STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105207	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Melbo	1415 S Hickory St Melbourne, FL 32901

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect by not ensuring staff implemented measures to mitigate risks to prevent elopement for 1 of 5 residents reviewed for elopement, of a total sample of 6 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury, harm, and/or death. While resident #1 was out of the facility unsupervised, there was likelihood he could have sustained serious life-threatening injuries, become lost, been accosted by unknown persons, drowned, or hit by a motor vehicle or high speed train and died . On [DATE] at approximately 8:05 PM, a physically and cognitively impaired resident exited the facility's front entrance when an unknown staff person unlocked the door and allowed him to leave the facility unsupervised. Resident #1 wandered through the parking lot in the dark, crossed a two lane road, and proceeded approximately 0.7 miles along a four lane road with moderate traffic at speed limits of 35 miles per hour. The route along the way had uneven terrain and curbs. Approximately 0.1 miles from the facility was a large lake, and approximately 0.4 miles, there was a high speed railroad crossing. The facility was unaware of the resident's elopement until a Registered Nurse (RN) realized he was missing but they failed to search for him for approximately 90 minutes. At approximately 9:50 PM, staff located the resident in the parking lot of a shopping center. The facility staff were unaware of the resident's whereabouts for approximately two hours until the resident's son called to inform them of his location. Findings: Cross reference F689 Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility from an acute care hospital on [DATE]. His diagnoses included dementia, diabetes, speech and language deficits following stroke, abnormalities of gait (walking pattern) and mobility, unsteadiness on feet, and history of falls. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of [DATE] revealed resident #1 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated he was cognitively impaired. Functional Abilities and Goals showed the resident required staff assistance with eating, self-care, mobility, and to complete Activities of Daily Living (ADL). The assessment noted the resident required skilled Physical Therapy, insulin for diabetes, anti-platelet medication to prevent blood clots, and diuretics (fluid removing) medications. The MDS Admission Assessment with ARD of [DATE] noted it was very important to the resident to be outside to get fresh air in good weather, and he fell within the previous month, and fell prior to his admission to the facility. The Admission Data Set assessment dated [DATE] revealed resident #1 was only oriented to himself and he required extensive staff assistance of 1 person for transfers, mobility, ADLs, and ambulated with the assistance of a walker. The Florida Agency for Health Care Administration ,d+[DATE] Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated [DATE] revealed resident #1 required a surrogate for decision making, a front-wheeled walker for ambulation and 1 assistant for transferring. Review of the Order Summary Report noted active physician's medication orders included: Jardiance (blood sugar lowering) 10 Milligrams (MG) once daily, Glargine Insulin 7 Units once daily for diabetes, Humalog Lispro Insulin 100 Units/Milliliter before meals and at bedtime if needed, Atorvastatin 40 MG at bedtime for cholesterol, Metoprolol 25 MG once daily for blood pressure, Midodrine 10 MG every 8 hours for blood pressure, Aldactone (diuretic) 12.5 MG once daily for excess fluid, Entresto (heart receptor response) , d+[DATE] MG once daily and at bedtime for heart failure, Plavix (anti-platelet) 75 MG once daily for heart disease, Xarelto (blood thinner) 10 MG once daily for heart disease, Trazodone (anti-depressant) 100 MG at bedtime for depression, and Lithium Carbonate (mood stabilizer) 150 MG three times daily for mood. Medications due when the resident eloped were Entresto, Atorvastatin, and Humalog Insulin at 9:00 PM, and Midodrine at 10:00 PM. Physician orders included behavior monitoring for wandering, (initiated on [DATE]), wandering/elopement risk ([DATE] and [DATE]), close monitoring for safety ([DATE]), one on one with sitter for exit seeking behavior ([DATE]). and wanderguard (alerting bracelet) placement and monitoring ([DATE]). A comprehensive Care Plan included potential for abnormal bleeding related to anticoagulant and antiplatelet medications, potential for falls/fall related injuries related to weakness, potential for elopement related to being ambulatory with intermittent confusion, and pacemaker ([DATE]), impaired cognition affecting communication, decision making, and judgement ([DATE]). Interventions in the care plan included to assist the resident as needed to specific destinations such as activity room or dining room, assist outside to patio if requested, divert from exits as needed, if goes outside, stay with resident and then assist back inside and report to nursing, report any noted exit seeking behaviors such as verbalizations of wanting to go home, verbalizations of plans to leave, and physical attempts to leave facility, ([DATE]). Elopement Risk Screens dated [DATE], [DATE], and [DATE] showed nurses determined resident #1 was at risk for elopement due to cognitive impairment, mobility, poor decision-making skills, wandering oblivious to safety needs, and his ability to exit the facility. Instructions indicated that if the resident exhibited any of the above behaviors, staff were to report to the Director of Nursing (DON). There were no other interventions noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Social Services Initial Social assessment dated [DATE] noted resident #1 fell and hit his head prior to admission to the facility, and he was slow in making decisions with memory problems. The Social Services Update note