STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105140	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bristol Care Center	1818 E Fletcher Ave Tampa, FL 33612

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide supervision to prevent an elopement for a resident with a known history of wandering for one resident (#1) of two residents sampled. On 4/19/26 at approximately 10:30 a.m., Resident #1 left the facility unsupervised and was missing for 10 hours.Findings included:Review of a progress note dated 4/19/26 revealed, At approximately 1 p.m., nurse entered resident's room to administer scheduled medications. Resident was not present in the room at that time. Immediate search of the unit was conducted with no success. Nurse proceeded to the front desk and spoke with the receptionist, who reported that the resident had left the facility earlier, appearing to sign out. There was no prior notification given to nursing staff regarding the resident's intent to leave the facility.Review of the admission record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including other toxic encephalopathy, cellulitis of lower limbs, generalized muscle weakness, adjustment disorder with depressed mood and age-related physical debility.Review of the minimum data set (MDS), dated [DATE], showed a brief interview for mental status (BIMS) score of 8 out of 15, indicating the resident was moderately impaired, and may forget daily tasks. Section E revealed the resident did not have wandering behaviors indicated.Review of the resident's medical record revealed the following:An admission elopement assessment dated [DATE] revealed the resident was not at risk.An elopement evaluation dated 3/31/26 revealed the resident has recent history of elopement or wanders with history of exit seeking within the last 90 days. The intervention called for placing the resident's picture in the elopement book. Apply wanderguard, if facility has system available.Review of a progress note dated 3/20/26 showed, Care Area Review: The IDT [interdisciplinary team] met to discuss the following care areas: Elopement. Emotional Well Being. Comments: on 3/13/26: resident was observed trying to leave out of back doors of the unit. Stated he was going home. Was easily redirected back to room and Wanderguard placed.Review of the current physician orders revealed: On 3/13/26: Wanderguard; every shift, Check for placement - right leg AND every day shift Check for function - right leg.Review of the care plan, initiated on 2/23/26 and discontinued on 5/2/26, revealed Resident #1 did not have a plan of care in place following the elopement assessment on 3/31/26 and did not have a wandering or elopement focus in place during the time of the elopement on 4/19/26.On 5/7/26 at 12:12 p.m. an interview was conducted with Staff A, Registered Nurse (RN)/ Supervisor. Staff A revealed having worked on the day Resident #1 left the facility. He stated around lunch time, the assigned nurse had discovered the resident was not in the room. He stated they immediately initiated the search and he called the code. Staff A stated having been informed that the receptionist had let the resident out.An interview with Staff B, Licensed Practical Nurse (LPN), on 5/7/26 at 12:35 p.m. revealed she was assigned to care for Resident #1 on the day he left the facility. She stated Resident #1 had wandering behaviors and wandered about the facility. She stated she did not know at the time the resident was at risk for elopement and could not confirm if he had a wanderguard. She stated when she realized he was missing, she went to the receptionist who said he went out the door. She stated the receptionist confused the resident for a visitor and let him out. She reported having searched the perimeters and (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when they could not immediately find him, they called Code Amber (an alert that generally indicates a vulnerable resident is missing). Staff B stated not knowing if Resident #1 was in their elopement book at the time. Staff B confirmed being notified by a family member that the resident was missing. She stated the resident was gone all day and had not been located at the time she left.During an interview with the Assistant Director of Maintenance (ADOM) on 5/7/26 at 12:58 p.m., he revealed he immediately reported to the facility following the elopement notification and checked all the doors. He confirmed if a resident had a wanderguard, it would activate the alarm, which would alert the staff the resident should not leave unsupervised. He stated, the way the system works, someone would have had to silence the alarm. He stated his inspection revealed all the doors were operating as expected. During this interview, the ADOM demonstrated the operation of the wanderguard device at the front door where Resident #1 left. The system was observed to work without concerns.An interview was conducted with the Lead MDS (LMDS) nurse on 5/7/26 at 2:10 p.m., revealing if a resident had a wanderguard, there would be a physician order, and a care plan would be in place. She stated nursing staff monitor the functionality and placement of the devices daily. In reviewing the care plan at the time of this interview, the LMDS confirmed Resident #1's wanderguard order was initiated on 3/13/26 and placed on him on 3/19/26, but a care plan was not implemented. The LMDS nurse said, The care plan was missed. It was oversight on my part. She confirmed if the care plan was not in place, the CNA task log would not show the interventions required related to monitoring and supervision of this resident. She stated unless they reviewed the elopement book, they would not have known Resident #1 was at risk for wandering or leaving.On 5/7/26 at 3:09 p.m., an interview was conducted with the Director of Nursing (DON), who confirmed having been notified at approximately 1 p.m. on 4/19/26 that Resident #1 had left the facility and his location was unknown. The DON stated she reported to the facility, joined the search and initiated their investigation process. She stated the police and family were immediately notified. The DON stated that she had interviewed all the staff who worked that day, including the receptionist. The DON stated the receptionist said Resident #1 had come to the front desk, carrying a back pack and ambulating with his walker. The receptionist asked the resident if he was a visitor and directed him to sign out but did not confirm the transaction. The DON stated the receptionist watched the resident proceed towards the front door, at which time the alarm went off. The DON stated the receptionist said she silenced the alarm and proceeded to let the resident out without confirming his identity. The DON said, She failed to notify anyone of the alarm going off and her silencing it. When I asked why she did that, she shrugged her shoulders. The DON stated no one else responded to the alarming door at the time. She stated the staff are expected to respond to all alarms. An interview with the Nursing Home Administrator (NHA) on 5/7/26 at 2:58 p.m. revealed Resident #1 had told another resident he was leaving. He stated the receptionist should not have let the resident leave the building when the wanderguard alarm sounded. The NHA said, It wasn't a competency issue; she was able to speak to the facility protocol. She was well trained. She just did not care. The NHA stated Resident #1 was was brought back by the police unharmed at 11:30 p.m., having been unaccounted for 10 hours. He stated the resident wanted to move closer to his people. The NHA stated they facilitated the move and educated all staff regarding their policies and procedures on elopement with on-going drills and audits.On 5/7/26 at 3:49 p.m., a telephone interview was conducted with the Physician. He stated he would have expected the staff to initiate the wanderguard orders sooner and implement the plan of care accordingly. He stated there was a complete breakdown with the receptionist not paying attention to the job. He stated the receptionist failed to follow their process and was let go. He stated they have introduced visitor's badges. The physician stated it was an isolated incident. Review of the facility policy titled Elopement, revised December 2007, revealed a policy statement: Staff shall investigate and report all cases of missing residents.Policy Interpretation and Implementation1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.2. If an employee observes a resident leaving the premises, he/she should:a. Attempt to prevent the (continued on next page)

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