| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105325 | A. Building<br>B. Wing | 05/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bedrock Rehabilitation and Nursing Center at Islan | 125 Alma Blvd<br>Merritt Island, FL 32953 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192<br><br>Based on observation, interview, and record review, the facility failed to prevent a mentally impaired resident from exiting the facility unsupervised and failed to provide adequate supervision and a secure environment for 1 of 4 residents reviewed for elopement, out of a total sample of 12 residents, (#2).<br><br>Findings:<br><br>Review of the medical record revealed resident #2 was readmitted to the facility on [DATE] with diagnoses including osteomyelitis (infection in the bone caused by bacteria or fungi) of the right ankle and right foot, type 2 diabetes with foot ulcer, cognitive communication deficit, difficulty walking, delusional disorders, schizoaffective disorder, and anxiety.<br><br>Review of the annual Minimum Data Set (MDS) assessment with Assessment Reference Date of 2/26/24 revealed resident #2's Brief Interview for Mental Status score of 6 out of 15, which indicated severe cognitive impairment. The MDS assessment showed resident #2 sometimes felt lonely or isolated from those around him. The assessment revealed resident #2 exhibited other behaviors symptoms not directed toward others from 1 to 3 days. Examples of the behaviors listed included pacing and rummaging, and they put the resident at a significant risk for physical illness or injury. The assessment noted he used an elopement alarm daily.<br><br>Review of a care plan revised on 10/18/23 revealed he was an elopement risk related to history of attempts to leave facility unattended, impaired safety awareness, history of hallucinations/delusions. The goal listed resident #2 would not leave the facility unattended through the review date of 6/09/24. The interventions included placing an electronic monitoring device to his left ankle, redirect resident, and to approach him in a calm manner. A care plan for impaired cognition function/dementia or impaired thought process was initiated on 3/23/23. The care plan directed staff to cue, orient, and supervise as needed.<br><br>Review of Elopement Risk Evaluation forms dated 10/18/23 and 12/01/23 revealed resident #2 was assessed and deemed at risk for elopement. An Elopement Risk Evaluation completed on 4/18/24 identified resident #2 as cognitively impaired, independently mobile, poor decision-making skills and ability to leave facility but he was incorrectly deemed not at risk for elopement.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a SBAR (Situation-Background-Assessment-Recommendation) Communication Form dated 4/23/24 identified a change in condition as behavior symptoms of aggression. The primary care clinicians recommended to move resident's room. A SBAR Communication Form dated 2/26/24 revealed a change in condition as behavior and read, punched window stating he needed more oxygen and the window was bolted shut. A SBAR Communication Form dated 11/16/23 revealed a change in condition as altered mental status, personality change, and read, slamming doors, exit seeking.<br><br>Review of a behavioral progress note dated 4/24/24 revealed he was seen per facility request due to altercation with another resident the previous day. The note mentioned he was seen in his room in a wheelchair in day clothing. The psychologist noted resident #2 told her, I get anxious, I don't have enough cigarettes and smoking is relaxing for me, it helps my stress. The note included the resident denied being involved in an altercation the previous day.<br><br>Review of a Progress Notes dated 4/24/24 read, Patient was returned to this facility with staff to this writers care. Evaluation was done no new injuries were found. Treatment to bilateral feet was completed because current bandages were soiled. Patient is his own responsible party but MD (physician) was notified of situation. Patient has been on close continuous monitoring and will continue until further notice.<br><br>On 5/13/24 at 11:38 AM, Certified Nursing Assistant (CNA) A stated at approximately 11:30 AM on 4/24/24 she was in the staffing office when she learned resident #2 was missing. She recalled she went to the front for further instructions and the staff were counting all residents. She indicated she walked outside with the Director of Nursing (DON) to start the search outside the facility. She stated she was heading back inside to get her car keys as each person was going in their own car to cover more ground. She recalled while getting back to the facility, Licensed Practical Nurse (LPN) B and the B-Wing Unit Manager (UM) were exiting the facility to join the search. CNA A stated she went with them in the same car. She recounted the route they followed until she spotted resident #2 walking on the sidewalk of the busy road. She indicated she asked him what he was doing, and he responded he was looking for a job. She stated she asked him how he got out of the facility, and he said out the window. She recalled he was wearing non-skid socks with no shoes. She stated it was not safe for resident #2 to cross the highway alone because that was a busy road.