dated [DATE] showed the resident had short term and long term memory problems with slow cognition, communication, and decision making abilities. Fall Risk Screens dated [DATE], [DATE], and [DATE] noted resident #1 fell at the facility. The Physical Therapist (PT) Evaluation and Plan of Treatment Assessment Summary completed on [DATE] noted diagnoses of unsteadiness on feet, abnormalities of gait and mobility, generalized muscle weakness, and abnormal posture. The resident was referred for skilled physical therapy following notable changes in function since his skilled therapy was discontinued on [DATE]. The assessment noted the resident had impaired hip, knee, and ankle strength, had increased difficulty with transfer, ambulation and balance, felt unsteady when walking, and worried about falling. The Plan of Treatment dated [DATE] noted resident #1 had an uneven step length and wide support base with Fall Predictors due to asymmetrical stance and discontinuity of steps with a Risk Factors of falls. The daily shift Behaviors records from [DATE] to [DATE] documented the resident had wandered 22 times prior to elopement. The Elopement Book used for staff to identify residents at high risk of elopement included resident #1's record dated [DATE], more than two months before the resident eloped. The psychiatric provider's progress notes dated [DATE] indicated resident #1 was diagnosed with Adjustment Disorder and noted agitation, wandering, verbal or physical aggressiveness, and safety concerns of fall risk. The [DATE] note revealed resident #1 was assessed for dementia with impaired insight and judgement, and the inability to complete instrumental or basic ADL activities without staff assistance. The report read, . Staff counseled regarding safety concern: Fall risk, risk of wandering, and physical aggression . According to historical data by zip code, on [DATE] between 8:00 PM and 10:00 PM the outside temperature was 75 degrees Fahrenheit (retrieved from timeanddate.com on [DATE]) and sunset was at 5:42 PM (retrieved from aa.usno.navy.mil on [DATE]). On [DATE] at 6:19 PM, resident #1 was observed in his room sitting on the bed supervised by Certified Nursing Assistant (CNA) E. The resident said he remembered leaving the facility, but not why he left and stated, I went home. I didn't make it because I stopped, this is the place where they crash people. The CNA said she knew the resident well, and was regularly assigned to his care. She added, he doesn't know where he is; he thinks he's at an apartment right now. On [DATE] at 2:15 PM, resident #1 was observed in his room walking to the bathroom with the assistance of a walker. The resident walked with short steps, and his feet did not fully clear the floor. The resident attempted to walk without the walker and visibly became unbalanced after two steps. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 12:58 PM, RN B said he worked the 7:00 PM to 7:00 AM shift on [DATE] and was assigned to resident #1. The RN recalled after he received off going report at approximately 8:05 PM, he was unable to locate resident #1, so he began looking around the building because the resident was known to wander everywhere. He said CNA D told him she last saw the resident around the time he received report. The RN explained he tried to locate resident #1 himself for about 30 minutes. He said the Wound Care Nurse was the Supervisor, and at approximately 8:45 PM, he told her he could not find resident #1. He explained at approximately 9:15 PM, he told the Supervisor a second time he still had not located resident #1. On [DATE] at 3:18 PM, CNA D said she knew resident #1 well and he was often included in her assignments during the 3:00 to 11:00 PM shift. The CNA described the resident as shaky, he wandered the facility, and often told staff he wanted to go home. She said the resident's son lived close by and visited frequently which made the resident feel better. The CNA recalled she was assigned to the resident #1's care on [DATE] on the evening shift and last saw him in his room between 7:45 PM and 8:00 PM, before he eloped. On [DATE] at 5:59 PM, Licensed Practical Nurse (LPN) C noted resident #1 was exit seeking and paced all over the place; he walked up and down the building. She recalled on [DATE] at approximately 9:00 PM, RN B asked her if she had seen resident #1. She said she checked back with the RN at 9:15 PM and he had not located the resident. She explained she was concerned the RN did not seem overly worried. She remembered within about 15 minutes, at approximately 9:30 PM, an elopement/missing resident alert was initiated and all staff engaged in an active search for the resident. On [DATE] at 11:00 AM, the Wound Care Nurse/Supervisor said she worked in her office and supervised staff during the 3:00 PM to 11:00 PM shift on [DATE]. She recalled LPN C called her at 9:33 PM to let her know staff were unable to locate resident #1. She explained she called the Director of Nursing (DON) who assisted her by telephone as she implemented the facility's missing resident/elopement protocol. She explained that while they searched for the resident, the resident's son telephoned and informed them the resident was at a nearby shopping center. Review of a nursing progress note written by RN A on [DATE] noted on [DATE] at 9:30 PM, the RN was alerted a resident was missing and a facility wide search was initiated. The note showed during the search, resident #1's son called the facility to inform them the resident was at a nearby shopping center and two nurses drove to the location and brought the resident back to the facility. On [DATE] at 7:44 PM, RN A said she knew resident #1 well and said he frequently wandered around the facility with his walker. The RN recalled on [DATE] at approximately 9:30 PM, she assisted with the search and drove around the surrounding area in the dark looking for resident #1. She said she returned to the facility after she was unable to locate the resident and received a call from the resident's son to let staff