STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105257	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Saint Lucie	611 S 13th St Fort Pierce, FL 34950

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on interview and record review, the facility failed to accurately assess a resident for wandering for 1 of 3 sampled residents reviewed for elopement (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE]. An interview was conducted with the Nursing Home Administrator (NHA) on 04/10/24 at 10:00 AM. The NHA confirmed Resident #1 had a room change done on 03/18/24 due to exit seeking/wandering behaviors. The resident was care planned for at risk for elopement on 03/19/24, with an intervention of an electronic monitoring device (wanderguard) in place on the right ankle. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment and did not exhibit any wandering behaviors.

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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(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 - 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** 36734 Based on interview, observation, and record review, the facility failed to provide adequate supervision and properly functioning wanderguard doors (wander monitoring system device) for 1 of 3 sampled residents reviewed for elopement risk (exiting the facility unsupervised) (Resident #1). The deficient practice allowed Resident #1 to exit the facility undetected on 03/27/24 at approximately 6:00 PM and walk 1.4 miles away from the facility. Resident #1 was found by the police while displaying confusion, resulting in a transfer to a local hospital. These actions resulted in Immediate Jeopardy. The facility administrator was informed of the Immediate Jeopardy on 04/10/24 at 4:48 PM. At the time of the investigation there were 11 residents who were identified as wander/elopement risk. The findings included: A review of the facility's Policies and Procedures titled Elopement/Wandering Risk Guideline dated 09/21/16 and revised 08/01/20 documented: If utilizing a wander monitoring system device check placement of the device every shift and functionality every day. Resident #1 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 0 out of 15. The resident was ambulatory without any assistive devices. The resident was care planned for at risk for elopement on 03/19/24, with an intervention of an electronic monitoring device (wanderguard) in place on the right ankle. An Elopement sreening dated 03/25/24 documented the resident as high risk for elopement. Resident #1 exited the facility on 03/27/24 at approximately 6:00 PM without the knowledge of any staff. The resident was determined missing by staff on 03/27/24 at approximately 8:00 PM. Staff notified police of the missing resident, and was informed by the police that the resident had been found by an officer at a gas station 1.4 miles from the facility at 8:26 PM. The resident was taken to the hospital by the officer (per the local Police Department Incident/Investigation form dated 03/27/24 at 8:26 PM, the resident was [NAME] Acted). The resident returned to the facility from the hospital on 03/28/24 at 12:30 AM. A review of the route Resident #1 walked revealed an area where there are hazards for an unsupervised cognitively impaired resident with poor decision-making skills. The resident walked 1.4 miles to a gas station, on a 4-lane divided road, with speed limits up to 45 MPH. While Resident #1 was out of the facility unsupervised, there was a high likelihood that he could have been seriously injured or harmed. He could have been hit by a car, fallen, or become lost. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Nursing Home Administrator (NHA) on 04/09/24 at 11:30 AM. The NHA stated it was believed Resident #1 had exited the north unit emergency exit doors. The NHA stated the north unit was closed and under construction. The NHA stated the doors must have been left unlocked/disalarmed by the construction crew. The NHA stated surveillance video from the outside security cameras were reviewed by corporate, and Resident #1 was not seen on video. The NHA stated there were no security cameras for the north unit emergency exit doors. The security cameras covered the parking lot and employee entrance/exit. The NHA stated after the incident occurred, they placed a lock keypad to the entrance of the north unit. Upon request, the NHA stated he did not have access to the surveillance video from the outside security cameras, and could not provide access to the surveyor. The NHA stated an elopement book was located at both nursing stations and the receptionist desk. An interview was attempted with Resident #1 on 04/09/24 at 12:00 PM. The resident was observed lying in bed on top of the covers with his hands crossed behind his head and legs crossed. When questioned about leaving the facility, Resident #1 stated, I can't leave this place. The resident could not answer any further questions. The resident was clean and fully dresses with a shirt, pants, and sneakers on. The resident had a sitter outside the his door. An interview was conducted with Staff B, a Licensed Practical Nurse, on 03/09/24 at 2:00 PM. Staff B stated he was Resident #1's primary nurse on 03/27/24 from 7:00 PM-7:00 AM. Staff B stated when he came on duty, Resident #1 was not in his room or unit area. Staff B stated he was told the resident was wandering around the facility by the offgoing nurse. Staff B stated he was informed by the CNA (Certified Nursing Assistant) that Resident #1 could not be found at approximately 8:00 PM. Staff B stated all staff began searching for Resident #1. Staff B stated he searched the north unit. The emergency exit doors were not alarming. Staff B further stated he tested the locks by attempting to open the doors and the doors started to alarm. The doors were locked. An interview was conducted with Staff G, Assistant Maintenance Director, on 04/09/24 at 3:30 PM. Staff G stated he checks all exit doors for functionality daily. Staff G stated he checked the emergency exit doors on 03/27/24 prior to leaving the facility on 03/27/24. Staff G stated the doors were locked. Staff G further stated he does not check doors with the wanderguard device. An interview was conducted with Staff C, a CNA, on 04/09/24 at 5:00 PM. Staff C stated she assisted Resident #1 with dinner on the day of the incident around 5:30 PM. Staff C stated she last saw the resident in church services at the facility at approximately 7:00 PM on 03/27/24. An telephone interview was conducted with the Clergy on 04/09/24 at 5:30 PM. The Clergy stated Resident #1 did not attend church services on 03/27/24. The Clergy stated she knows everyone that attends service. The Clergy stated she was let out of the facility by staff between 7:00 PM-7:30 PM. No one followed her out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Staff D, a part time receptionist, on 04/10/24 at 10:00 AM. Staff D stated she was not familiar with Resident #1 and had never seen the resident before 03/27/24. Staff D stated she saw Resident #1 at the time clock hallway where the employee entrance/exit doors were located around 6:00 PM on 03/27/24. The resident was standing there like a regular employee, and was seen trying to press buttons on the time clock. Staff D stated she could not see the door at the time clock from where she sits, but did hear the door close and did not see the resident or any other employees in the area. Staff D stated when she came into work on 03/29/24, she was told a resident had eloped. The resident was described to her as carrying a yellow bag. Staff D stated that jogged her memory of the resident standing next to the time clock. Staff D explained she did not see the resident exit, but saw the resident go towards the employee door and heard the door shut. No alarm went off. Staff D stated she told the facility in a written statement. Staff D left the facility a little after 6:00 PM on 03/27/24. Staff D stated she did not know Resident #1 was a resident at the time. Staff D further stated she was not aware of an elopement book at the receptionist desk. She knew that residents who are at risk of elopement usually have a band on the arm or leg. Staff D stated she did not see a band on Resident #1's arm. An interview was conducted with Staff G, Assistant Maintenance Director, on 04/10/24 at 12:00 PM. Staff G confirmed there are 3 exit doors with wanderguard sensors: the front entrance, the employee entrance and the [NAME] unit entrance. The Surveyor was able to exit the employee entrance door without the door alarming, while holding the wanderguard in hand, with the NHA, Director of Nursing (DON), and Staff G present. It was tested several times. It was observed at times the door would remain locked while trying to exit, other times the door would open and alarm. It was confirmed by all parties present that the door should not open with the wanderguard band in place. The NHA and DON were notified of review for Immediate Jeopardy on 04/10/24 at 12:20 PM. The facility then posted staff at the employee entrance until the door could be properly secured. Surveillance footage was still not available for surveyor review. On 04/10/24 at 4:48 PM, the NHA and DON were notified of ongoing Immediate Jeopardy. At the time of the survey, the facility had 11 residents identified as at risk for elopement.