<br><br>On 5/13/24 at 12:22 PM, LPN B stated she was in the MDS office which is in the same hallway as resident #2's room, when the MDS Lead came in and stated resident #2 was not in the building. She indicated she came out of the office and met with CNA A and the B-Wing UM. She recalled they got into her car to search for resident #2. She explained they spotted resident #2 walking near an intersection. She indicated resident #2's cognition fluctuated, at times he was verbally aggressive, and he was a smoker. She mentioned she could not recall if he wore an elopement bracelet. She explained residents who wore elopement bracelets had an assessment which identified them as a high risk for elopement. She explained the purpose was to avoid or alert staff to a possible elopement and minimize the risk. She stated none of their residents was safe to be out there without supervision because that was a major highway, and they could be hit by a car.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/13/24 at 12:54 PM, CNA C stated she was assigned to resident #2 when he eloped. She explained she did not observe anything unusual with him that morning. She indicated he was a smoker and his routine included eating breakfast, going to the smoking patio, returning to his room to watch television. She recalled he talked to himself a lot. She stated when she noticed he was not in his room, she told LPN D, the nurse assigned to resident #2. She recounted she started checking rooms with LPN D as she was trying to figure out how he left. She said, I was searching and freaking out because he was my resident. She stated she was with LPN D when resident #2 was returned to the facility and she observed his foot wound dressing was bloody. She explained after resident #1 returned to the facility, she was assigned to do one on one (1:1) observation with him. She stated while he was out, she was afraid he could get hit by a car because there were so many cars and it was not safe for him to be out there by himself.<br><br>On 5/13/24 at 1:30 PM, LPN D stated resident #2 was alert and oriented with some confusion. She explained he wore an elopement bracelet due to a previous incident, and he had broken a window because he wanted to get cigarettes, but he was caught. She stated he had been transferred to a new room because of an incident with his roommate. She recalled the morning resident #2 eloped, he took his medications as usual, went to the smoking porch and walked up and down the hallway a couple of times, all which was normal behavior for him. She mentioned when the A-Wing UM told her resident #2 had gotten out she checked his room. She stated the window blinds were kind of funny but the window was closed. She indicated she went out in her car to look for him but did not see him and returned to the facility a few minutes later. She stated when resident #2 returned to the facility, she took his vital signs, performed a head-to-toe skin sweep, and performed wound care. She stated he was not wearing shoes, only non-skid socks. She mentioned he had an open area on the bottom of his right foot and had an old amputation of all the toes on his left foot. She recalled resident #2 stated he left to get a job so he could buy cigarettes. She stated she did not know he had no or was low on cigarettes as that was something not communicated to her.<br><br>On 5/13/24 at 2:31 PM, during a telephone interview, Registered Nurse E, a hospice nurse who visited residents in the facility, stated at approximately 11:30 AM, he returned to the facility, and told the receptionist he saw resident #2 walking and heading south on the parkway.<br><br>On 5/14/24 at 10:22 AM, the Maintenance Director stated he learned resident #2 left the facility when he saw commotion with the staff near the B-Wing's nurses station. He indicated he knew who resident #2 was because he had slammed the punch clock machine and slammed the window of his room a few months back. He stated he secured that window so the resident could not open it anymore. He indicated the windows were not alarmed and he did not check the new room resident #2 was moved into on 4/23/24. He explained he inspected the window resident #2 exited from and the latch was broken. He stated checking the windows was not part of his daily inspections before the elopement occurred. He said, Now I have something else to check. He indicated had he known resident #2 was transferred to that room, he would have checked and secured the window.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/14/24 at 11:07 AM, the B-Wing UM stated resident #2 resided on the B unit until 4/23/24, the day before he eloped. She indicated his orientation varied and he had chronic non-healing wound on the plantar and lateral right foot. She mentioned he walked on that foot despite the wounds and was a smoker. She explained resident #2 had broken a window before but she never learned why he did that. She indicated it was not safe for him to be out of the facility by himself. She recalled on the day resident #2 eloped, she went out to search for him with CNA A and LPN B and returned him to the facility. She said, Safety definitely failed. She indicated they did not ensure he was kept safe and prevent him from going out. She explained communication was also an issue. She mentioned he should have been on 1:1 after the incident with his roommate the day before.