know resident #1 was at a nearby shopping center. She said the resident's son was concerned as his father was lost and did not know how to get back to the facility. She explained she immediately drove to the shopping center and saw the resident in the parking lot with LPN C. The RN stated, he said he went for a ride and there was a lady at the door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:45 PM, RN K said she sometimes worked the 7:00 PM to 7:00 AM shift and she knew resident #1 well. She said resident #1 often had trouble using his phone to call his son and she had to help him. The RN recalled an occurrence before the resident eloped when he said he wanted to go home. She discussed the resident being out in the dark by himself and said the resident could have easily fallen and hit his head because he had a shuffled gait. The RN stated, I never thought he would go out of the building. On [DATE] at 3:45 PM, CNA Q said he worked on [DATE] during the 3:00 PM to 11:00 PM shift. The CNA recalled he assisted in the search to locate resident #1, but he did not know what the resident looked like, so he checked the computer. The CNA explained he started work at the facility approximately two weeks prior to the incident and he did not recall receiving education about how to locate missing residents during his new employee orientation. The CNA stated, the active search was mostly word of mouth. On [DATE] at 3:19 PM, the DON said before resident #1 eloped, he was included in the Elopement Books for staff reference, and the Electronic Health Record (EHR) noted special instructions to alert staff of his elopement risk. She explained nurses and CNAs were expected to know who the high risk residents were and they relied on the binders and EHR to alert them. In a telephone interview on [DATE] at 11:22 AM, resident #1's son recalled on [DATE] at approximately 9:50 PM, he spoke to his father by phone. He said the resident told him the phone was not working, he was lost and did not know how to get home. The resident's son stated, he was incoherent, calling me about money and the phone. He said he determined through their conversation the resident was close to a nearby grocery store. He explained he immediately hung up, called the facility to let them know where the resident was, and called his father back while he maintained the call until the resident was located by facility staff. The resident's son conveyed he was very concerned because it was dark and there was a train crossing and open water nearby where his father could have fallen into. He stated, he has in an out confusion and needs a walker just to get to the bathroom. He explained the resident had history of falls and wandered into traffic. He recalled he informed staff that police had once found his father laying down on a 4 lane road at 3:00 AM. He added, he didn't know where he was, or which way to go. He explained his father had a simple flip-style cellular phone with my name in it so it's easier for him to call me. He stated it was a wonder his father managed to call him when he eloped as he usually could not remember how to use the phone. He recalled about a month ago, he was asked to come to the facility to calm the resident down and added, he was packing his stuff to leave. On [DATE] at 10:17 AM, the DON explained she expected staff to immediately initiate the facility's elopement protocols when they were unable to locate a resident. She said she was not aware the resident often verbalized he wanted to leave and stated, he wasn't exit-seeking; if he was, I would put him on one to one immediately. The DON conveyed staff did not act timely or with a sense of urgency after they realized the resident was missing. She stated, it wasn't activated per policy. On [DATE] at 3:30 PM, the DON was asked why local police were not called to assist their search to which she replied, that's a great question; they should have called the police before they called me. The DON acknowledged resident #1 was subjected to dangerous hazards while out in the dark unsupervised and she did not explain why she did not direct staff to call law enforcement after she was notified the resident was missing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 11:21 AM, the Medical Director recalled the facility notified him resident #1 eloped. He said he was not familiar with the resident and conveyed he expected the facility to ensure residents at risk for elopement were kept safe with appropriate interventions and re-evaluations when behaviors escalated. Review of the facility's standards and guidelines dated [DATE] titled Nursing Elopement Prevention read, . it is the policy of this facility to provide a safe environment for all residents and to eliminate and/or control elopement behavior of residents. The facility shall do all that is reasonable to identify and prevent unsafe wandering and/or elopement and to act quickly and prudently should either occur. Examples of wandering or elopement behaviors include . exit seeking with or without rational purpose, verbalization of plans to leave the facility . if the resident is not located promptly, the Administrator/Director of Nursing should notify the local police (or 911) . Review of the facility's standards and guidelines dated [DATE] titled Nursing Missing Resident/Elopement read, . the staff who noted the resident to be missing should notify the Nursing Supervisor immediately. The Nursing Supervisor/designee on duty should be responsible for: I. Organizing a search team . Review of the facility's standards and guidelines dated [DATE] titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, Injury of Unknown Source and Investigation read, . Neglect is the failure of the facility, it's 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 . Review of the immediate actions to remove the Immediate Jeopardy implemented by the facility as noted in their accepted Immediate Jeopardy Removal Plan revealed the following, which were verified by the surveyors: *On [DATE], the resident was returned