of emergency, and failed to provide written notification to residents and/or their representatives upon submission of the plan to the local emergency management agency, and again upon implementation of the plan.

The findings include:

A review of the facility's Comprehensive Emergency Management Plan was conducted with the Administrator and the Maintenance Director at 1:37 pm on . Thorough review revealed there was no Emergency Power Plan (EPP) addendum that included written policies and procedures to ensure the activation, operation and maintenance of the fixed generator, or that addressed resident care and the mitigation of the potential for heat related injury during a power loss. There were no procedures for the use of cooling devices such as fans or spot coolers, refrigerators or freezers for ice production, or for obtaining emergency medical intervention residents whose life safety was in jeopardy.

An interview was conducted with the Administrator at 2:15 pm on . He reviewed the emergency plan binder, and was unable to locate and policies or procedures for the alternate power source. The regulatory requirements were reviewed with him. He confirmed the facility had not developed policies and procedures the requirements for the facility's environmental control plan. There was no indication that residents or their representatives were notified in writing of the submission of the plan to the local emergency management authority, and no indication written documentation was provided following the facility's implementation date, which was self-reported as , , .

An interview was conducted with the Administrator at this time. She searched the records, and could not

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locate any of the required policies or procedures, or notification letters. She stated she would look for it, that perhaps the prior Administrator had done it.

In a telephone call with the Administrator on 11/20/18 at 4:45 pm, she confirmed the oversight, and stated the facility had failed to develop policies and procedures that met the requirements, or to notify residents/representatives, as required.

Class III