<br><br>On 5/14/24 at 12:36 PM, the A-Wing UM stated she did not know about the window incident in resident #2's room until after the elopement. She indicated when she learned resident #2 was missing, she told LPN D. She stated she noticed the window in his room was closed and he was not in the bathroom. She recalled they searched all the rooms as she was unaware someone had seen him outside the facility. She mentioned he had an elopement bracelet, and the exit doors would have triggered the alarm. She stated the receptionist told her someone reported seeing him outside and staff were searching for him outside. She mentioned they went into his room, checked how the window opened, and noticed a screw on the windowsill. She recalled they were able to open the window and it did not take a lot of strength to open it. She said, He was smart enough to know what he was doing. Who would have thought the window?<br><br>On 5/14/24 at 1:21 PM, the Assistant Business Office Manager (ABOM) stated she recalled receiving a call from one of the vendors stating he saw resident #2 walking down the street. She stated she immediately notified the DON and the Administrator. She mentioned before the elopement, they tried to keep him away from the front door. She recalled every time he saw a new face at the reception desk, he would say he wanted to go out and sit on the bench. She indicated they redirected him with no problems.<br><br>On 5/15/24 at 11:49 AM, the Assistant DON stated the elopement risk she completed on 10/18/23 could have been from something resident #2 said or a discussion during their clinical meeting. She reviewed the elopement risk evaluation she completed for resident #2 on 10/18/23 and indicated there would have been documentation of any previous attempts to exit the facility unsupervised. She stated after reviewing the progress notes in his medical record there was a discussion about the elopement bracelet placement, but no specific incident was noted. She said she was not certain what triggered the elopement risk evaluation, elopement bracelet placement and care plan that was initiated on 10/18/23.<br><br>On 5/15/24 at 4:10 PM, the MDS Lead stated the care plan helped staff identify interventions appropriate for the care of each resident. She explained she updated the care plan with new interventions discussed and agreed upon by interdisciplinary team during clinical meetings. The MDS Lead reviewed resident #2's elopement care plan initiated on 10/18/23 and stated she would have received the information she included in the care plan from progress notes or the elopement risk assessment. The MDS Lead stated she was not clear on the reason he left the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/14/24 at 2:25 PM, the Administrator and DON reviewed the investigation into resident #2's elopement on 4/24/24. The Administrator stated at approximately 11:20-11:25 AM on 4/24/24, the Assistant Business Office Manager told him the hospice representative came to the building and told her he had seen resident #2 by a nearby bank. The Administrator stated he hopped into his liaison's car, and they went out to search for resident #2. The DON stated she went to the A-Wing unit and checked resident #2's room, noted his window was closed, and checked all exit doors. The DON stated she left in her car at approximately 11:40 AM to look for resident #2. They stated they did not see resident #2 and returned to the facility. The Administrator stated while on hold with the non-emergency police department, he received a call from his staff informing him resident #2 was found safely. The Administrator stated resident #2 was returned to the facility at approximately 12:05 PM. The Administrator indicated they learned resident #2 was outside by the hospice nurse who alerted them. He stated during the investigation he learned resident #2 was told he did not have any cigarettes left. Later at 4:04 PM, the Administrator stated he interviewed the smoking attendants and learned resident #2 was told he did not have any cigarettes. He explained resident #2 went to the receptionist and this started the whole thing. The Administrator indicated he was informed resident #2 had broken a window because he was told he could not go out to smoke. The Administrator stated the window in the new room resident #2 was transferred to the day before was not checked because he was not actively exit-seeking. The Administrator said they did not consider or thought the window could be a problem. He indicated they identified the root cause as failure to ensure the resident's window was secured, failure to notice an increase in behaviors and the need to increase supervision.<br><br>On 5/16/24 at 8:03 AM, the Medical Director, during a telephone interview, stated resident #2 was for the most part stable but prone to behaviors from his underlying mental illness. He explained one of his concerns included resident #2 was not wearing shoes and had a wound on his foot, and anything could happen once outside the facility.<br><br>Review of the policy and procedure titled Elopement: Missing Resident Procedure/Drill dated 7/03/22 revealed it was the facility's policy to provide a safe and secure environment for all residents. The policy revealed its primary goal was to maintain resident safety for all residents at high risk of elopement from the facility.<br><br>Review of the Facility Assessment Tool updated on 1/23/24 revealed the facility was able to care for residents with psychiatric/mood disorders including psychosis, impaired cognition, mental disorders, and behavior that needed intervention. The document indicated the facility would identify and implement interventions to help support individuals with issues such as dealing with anxiety and care of someone with cognitive impairment. Care and services were individualized and personalized to each resident preference. The form mentioned every staff member had knowledge competency in abuse, neglect, and identification of condition change. |