to the facility and immediately received a nursing physical assessment with no findings of injuries or identified concerns. The physician and resident representative were notified of the event. *On [DATE], the Elopement Risk Alert Binder was reviewed to ensure all residents at risk for elopement had a picture and demographics in place. The affected resident remained on 1:1 supervision. *On [DATE], the facility conducted a head count of all current residents; all were safe and accounted for. *On [DATE] and [DATE], all exit doors were assessed by the Executive Director and Maintenance Director to ensure proper functioning; no issues or concerns were identified. *On [DATE], re-evaluations/review of all current residents for elopement risk was conducted. *On [DATE], all door codes were changed. *On [DATE], an Immediate Federal Report was filed. *On [DATE], DCF (Florida Department of Children and Families) agent arrived to investigate inadequate supervision with findings unsubstantiated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 46665 Based on observation, interview, and record review, the facility failed to provide adequate supervision and a secure environment to prevent elopement for 1 of 5 residents reviewed for Elopement, of a total sample of 6 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious life-threatening injury, harm, or even death. While resident #1 was out of the facility unsupervised, there was likelihood he could have sustained serious life-threatening injuries, become lost, been accosted by unknown persons, drowned, or hit by a motor vehicle or high speed train and died . On [DATE] at approximately 8:05 PM, a physically and cognitively impaired resident exited the facility's front entrance when an unknown staff person unlocked the door and allowed him to leave the facility unsupervised. Resident #1 wandered through the parking lot in the dark, crossed a two lane road, and proceeded approximately 0.7 miles along a four lane road with moderate traffic at speed limits of 35 miles per hour. The route along the way had uneven terrain and curbs. Approximately 0.1 miles from the facility was a large lake, and approximately 0.4 miles, there was a high speed railroad crossing. The facility was unaware of the resident's elopement until a Registered Nurse (RN) realized he was missing but they failed to search for him for approximately 90 minutes. At approximately 9:50 PM, staff located the resident in the parking lot of a shopping center. The facility staff were unaware of the resident's whereabouts for approximately two hours until the resident's son called to inform them of his location. Findings: Cross reference F600 Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility from an acute care hospital on [DATE]. His diagnoses included dementia, diabetes, speech and language deficits following stroke, abnormalities of gait (walking pattern) and mobility, unsteadiness on feet, and history of falls. The Admission Data Set assessment dated [DATE] revealed resident #1 was only oriented to himself and he required extensive staff assistance of 1 person for transfers, mobility, Activities of Daily Living (ADLs), and required a walker to walk safely. The Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of [DATE] revealed resident #1 scored 8 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated he was cognitively impaired. Functional Abilities and Goals showed the resident required staff assistance with eating, self-care, mobility, and to complete Activities of Daily Living (ADL). The assessment noted the resident required skilled Physical Therapy, insulin for diabetes, anti-platelet medication to prevent blood clots, and diuretics (fluid removing) medications. The MDS Admission Assessment with ARD of [DATE] noted it was very important to the resident to be outside to get fresh air in good weather, and he fell within the previous month, and fell prior to his admission to the facility. (continued on next page)

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	105207	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrock Rehabilitation and Nursing Center at Melbo	1415 S Hickory St Melbourne, FL 32901

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Speech and Language Pathologist (SLP) Evaluation and Plan of Treatment completed [DATE] noted the resident's memory function and cognitive impairments were unsafe for participation in daily life tasks with risk factors that read, fall risk. The SLP Discharge Summary dated [DATE] showed the resident required cues to recall important information. Review of Elopement Risk Screens dated [DATE], [DATE], and [DATE] showed nurses determined resident #1 was at risk for elopement due to cognitive impairment, decreased mobility, poor decision-making skills, wandering oblivious to safety needs, and his ability to exit the facility. Instructions indicated a positive risk finding was to be reported to the Director of Nursing (DON). No other interventions were noted. The Social Services Initial Social assessment dated [DATE] noted the resident fell and hit his head prior to admission to the facility, and he was slow in making decisions with memory problems. The Social Services Update note dated [DATE] noted the resident had short term and long term memory problems with slow cognition, communication, and decision making abilities. In a telephone interview on [DATE] at 11:22 AM, resident #1's son recalled on [DATE] at approximately 9:50 PM, his father called him and told him he was lost and did not know how to get home. The resident's son stated, he was incoherent, telling me about money and the phone. He said he determined through their conversation that his father was close to a nearby grocery store. He explained he immediately hung up, called the facility to let them know where the resident was, and called his father back while he maintained the call until the resident was located by facility staff. The resident's son conveyed he was very concerned because it was dark and there was a train crossing and open water nearby that his father could have fallen into. He said, he has in an out confusion and needs a walker just to get to the bathroom. He explained the resident had history of falls and wandered into traffic. He recalled he informed staff that police had once found his father laying down on a 4 lane road at 3:00 AM. He added, he didn't know where he was, or which way to go. He explained his father had a simple flip-style cellular phone with my name in it so it's easier for him to call me. He stated it was a wonder his father managed to call him when he eloped as he usually could not remember how to use the phone. He recalled about a month ago, he was asked to come to the facility to calm the resident down and added, he was packing his stuff to leave. According to historical data by zip code, on [DATE] between 8:00 PM and 10:00 PM at the facility, the outside temperature was 75 degrees Fahrenheit (retrieved from timeanddate.com on [DATE]) and sunset was at 5:42 PM (retrieved from aa.usno.navy.mil on [DATE]). On [DATE] at 3:45 PM, RN K said she knew resident #1 well. She said resident #1 often had trouble using his phone to call his son and she had to help him. The RN recalled an occurrence before the resident eloped when he said he wanted to go home. She said the resident could have easily fallen and hit his head when he left the facility in the dark as his gait was not steady and he shuffled. On [DATE] at 6:19 PM, resident #1 was observed in his room sitting on the bed supervised by Certified Nursing Assistant (CNA) E. The resident said he remembered leaving the facility, but not why he left and stated, I went home. I didn't make it because I stopped, this is the place where they crash people. The CNA said she knew the resident well and was regularly assigned to his care. She added, he doesn't know where he is; he thinks he's at an apartment right now. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:15 PM, resident #1 was observed in his room walking to the bathroom with the assistance of a walker. The resident walked with short steps, and his feet did not fully clear the floor. The resident attempted to walk without the walker and visibly became unbalanced after two steps. On [DATE] at 11:33 AM, Physical Therapist I explained the resident required assistance of a walker to stabilize and walk safely. He said the resident required increased staff assistance while outside with the additional obstacles and stated, he does not walk very fast; I would say he had no shot navigating streets independently; if it's dark outside, it's even worse. On [DATE] at 12:43 PM, CNA L said resident #1 was confused, and he did not walk very well without his walker because his balance was not good. He said CNAs were expected to check residents who wandered every 15 minutes. He noted that before resident #1 eloped, he was not aware of all the high risk residents, only those he was assigned to or informed of by other staff. The CNA recalled a month or two prior to the incident, resident #1 was distressed and told staff he wanted to go home. He said the resident packed a bag and nurses had to call his son to come to the facility to calm him down. The CNA stated, he loved to pack his things in a bag, like he's ready to go. On [DATE] at 10:22 AM, CNA O explained before resident #1 eloped, residents who were a high risk for elopement and falls were checked by CNAs every 15 minutes and after the alerting bracelet system was implemented, checks were changed to every hour. She said if a resident was missing, she reported it to the nurse and staff started a facility wide head count. On [DATE] at 3:45 PM, CNA Q said he worked on [DATE] during the 3:00 PM to 11:00 PM shift. The CNA recalled he assisted in the search to locate resident #1, but he did not know what the resident looked like so he checked the computer. The CNA explained he started work at the facility approximately two weeks prior to the incident and he did not recall receiving education about how to locate missing residents during his new employee orientation. The CNA stated, the active search was mostly word of mouth. On [DATE] at 5:59 PM, Licensed Practical Nurse (LPN) C noted resident #1 was exit seeking and paced all over the place; he walked up and down the building. She recalled on [DATE] at approximately 9:00 PM, RN B asked her if she had seen resident #1. She said she checked back with the RN at 9:15 PM and he had not located the resident. She explained she was concerned the RN did not seem overly worried. She remembered within about 15 minutes, at approximately 9:30 PM, an elopement/missing resident alert was initiated and all staff engaged in an active search for the resident. In a telephone interview on [DATE] at 12:58 PM, RN B said he worked the 7:00 PM to 7:00 AM shift on [DATE] and was assigned to resident #1. The RN recalled after he received off going report at approximately 8:05 PM, he was unable to locate resident #1, so he began looking around the building because the resident wandered everywhere. He said CNA D told him she last saw the resident around the time he received report. The RN explained he tried to locate resident #1 himself for about 30 minutes. He said the Wound Care Nurse was the supervisor that evening and at approximately 8:45 PM, he told her he could not find resident #1. He explained at approximately 9:15 PM, he told the Wound Care Nurse a second time he still hadn't found the resident. The RN explained when he worked after hours, staff left the inside lobby french doors opened. He recalled when he worked on [DATE] he passed the lobby on his way to get report and, the two double doors were not locked, and residents could get into the lobby. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:18 PM, CNA D said she knew resident #1 well and he was often included in her assignments during the 3:00 to 11:00 PM shift. The CNA described the resident as shaky, he wandered the facility, and often told staff he wanted to go home. She said the resident's son lived close by and visited frequently which made the resident feel better. The CNA recalled she was assigned to the resident #1's care on [DATE] on the evening shift and last saw him in his room between 7:45 PM and 8:00 PM, before he eloped. On [DATE] at 9:50 AM, the Wound Care Nurse recalled on [DATE] at 8:11 PM, she sent a group text asking if a new admission was expected because ambulance personnel had arrived with a patient. The nurse said CNA Q assisted her in the lobby and entered the code to unlock the front entrance doors to let the ambulance personnel out. She explained the inside lobby french doors did not lock and made a sound to alert staff when they opened. The nurse stated, we try to have the inside doors open. On [DATE] at 3:45 PM, CNA Q recalled on ,d+[DATE]//24 at approximately 8:15 PM, he assisted the Wound Care Nurse with ambulance personnel at the front lobby entrance. The CNA explained prior to resident #1's elopement, the inside lobby double doors were never closed. On [DATE] at 4:49 PM, Receptionist F explained visitors were required to sign in and out at the reception desk and there was an Elopement Book with photos and information kept there to alert staff of residents that were high risk. She said she activated the front door exit alarms when she left for the day and staff had to use the keypad code to unlock it. She recalled on [DATE] at approximately 4:45 PM, she left for the day and after that, the staff were responsible for the front keypad visitor entrance/exit access. On [DATE] at 8:17 AM, the Maintenance Director recalled before resident #1 eloped, the inside lobby double doors were not alarmed. He explained, the former Nursing Home Administrator (NHA) was aware the doors required an electrical inspection in order to use the alarm box because it was connected to the fire panel alarm system for magnetic doors. He said the double doors never had a lock. On [DATE] at 7:44 PM, RN A said she knew resident #1 well and staff knew he frequently wandered around the facility with his walker and he paced. The RN recalled on [DATE] at approximately 9:30 PM, she assisted the search and drove around the surrounding area which was more difficult to see in the dark. The nurse said she returned to the facility after she was unable to locate the resident and received a call from the resident's son to let staff know resident #1 was at a nearby shopping center. She said the resident's son was concerned as his father was lost and did not know how to come back. She explained she immediately drove to the shopping center and saw the resident in the parking lot with LPN C. The RN stated, he said he went for a ride and there was a lady at the door. On [DATE] at 11:00 AM, the Wound Care Nurse said she worked in her office and supervised staff during the 3:00 PM to 11:00 PM shift on [DATE]. She said according to her phone record, LPN C called her at 9:33 PM to let her know staff were unable to locate resident #1. She explained she called the DON who assisted her by telephone as she implemented the facility's missing resident/elopement procedures. The nurse said while staff searched, a call came in from the resident's family member who informed them the resident was at a nearby shopping center. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nursing progress note written by RN A on [DATE] noted on [DATE] at 9:30 PM, the RN was alerted a resident was missing and a facility wide search was initiated. It was noted during the search, resident #1's son called the facility to inform them the resident was at a nearby shopping center; two nurses drove to the location and he was transported back to the facility. On [DATE] at 5:59 PM, LPN C recalled on [DATE] at approximately 9:50 PM, she found resident #1 lost and alone without his walker in the nearby shopping center parking lot. She said the resident told her he went for a walk. The nurse said she was concerned about the resident because his gait was unsteady and he needed his walker. The LPN stated, I couldn't believe he got that far; I was worried because there's water right over there, and his cognition is off. On [DATE] at 3:19 PM, the DON said before he eloped, resident #1 was included in the Elopement Books for staff reference, and the Electronic Health Record (EHR) noted special instructions to alert staff of his elopement risk. She explained nurses and CNAs were expected to know who the high risk residents were and they relied on the books and EHR to alert them. Review of the Elopement Book used for staff to identify residents at high risk of elopement included resident #1's record dated [DATE], more than two months before the resident eloped. On [DATE] at 1:31 PM, the DON recalled on [DATE], the Wound Care Nurse was in the building during the evening shift and covered staff supervision. She said at approximately 9:30 PM, she received a call from the nurse to inform her resident #1 was missing and she assisted her over the phone to implement the facility's elopement policy. The DON explained after 5:00 PM on weekends, the front exit doors were unlocked by keypad and all staff had the code. She said between approximately 8:00 PM and 8:15 PM, the front lobby exit doors were unlocked by staff for entry of ambulance personnel with a stretcher. She said after the incident, resident #1 was interviewed and gave a physical description of CNA G who was outside in the parking lot when he exited. She concluded the CNA may have been outside on a smoke break. The DON said resident #1 left his walker and told them when transportation personnel exited, he got to the door before it latched and she stated, as his words, I high-tailed it; I had to move fast. On [DATE] at 10:17 AM, the DON explained she expected staff to immediately initiate the facility's resident/elopement protocols when they were unable to locate a resident. She said she was not aware resident #1 often verbalized he wanted to leave and stated, he wasn't exit-seeking; if he was I would put him on one to one supervision immediately. The DON conveyed staff did not act timely or with a sense of urgency after they realized the resident was missing and noted, it wasn't activated per policy. On [DATE] at 3:30 PM, the DON was asked why local police were not called to assist their search and she replied, that's a great question, they should have called the police before they called me. The DON acknowledged resident #1 was subjected to dangerous hazards while out in the dark unsupervised and she did not explain why she did not direct staff to call law enforcement after she was called. In a telephone interview on [DATE] at 11:21 AM, the Medical Director recalled that some time shortly after the incident, the facility notified him resident #1 eloped. He said he was not familiar with the resident and conveyed he expected the facility to ensure residents at risk for elopement were kept safe with appropriate interventions and re-evaluations when behaviors escalated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's standards and guidelines dated [DATE] titled Nursing Elopement Prevention read, . it is the policy of this facility to provide a safe environment for all residents and to eliminate and/or control elopement behavior of residents. The facility shall do all that is reasonable to identify and prevent unsafe wandering and/or elopement and to act quickly and prudently should either occur. Examples of wandering or elopement behaviors include . exit seeking with or without rational purpose, verbalization of plans to leave the facility . if the resident is not located promptly, the Administrator/Director of Nursing should notify the local police (or 911) . All staff are to be aware of the potential wandering/elopement attempts and be prepared to intervene: a. All door alarms must be operational 24 hours per day . Review of the facility's standards and guidelines dated [DATE] titled Nursing Missing Resident/Elopement read, . the staff who noted the resident to be missing should notify the Nursing Supervisor immediately. The Nursing Supervisor/designee on duty should be responsible for: I. Organizing a search team . Review of the facility's standards and guidelines dated [DATE] titled Visitor Sign In Policy stated the facility's policy ensured residents were not accidentally let out of the facility. Review of the immediate actions to remove the Immediate Jeopardy implemented by the facility as noted in their accepted Immediate Jeopardy Removal Plan revealed the following, which were verified by the surveyors: *On [DATE], the resident was returned to the facility and immediately received a nursing physical assessment with no findings of injuries or identified concerns. The physician and resident representative were notified of the event. *On [DATE], the Elopement Risk Alert Binder was reviewed to ensure all residents at risk for elopement had a picture and demographics in place. The affected resident remained on 1:1 supervision. *On [DATE], the facility conducted a head count of all current residents; all were safe and accounted for. *On [DATE] and [DATE], all exit doors were assessed by the Executive Director and Maintenance Director to ensure proper functioning; no issues or concerns were identified. *On [DATE], re-evaluations/review of all current residents for elopement risk was conducted. *On [DATE], all door codes were changed. *On [DATE], an Immediate Federal Report was filed. *On [DATE], DCF (Florida Department of Children and Families) agent arrived to investigate inadequate supervision with findings unsubstantiated. *On [DATE] and [DATE], the DON/designee reviewed elopement binders to ensure residents at risk for elopement were present and identified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On [DATE], the Executive Director/designee and DON/designee began reviews to ensure the safety and well-being related to elopement was maintained by the continued participation, evaluation, and intervention through maintaining the Quality Assurance/Performance Improvement (QAPI) process. *On [DATE], weekly audits were initiated on the components of elopement care management system with emphasis on adequate supervision. Audit findings were reported to the QAPI Committee weekly until a committee determination of substantial compliance and recommendation of monthly monitoring by the Regional Director of Clinical Operations when completing their systems review. *On [DATE], French door magnetic lock system was reactivated by maintenance. The front door screamer system was assessed and found to be working properly; the volume was increased. *On [DATE], review of all residents identified at risk for elopement was completed by Unit Manager/designee for Elopement Screen, Care Plans related to wandering risk, CNAs Kardex reflective of resident status, and presence in Elopement Binders. *On [DATE], the Maintenance Director contacted local electrical vendor for door alarm and nurse call system inspections; inspections were completed [DATE], with no identified concerns. *From [DATE] to [DATE], the DON/designee educated staff on: components of regulation F600 with an emphasis on abuse, neglect, and adequate supervision with posttests. *On [DATE], 100% of actively working staff were re-educated in person and/or via telephone; no inactive or scheduled staff were permitted to work without prior receipt of in-person education. Any future newly hired employees were to receive the same education with orientation. *On [DATE], electrician provider was contacted for addition of wanderguard (alerting bracelet) system installation. *On [DATE], 24-hour door monitors were scheduled until the wanderguard system installation completion. *On [DATE], Ad Hoc QAPI attended by Medical Director, DON, and Regional [NAME] President (in place of Nursing Home Administrator), and Regional Nurse Consultant was convened to review the components of ongoing elopement, the Charter Performance Improvement Plan (PIP) that included education, drills, resident evaluations, door and alarm checks, elopement risk binders placement and accuracy, french door at lobby exit magnetic lock functioning, 24-hour door monitors, new wanderguard system in place and audits completed, and systemic change and effectiveness review. *[DATE], plans and interventions in place were determined by the facility to be effective. Review of the facility's attendance records noted staff participated in education on the topics listed above. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*From [DATE] to [DATE] interviews were conducted with 32 staff members who represented all shifts. The facility's staff included 37 licensed nurses and 67 CNAs. Interviewed staff included 6 RNs, 6 LPNs, 14 CNAs, 1 Certified Dietary Manager, 1 Housekeeper, 1 Physical Therapy Assistant, 2 Receptionists, and 1 Maintenance Director. All interviewed staff verbalized understanding of the education provided. The resident sample was expanded to include 4 additional residents at risk for elopement/neglect. Observations, interviews, and record reviews revealed no concerns related to elopement for residents #2, #3, #5 and #6.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46665 Based on observation, and interview, the facility's administration failed to implement it's resources to maintain effective elopement prevention measures to ensure the safety of residents known to be at high risk of elopement. On 10/26/24 at approximately 8:05 PM, a physically and cognitively impaired resident exited the facility's front entrance when an unknown staff person unlocked the door and allowed him to leave the facility unsupervised. Resident #1 wandered through the parking lot in the dark, crossed a two lane road, and proceeded approximately 0.7 miles along a four lane road with moderate traffic at speed limits of 35 miles per hour. The route along the way had uneven terrain and curbs. Approximately 0.1 miles from the facility was a large lake, and approximately 0.4 miles, there was a high speed railroad crossing. The facility was unaware of the resident's elopement until a Registered Nurse (RN) realized he was missing but they failed to search for him for approximately 90 minutes. At approximately 9:50 PM, staff located the resident in the parking lot of a shopping center. The facility staff were unaware of the resident's whereabouts for approximately two hours until the resident's son called to inform them of his location. Findings: On 11/17/24, it was noted the facility's inside lobby doors and alerting bracelet alarm systems were not activated. Facility staff stated the former Nursing Home Administrator (NHA) was aware of the problems since approximately March 2024, however measures required to fully inspect and activate the equipment were not taken, for 9 months. In an interview on 11/20/24 at 8:17 AM, the Maintenance Director recalled when he began work at the facility approximately nine months prior, the facility's magnetic lock system was not working properly. He said the inside lobby double door alarm worked, but it was not being utilized by staff. He said equipment was installed prior to his employment however, it was connected to the fire alarm system and unknown if the double door alarm box was programmed for proper functioning without arming the fire alarms. He said a certified service company was required for electrical and alarm inspections to ensure there were correct operations. He said approximately four to five months prior, partial inspections were completed but required additional fire system operational revisions which were not completed until after resident #1 eloped. He said on 7/29/24, invoices were provided to secure the alarms and alerting bracelet systems and stated, it was very costly; the administrator said the person before him wanted to get it started, but he never got it started. I believe it was on the back burner for some time. Review of an Invoice and Call Summary for services provided on 7/25/24 read, . wiring mag (magnetic) locks on front door . unable to test . need to get door locks to activate before testing . In a telephone interview on 11/18/24 at 12:58 PM, Registered Nurse (RN) B recalled on 10/26/24, at approximately 7:45 PM, he passed the lobby on his way to receive shift report. He said there was no receptionist on duty and the inside double doors were open, the double doors were not locked and residents could get into the lobby. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 3:19 PM, the Director of Nursing (DON) recalled when she began working at the facility approximately 5 months prior, she was concerned the facility did not have an alerting bracelet system. She said the former NHA relayed there was an equipment box installed at the front exit doors that was not activated. She explained she asked about having the system implemented and was aware of a very high cost requirement. The DON stated, it was constantly at my forefront trying to get the system. We were always told it was being looked at but never given a reason why the system wasn't fixed. On 11/18/24 at 1:45 PM, the Regional Nurse Consultant said the NHA was not available and was not working at the facility. Review of the facility's standards and guidelines dated 4/01/22 and titled Administration/Governing Body read, . Policy Interpretation and Implementation: . provision of a safe physical environment equipped and staffed to maintain the facility and services . Review of the facility's standards and guidelines dated 4/01/22 and titled Nursing-Elopement Prevention read, . If identified as high risk for elopement, the nurse should apply an electronic monitoring device to the resident, initiate an elopement risk care plan and obtain an MD (Medical Doctor) order for the electronic monitoring device. Review of the facility's undated job description with the job title, Nursing Home Administrator read, . Collaborates with consultants, contractors, referring physicians, community resources, government agencies and advocacy groups. Implements operational and financial objectives of Management and allocates resources in an efficient and economical manner to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident.