

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Lakeland		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Lakeland Hills Blvd Lakeland, FL 33805	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from neglect for two residents (#1 and #2) out of five residents identified by the facility at risk for elopement, to prevent elopement.</p> <p>Serious harm occurred on 4/19/25, when Resident #1 was allowed to walk away from the facility unnoticed, walk along high traffic streets for eight miles, and end up on an Interstate Highway where he was found by the [State Highway Patrol]. Resident #1 was taken to a higher level of care for evaluation and treatment of dehydration. On 3/25/25 Resident #2 exited the facility through an emergency exit door and was found 10 -15 feet from the door walking away from the facility.</p> <p>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/ or death to Resident #1 and resulted in the determination of Immediate Jeopardy occurring on 4/19/25. The findings of Immediate Jeopardy were determined to be removed on 4/30/25 and the scope and severity was reduced to D after verification of removal of immediacy of harm.</p> <p>Findings included:</p> <p>Review of the medical record revealed Resident #1 was admitted on [DATE], with diagnoses including other specified disorders of [the] brain, unspecified lack of expected normal physiological development in childhood, anemia, mood disorder due to known physiological condition with mixed features, major depressive disorder, recurrent, moderate, hypertension, psychotic disorder with delusions due to known physiological condition, pedestrian on foot injured in collision with motor vehicle in nontraffic accident, pelvis fracture, skull and facial bone fractures, and lung contusion.</p> <p>A review of Resident #1's physician order summary report, dated 4/01/2025-4/30/2025, revealed the following:</p> <ul style="list-style-type: none"> - Divalproex 250 mg (milligrams) AM (morning) dose and Divalproex 500 mg at bedtime for unspecified mood disorder. -Mirtazapine 15 mg for major depressive disorder. -Risperidone 0.5 mg for psychotic disorder with delusions. <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's physician attestation of a resident incapacitated form, dated 7/31/24, revealed the resident is physically and cognitively unable to communicate a willful and knowing health decision.</p> <p>Review of Resident #1's Brief Interview for Mental Status (BIMS), dated 3/31/25, revealed a score of 0, indicating severe cognitive impairment.</p> <p>Review of Resident# 1's Activity Participation Note, dated 3/24/25, revealed He gets around on his own and enjoys sitting in the porch enjoying fresh air .</p> <p>Review of Resident# 1's Narrative Nurses Note, dated 3/29/25, revealed Resident has been up walking about facility. Staff on 100 unit didn't know him and they tried to tell him he couldn't go and to go back to his floor. He went down towards the porch where he sits.</p> <p>Review of Resident# 1's Narrative Nurses Note, dated 3/30/25, revealed Male resident on 400 stuck up his middle finger at Resident #1, he leaned towards the other resident and mumbles no giving him (other resident) the finger back. I redirected Resident #1 back towards his room.</p> <p>Review of the Resident# 1's eInteract SBAR (situation, background, assessment, recommendation) summary for a Provider Note, dated 3/30/25, showed the following:</p> <p>Nursing observations Resident alleged to have hit another resident, [MD] and family notified, Psych consult, Psychosocial monitoring q (every) shift x (for) 72 hours, Lab work, and enhanced monitoring x 72 hours. Resident is not easily understood, reminded not to touch other residents.</p> <p>Review of Resident #1's Interdisciplinary Team (IDT) Narrative Note, dated 3/31/25, showed Review of incident resident allegedly hit another resident on the back . BIMS 0, post allegation abuse protocol initiated.</p> <p>Review of Resident #1's Medication Administration Report (MAR), dated April 2024, behavior monitoring, either 0 indicating none or N/A is documented daily from 4/1/25 to 4/18/25.</p> <p>Review of Resident #1's laboratory results, reported on 3/5/25, showed Valproic Acid (Depakote) 32.4 L (low) (range 50-100).</p> <p>Review of Resident #1's laboratory results, reported on 4/4/25 showed Valproic Acid (Depakote) 39.3 L (range 50-100) and Ammonia 125 H (high) (range 27-102).</p> <p>Review of the Resident# 1's eInteract SBAR summary for a Provider Note, dated 4/19/25 at 9:39 P.M., showed, Resident visually observed while in back of law enforcement vehicle and during transfer from one law enforcement vehicle to another. At the time, there were no injuries or signs or symptoms of medical distress . Resident transported to the ED (emergency department) for further evaluation.</p> <p>Review of Resident #1's care plan showed the following:</p> <p>Focus area: initiated on 4/22/25, elopement risk/wanderer related to history of leaving the facility impaired safety awareness, wanders aimlessly.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The interventions included the following: allow to wander safely on the secured unit, distract resident from wandering by offering pleasant diversions, structures activities, food, conversation, television, books; provide structured activities: .walking inside and outside .</p> <p>Review of Resident# 1's Psychiatric report, dated 3/31/25, revealed Per staff report, the resident was involved in an altercation with another resident ., the patient allegedly struck another resident on the back of the head. Primary concern: impulsivity and agitation in the context of severe cognitive impairment. Depakote and Ammonia level ordered. Monitoring: continue to assess behavioral changes and adjust interventions as needed. The mental status exam showed Resident #1's thought association was non intact.</p> <p>During an interview on 4/28/25 at 10:10 A.M. Staff J, LPN said Resident #1 mumbles and is hard to understand, Walks all over the building, mumbles a lot. She said they are often short and sometimes work 12-16-hour shifts.</p> <p>During an interview on 4/28/25 at 10:20 A.M. the Activities Director, (AD) said prior to 4/19/25 the door from the facility to the non-smoking patio was left unlocked and residents could enter the patio unsupervised. She said Resident #1 told her he Wanted to go home.</p> <p>During an observation and interview on 4/28/25 at 12:46 P.M., Resident #1 was sitting on the side of his bed eating lunch. Resident #1's speech was slurred and difficult to understand. He said he was walking to see mother when he was found on the Interstate.</p> <p>During an interview on 4/28/25 at 1:00 P.M. Staff C, LPN, Unit Manager (UM) said on 4/19/25 at approximately 7:20 P.M. she received a call from Staff B, RN, NS telling her an elopement drill had been started because they could not find [Resident #1]. She notified the Nursing Home Administrator (NHA) and the Risk Manager (RM) immediately. Staff C, LPN, UM said, at approximately 730 P.M. a group text was sent to all department heads to come to the facility. The exit doors were checked. Staff C, LPN UM said she did not participate in the elopement investigation.</p> <p>During an interview and observation on 4/28/25 at 1:10 P.M. with the Director of Maintenance (DOM) and the Regional Maintenance Director, the DOM said the maintenance staff checks all facility exit doors daily. The DOM said the exit doors have a magnetic lock, and the process is to push the door for 15 seconds to verify the latch and alarm works. He said when the latch is disengaged a secondary keyed alarm is activated. He said, in the screened patio area, the screen door to exit the building has a padlock which is checked daily. The DOM said doors are checked between 8:00 A.M. and 10:00 A.M., Monday through Thursday and around 3:00 P.M. on Friday. The DOM said he checked all the exit doors on 4/18/25. The DOM stated on 4/19/25 after Resident #1 eloped all doors were checked; no issues were identified. He said the secondary alarm batteries were changed as a preventative measure. He said on 4/19/25 the screen in the lower portion of the patio screen door was pushed out and the rubber tubing to hold the mesh in place was laying on the ground.</p> <p>On 4/28/25 at 1:10 P.M. during a tour of the screened patio, observation revealed the screen door was secure with a padlock. The screen on the lower portion of the door screen was intact and a silver metal grate was secured on the exterior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the [Local Police] case report revealed the following:</p> <p>On 4/19/25 at 7:34 P.M. Resident #1, a missing, an endangered adult was reported.</p> <p>At 7:36 P.M. The local police department arrived at the facility upon arrival spoke with {Resident #1's nurse, Staff NN, Licensed Practical Nurse (LPN)}, who stated she last saw her patient {Resident #1} at 5:40 P.M., when he was walking towards the patio on the south side of the facility. {Staff NN, LPN} stated he usually walks the hallways or sits on the patio and looks outside. He {Resident #1} has been diagnosed with major depression, psychotic disorder, and brain disorders. There was a large hole in the patio screen door. I did not observe any footprints in the dirt near the door. {LPD} dispatch notified us that {SHP} located {Resident #1} near mile marker 37 on I-4 WB (westbound). Resident #1 was to walk to his former address { .Road}, {city}. {Resident #1} was returned to the facility by the State Highway Patrol. {Resident #1} was placed in a secure unit. The facility administrator was notified. {Resident #1} was taken to a local hospital for altered mental status. After arrival at the facility the local police responding officer received notification [Resident #1] had been located by the [SHP] The local police report showed transported to a local hospital for altered mental status.</p> <p>Review of Resident #1's local hospital records, showed the following:</p> <p>On 4/20/25 at 12:43 A.M. history and physical examination revealed the Chief Complaint was patient missing from {facility name} .found by law enforcement and brought to the ED patient non-verbal in triage. Patient is a {age} year old male with a history of unspecified brain disorders, prior skull fracture, and psychotic disorder, who is chronically housed at {name of facility}. Patient was reported missing and was found by the State Highway Patrol. He is difficult to obtain a reliable history due to significant dysarthria (motor speech disorder) and developmental delay, .he is intermittently redirectable and moderately communitive. {Resident #1's} laboratory testing was notable for Blood Urea Nitrogen (BUN) of 31 mg/dL (deciliter) (ref range 8-23), Creatinine of 2.09 mg/dL increased from 1.13 mg/dL baseline. (ref range 0.67-1.17), and Potassium of 5.2 mmol/L. (ref range 3.5-5.1) .Patient was admitted for further work up and management of AKI (acute kidney injury) and mild hyperkalemia (elevated potassium). Assessment and Plan: Acute kidney insufficiency, . dehydration, .acute kidney injury most likely secondary to volume depletion. Interventions included the following: monitor renal function , IV (intravenous) fluids, monitor intake and output, .Potassium 5.2 likely secondary to AKI.</p> <p>On 4/20/25 Resident #1's laboratory report revealed BUN 29 mg/dL, creatinine 1.47 mg/dL and potassium 4.7 mmol/L.</p> <p>On 4/21/25 Resident #1 was discharged from the local hospital and returned to the facility.</p> <p>Review Resident #1's Hospital to Nursing Home Medical Center Transfer Form (Form 5000-3008), dated 4/21/25, showed a primary diagnosis of dehydration.</p> <p>On 4/29/25 at 8:20 A.M. during an interview the Medical Records Director she said she interacts with Resident #1 on a regular basis, and they have a good rapport. She said Resident #1 usually saunters around the facility and does not bother anyone. She said Resident #1 normally sits in the nonsmoking (screened in) patio and prefers verbal redirection rather than being touched. She said prior to the incident on 4/19/25 Resident #1 stated he wanted to go home.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/29/25 at 8:52 A.M. during an interview and observation, with assistance of the Medical Records Director, Resident #1 said and gestured he left the facility from the non-smoking patio door. He said and gestured his removal of part of the screen on the patio door, crawling out to exit the facility. Resident #1 said he walked mile, mile (a long distance) and the police picked him up and took him to his former home in [city]. He said he did not have a key to open the door. Resident #1 said and gestured the police transported him back to the facility. Resident #1 was unable to communicate the time he exited the facility. Resident #1 was observed walking in a shuffle gait with tremors to bilateral upper extremities.</p> <p>On 4/29/25 at 9:09 A.M., during an interview Staff A, CNA said on 4/19/25 she was assigned to take care of Resident #1 during the 7:00 A.M. -3:00 P.M. and the 3:00 P.M. to 11:00 P.M. shifts. She stated before the incident Resident #1 did not have any behaviors, she said he normally walks down the 300 hall and sits in the screened patio area. Staff A, CNA said on 4/19/25 she went to the dining room around 5:00 P.M. and that was the last time I saw [Resident #1]. Staff A, CNA, said around 5:45 P.M. she went to Resident #1's room and noticed He had not touched his food. She said she went to check the screen patio where Resident #1 usually sits and the door [to enter from the hallway] was locked. Staff A, CNA notified Staff NN, Licensed Practical Nurse (LPN) to Call Code Amber (missing resident code) because she Knew the resident was not in the building because I looked in all the usual places the resident would have been. Staff A, said most of the staff began searching for Resident #1 and searched longer than we should have, there is a time limit for the {facility name} to search for a resident before they call the police, and they searched longer. Staff A, CNA said she did not see any damage to the door in the screened patio area, because the door from the hallway was locked. She said the hallway door was locked by someone in the activity department around 5:30 P.M. Staff A, CNA said Resident #1 was an elopement risk before this event but has never tried to leave.</p> <p>On 4/29/25 at 9:09 A.M. during an interview with Staff NN, Licensed Practical Nurse (LPN), said she was assigned to Resident #1 on 4/19/25 during the elopement. Staff NN said Resident #1 Likes to walk all over the facility. Staff NN, LPN said Staff A, CNA, told her Resident #1 had not eaten his dinner. Staff NN, LPN said she administered medications to Resident #1 at approximately 4:45 P.M. and the last time she saw the resident was around 5:00 P.M. Staff NN, LPN said Staff A, CNA Came up to me around 6:40 P.M. and asked if I had seen {Resident #1} because he had not touched his dinner. Staff NN, LPN said she told Staff A, CNA to check Resident #1's usual spots, In the green room on 400 Hall. Staff NN, LPN said she was not aware They locked the porch at a specific time, but she wanted Staff A, CNA to check All the areas the resident usually walks. Staff NN, LPN said Staff A, CNA told her Resident #1 was not on the porch. She said a Code [NAME] was called around 6:48 or 6:50 P.M. Staff NN, LPN said another nurse notified Staff B, Registered Nurse (RN) Nursing Supervisor (NS). Staff B, RN, NS notified the police and Resident #1's representative. Staff NN, LPN said when the police arrived an Activity person unlocked the green room, that's when I saw the screen was cut, the police put an alert out and they found the resident on I-4. Staff NN, LPN said they Only have 10 minutes to notify police during an elopement.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/29/25 at 11:01 A.M. during a telephone interview with Resident #1's Primary Care Physician (PCP) he stated he was notified of Resident #1's elopement and I was surprised to hear {Resident #1} got out. Resident #1's PCP said he did not have much information regarding recommendations because the facility had alarms on all their doors. The PCP said when Resident #1 returned from the hospital he was assigned to the 200 Hall, the locked unit, and now Resident #1 is back in his previous room. The PCP said, The facility should put Resident #1 back on the more secured unit, (200 hall) because it is safer for him, and he could be watched all the time. He said, It was very concerning when he was notified Resident #1 was found on I-4.</p> <p>On 4/29/25 at 11:15 A.M. during a telephone interview with the facility's Medical Director he said he was notified on 4/19/25 Resident #1 eloped from the facility and was found on I-4. He said Resident #1 is not his patient, but he has seen the resident walk all over the facility. The Medical Director said, the only recommendation is to have more monitoring for this patient. He said, I don't think he would benefit from a locked unit because he likes to walk around.</p> <p>During an interview on 4/29/25 at 11:30 A.M. with Staff B, RN, NS she said on 4/19/25 she went to lunch about 7:09 P.M., while on lunch break she received a call from one of the nurses, telling her a resident [Resident #1] was missing. She said by the time she came back into the facility the code had been called, and she saw staff looking for {Resident #1}. Staff B RN, NS, said she notified the Director of Nursing (DON) and the Risk Manager (RM) to let them know the resident was missing. Then she contacted Resident #1's family member to see if {the family member} had picked up {Resident #1} from the facility. Staff B, RN, NS said she called the local police around 7:34 pm, 15 to 20 minutes after she was informed the resident was missing. She said she was familiar with Resident #1 because he walks all over the facility and the last time she saw the resident was in the morning. Staff B, RN, NS, said, As soon as management arrived at the facility, they took over the investigation.</p> <p>An interview was conducted on 04/29/25 at 3:00 P.M. with Staff BB, Activity Assistant (AA). Staff BB said the door from the hallway to the screened patio used to remain unlocked. Staff BB, AA, said she was working on 4/19/25 and arrived at work at 8:30 A.M. and did not leave the facility until 9:00 P.M. She said Resident #1 usually comes to the patio around 9:30 A.M. or 10:00 A.M. and after lunch he returns to the patio usually around 3:30 P.M. and stays until it is time to lock the door. Staff BB, AA said Resident #1 usually sits in a chair on the patio porch and looks out the door, and on 4/19/25 she did not see the Resident #1 all day. Staff BB, AA said, I think he wanted to go home for Easter. Staff BB, AA said she locked the door from the hallway to the patio around 5:15 P.M.</p> <p>A phone interview was conducted on 4/29/25 at 4:06 PM with Resident #1's representative. The Resident Representative (RR) said on 4/19/25 someone from the facility called to ask if he had checked the resident out from the facility. The RR said he told the facility around 6:00 P.M. or 7:00 P.M. a call was received from a State Trooper saying Resident #1 was found sitting on the side of I-4 and wanted a ride to his home. The RR said he informed the State Trooper Resident #1 does not live at the address and gave them the facility's name and address. The RR said he was concerned about a call he received from the facility today about finding another facility for Resident #1. The RR said the facility's Social Service said they would assist him with finding another facility, but he was concerned because, It was hard to get {Resident #1} admitted to the current facility, and he does not know how he will be able to find another facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/2025 at 4:45 P.M. with the NHA and the RM, the RM said elopement risk residents are identified before admission when a referral is received. After admission they use different tools such as the Hospital to Nursing Home Medical Center Transfer Form (Form 5000-3008), Preadmission and Resident Review (PASRR) forms, the history and physical, and the medication lists to determine if there are elopement concerns. She said nurses complete an elopement assessment on admission and the resident is given a score to indicate their elopement risk. She said if the resident has a score of 5 and above, they are at risk. The NHA said not all residents identified as an elopement risk are placed in the locked unit. There are different factors that could place a resident on the locked unit, such as preferences related to dementia care. The NHA said there are elopement books on every unit and the receptionist desk with pictures of residents identified as high risk for elopement. The NHA said information related to elopement risk is in the Electronic Health Record (EHR) on the resident profile. They said staff use care plans and Kardex for resident specific interventions. The NHA stated elopement risks are assessed on admission, quarterly and as needed.</p> <p>On 4/30/2025 at 11:38 A.M. an interview was conducted with the NHA and RM to review the facility's investigation of Resident #1's elopement on 4/19/25. They were notified Resident #1 was missing at approximately 7:21 P.M. by Staff C, LPN, UM. The NHA said a group message was sent to managers to report to the facility immediately. The NHA said the facility's investigation of the elopement on 4/19/25 showed the following:</p> <p>4:53 P.M. Staff NN, LPN administered medication to Resident #1.</p> <p>5:00 P.M. Staff A, CNA observed Resident #1 across the hall from the screened porch area.</p> <p>6:00 PM Resident #1's meal was left in his room;</p> <p>6:30 P.M. the State Highway Patrol found Resident #1 on I-4 and MM 37.</p> <p>6:50 P.M. Staff A noticed the meal had not been eaten,</p> <p>7:05 P.M. Code [NAME] was called,</p> <p>7:21 P.M. Staff B, RN NS notified Staff C, LPN, UM;</p> <p>7:25 P.M. Staff B, RN NS notified Resident #1's representative;</p> <p>7:42 P. M. local police department arrived;</p> <p>9:10 P.M. Resident #1 arrived to the facility. When Resident #1 said he wanted to go home, he was transported by the State Highway Patrol to an address listed on identification card for the resident. Resident #1 was taken to [city] approximately 45 minutes from the facility and the State Highway Patrol had to transport him back to the facility. The local police department transported Resident #1 to a local hospital.</p> <p>The NHA said the facility concluded that the door from the hallway to the screened patio was not secure and residents had unsupervised access. The NHA said there was a delay in notifying the local police department and they should have been notified after 10 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident #2's admission record revealed an admission date of 11/5/23 with the following diagnoses: Heredity and idiopathic neuropathy, asthma with status asthmaticus, protein calorie malnutrition, chronic obstructive pulmonary disease (COPD), mood disorder, major depressive disorder, and dementia.</p> <p>A Review of Resident #2's MDS, dated [DATE], Section C-Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of is 0 indicating severe cognitive impairment. A review of Section E-Behavior showed wandering behavior has occurred 1-3 days.</p> <p>A review of Resident #2's Care Plan, dated 4/21/25 showed the following:</p> <p>Focus area of elopement/wanderer r/t History of attempts to leave facility unattended, Impaired safety awareness with an initiated date of 4/21/25 and interventions for this focus area to include allow to wander safely on the secure unit.</p> <p>A review of Resident's #2 Narrative Nurses Note, dated 3/25/25, showed nurse heard alarm from side door on 300 hall door was open wide nurse observed {Resident #2} ambulating away from the building. {Resident #2} stated she was trying to leave. She was assisted to her room and placed on one-to-one observation.</p> <p>During a telephone interview on 4/29/25 at 11:15 A.M. the facility's Medical Director said he was not familiar with Resident #2. He stated he did not consider Resident #2 exiting the facility's locked door to be an elopement. He stated he does not have any concerns about the supervision of the residents. He stated he would be more concerned if these types of events happened more frequently.</p> <p>An interview was conducted on 4/30/25 at 2:26 P.M. with the NHA and the DON regarding the facility investigation of Resident #2's elopement on 3/25/25. They stated the investigation showed:</p> <p>At 6:45 Staff AA, LPN observed Resident #2 walking on 300 Hall</p> <p>At approximately 7:00 P.M. Staff AA, LPN heard the emergency exit door alarm, exited the medication room and observed Resident #2 walking away from the door, approximately 23 feet from the doorway.</p> <p>At 7:08 P.M. the NHA was notified of the elopement.</p> <p>The NHA said on 3/26/26 there was an Ad Hoc committee meeting held and after investigating the event the facility concluded Resident #2's elopement was an isolated event. The NHA said the facility provided a review of the Abuse, Neglect and Exploitation policy, wandering and elopement education, and increased the frequency of elopement drills.</p> <p>A review of the facility's policy titled Abuse, Neglect and Exploitation, revision date 4/2004, showed the following:</p> <p>Policy: It is the policy of this facility to provide protections for the health, welfare .and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Definitions: Neglect means failure of the facility, its 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.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. b. Establish policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention;</p> <p>. Employee Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: .b wandering ort elopement-type behaviors Prevention of Abuse, Neglect and Exploitation</p> <p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect .G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur.</p> <p>Coordination with QAPI: The facility has written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.</p> <p>Review of the facility's policy titled Exit Doors, implementation date 9/1/23, showed the following:</p> <p>Definitions- Egress refers to the action of going out of or leaving a place.</p> <p>Policy Explanation and Compliance Guidelines: Check operation of magnetic door locks (if applicable) 1. Inspect door lock mounting and operation and inspect panic hardware .3. Any magnetically locked doors must automatically unlock during a fire alarm (verify this during your normal fire drill) .Check delayed egress operation (if applicable) 1. Push door release hard for a fraction of a second - door should not open and alarm should not sound 2. Apply pressure to the door release for the pre-determined nuisance period setting (normally 1-3 seconds) 3. Door should go into irreversible unlocking sequence 3 a. Door alarm will sound 3 b. Door will automatically open within 15 seconds . Ensure signs are placed on doors adjacent to the release device that read 'Push until alarm sounds. Door can be opened in 15 seconds Document results of inspection in logbook.</p> <p>Review of the facility's policy titled Elopements and Wandering, implementation date, [undated], showed the following: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Definitions:</p> <p>Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit), or non-goal directed or aimless.</p> <p>Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.</p> <p>Policy Explanation and Complia[TRUNCATED]</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to implement an effective performance improvement plan to prevent the elopement of one resident (#1) out of five residents identified by the facility at risk for elopement.</p> <p>Findings included:</p> <p>1. A review of Resident #2's admission record revealed an admission date of 11/5/23 with the following diagnoses: Heredity and idiopathic neuropathy, asthma with status asthmaticus, protein calorie malnutrition, chronic obstructive pulmonary disease (COPD), mood disorder, major depressive disorder, and dementia.</p> <p>A Review of Resident #2's Minimum Data Set (MDS), dated [DATE], Section C-Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of is 0 indicating severe cognitive impairment. A review of Section E-Behavior showed wandering behavior has occurred 1-3 days.</p> <p>A review of Resident #2's Care Plan, dated 4/21/25 showed the following:</p> <p>Focus area of elopement/wanderer r/t History of attempts to leave facility unattended, Impaired safety awareness with an initiated date of 4/21/25 and interventions for this focus area to include allow to wander safely on the secure unit.</p> <p>A review of Resident's #2 Narrative Nurses Note, dated 3/25/25, showed nurse heard alarm from side door on 300 hall door was open wide nurse observed {Resident #2} ambulating away from the building. {Resident #2} stated she was trying to leave. She was assisted to her room and placed on one-to-one observation.</p> <p>During a telephone interview on 4/29/25 at 11:15 A.M. the facility's Medical Director said he was not familiar with Resident #2. He stated he did not consider Resident #2 exiting the facility's locked door to be an elopement. He stated he does not have any concerns about the supervision of the residents. He stated he would be more concerned if these types of events happened more frequently.</p> <p>An interview was conducted on 4/30/25 at 2:26 P.M. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding the facility investigation of Resident #2's elopement on 3/25/25. They stated the investigation showed:</p> <p>-At 6:45 Staff AA, LPN observed Resident #2 walking on 300 Hall</p> <p>-At approximately 7:00 P.M. Staff AA, LPN heard the emergency exit door alarm, exited the medication room and observed Resident #2 walking away from the door, approximately 23 feet from the doorway.</p> <p>-At 7:08 P.M. the NHA was notified of the elopement.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The NHA said on 3/26/25, an Ad Hoc QAPI committee meeting was held to discuss the 3/25/25 incident when a resident was found walking away from the facility. The NHA said committee response was to focus on a More person-centered approach The QAPI committee decided to increase the frequency of elopement drills, review all residents who were at risk for elopement and update their care plans. The NHA said the committee reeducated staff about abuse, neglect, and exploitation, the wandering, and elopement policies. The NHA said there was an increase in focus on door checks, elopement drills, and ensuring elopement risk residents were included in the elopement book. The NHA said they reviewed the investigation and audit process through QA to ensure we completed a thorough investigation. The NHA said the Medical Director was part of the QAPI plan we put in place., and he did not have any additional recommendations.</p> <p>A review of the facility's elopement audits, completed between 3/26/25 and 4/26/25, revealed five resident records for elopement evaluations, elopement care plans with interventions on [NAME], and verifying the elopement book was correct. The audits revealed no deviations were identified.</p> <p>Review of the facility's staff education sign in sheets, dated 3/27-4/1/2025, revealed 256 staff signatures for education titled Prevention of Resident Elopement-Video.</p> <p>2. Review of the medical record revealed Resident #1 was admitted on [DATE], with diagnoses including other specified disorders of [the] brain, unspecified lack of expected normal physiological development in childhood, anemia, mood disorder due to known physiological condition with mixed features, major depressive disorder, recurrent, moderate, hypertension, , psychotic disorder with delusions due to known physiological condition, pedestrian on foot injured in collision with motor vehicle in nontraffic accident, pelvis fracture, skull and facial bone fractures, and lung contusion.</p> <p>A review of Resident #1's physician order summary report, dated 4/01/2025-4/30/2025, revealed the following:</p> <ul style="list-style-type: none"> - Divalproex 250 mg (milligrams) AM (morning) dose and Divalproex 500 mg at bedtime for unspecified mood disorder. -Mirtazapine 15 mg for major depressive disorder. -Risperidone 0.5 mg for psychotic disorder with delusions. <p>Review of Resident #1's physician attestation of a resident incapacitated form, dated 7/31/24, revealed the resident is physically and cognitively unable to communicate a willful and knowing health decision.</p> <p>Review of Resident #1's Brief Interview for Mental Status (BIMS), dated 3/31/25, revealed a score of 0, indicating severe cognitive impairment.</p> <p>Review of Resident# 1's Activity Participation Note, dated 3/24/25, revealed He gets around on his own and enjoys sitting in the porch enjoying fresh air .</p> <p>Review of Resident# 1's Narrative Nurses Note, dated 3/29/25, revealed Resident has been up walking about facility. Staff on 100 unit didn't know him and they tried to tell him he couldn't go and to go back to his floor. He went down towards the porch where he sits.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/19/25, when Resident #1 was allowed to walk away from the facility unnoticed, walk along high traffic streets for eight miles, and end up on an Interstate Highway where he was found by the [State Highway Patrol]. Resident #1 was taken to a higher level of care for evaluation and treatment of dehydration.</p> <p>Review of the Resident# 1's eInteract SBAR summary for a Provider Note, dated 4/19/25 at 9:39 P.M., showed, Resident visually observed while in back of law enforcement vehicle and during transfer from one law enforcement vehicle to another. At the time, there were no injuries or signs or symptoms of medical distress . Resident transported to the ED (emergency department) for further evaluation.</p> <p>On 4/28/25 at 10:05. A.M. Resident #1 was observed lying in the bed with his head covered and determined to be sleeping by the pattern of his breathing</p> <p>During an interview on 4/28/25 at 10:10 A.M. Staff J, LPN said Resident #1 mumbles and is hard to understand, Walks all over the building, mumbles a lot. She said they are often short and sometimes work 12-16-hour shifts.</p> <p>During an interview on 4/28/25 at 10:20 A.M. the Activities Director, (AD) said prior to 4/19/25 the door from the facility to the non-smoking patio was left unlocked and residents could enter the patio unsupervised. She said Resident #1 told her he Wanted to go home.</p> <p>During an observation and interview on 4/28/25 at 12:46 P.M., Resident #1 was sitting on the side of his bed eating lunch. Resident #1's speech was slurred and difficult to understand. He said he was walking to see mother when he was found on the Interstate.</p> <p>During an interview on 4/28/25 at 1:00 P.M. Staff C, LPN, Unit Manager (UM) said on 4/19/25 at approximately 7:20 P.M. she received a call from Staff B, RN, NS telling her an elopement drill had been started because they could not find [Resident #1]. She notified the Nursing Home Administrator (NHA) and the Risk Manager (RM) immediately. Staff C, LPN, UM said, at approximately 730 P.M. a group text was sent to all department heads to come to the facility. The exit doors were checked. Staff C, LPN UM said she did not participate in the elopement investigation.</p> <p>During an interview and observation on 4/28/25 at 1:10 P.M. with the Director of Maintenance (DOM) and the Regional Maintenance Director, the DOM said the maintenance staff checks all facility exit doors daily. The exit doors have a magnetic lock, and the process is to push the door for 15 seconds to verify the latch and alarm works. When the latch is disengaged a secondary keyed alarm is also activated. He said, in the screened patio area, the screen door to exit the building has a padlock which is checked daily. The DOM said doors are checked between 8:00 A.M. and 10:00 A.M., Monday through Thursday and around 3:00 P.M. on Friday. The DOM said he checked all the exit doors on 4/18/25. On 4/19/25 after Resident #1 eloped all doors were checked; no issues were identified. The secondary alarm batteries were changed as a preventative measure. On 4/19/25 the screen in the lower portion of the patio screen door was pushed out and the rubber tubing to hold the mesh in place was laying on the ground.</p> <p>On 4/28/25 at 1:10 P.M. during a tour of the screened patio, the screen door was secure with a padlock. The screen on the lower portion of the door screen was intact and a silver metal grate was secured on the exterior.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/28/25 at 1:32 PM with Staff H, LPN, Minimum Data Set (MDS) Nurse said on 4/19/25 at about 7:30 P.M. he received a group text notification a resident was not in the building, with instructions to come and assist. When Staff H, LPN, MDS arrived at a 7:40 P.M., the local police department was on the scene, and he was the first manager to arrive, and he accompanied the officer to search the facility for Resident #1. Staff H, LPN, MDS said, Staff OO, unlocked the door to search the immediate area. He said, In the 400-hall screened in area they observed the bottom screen broken, blowing in the wind. Staff H, LPN, MDS said at approximately 8:20 P.M. a police officer told him Resident #1 was found. Staff H, LPN, MDS said, when the State Highway Patrol arrived with Resident #1, he assisted the DON to assess, check neuros. He said the facility staff asked a local police officer to transport Resident #1 to a local hospital, they felt it was a safe transfer, a courtesy, did not have to use other resources.</p> <p>On 4/29/25 at 8:52 A.M. during an interview and observation, with assistance of the Medical Records Director, Resident #1 said and gestured he left the facility from the non-smoking patio door. He said and gestured his removal of part of the screen on the patio door, crawling out to exit the facility. Resident #1 said he walked mile, mile (a long distance) and the police picked him up and took him to his former home in [city]. He said he did not have a key to open the door. Resident #1 said and gestured the police transported him back to the facility. Resident #1 was unable to communicate the time he exited the facility. Resident #1 was observed walking in a shuffle gait with tremors to bilateral upper extremities.</p> <p>On 4/29/25 at 9:09 A.M., during an interview Staff A, CNA said on 4/19/25 she was assigned to take care of Resident #1 during the 7:00 A.M. -3:00 P.M. and the 3:00 P.M. to 11:00 P.M. shifts. She stated before the incident Resident #1 did not have any behaviors, she said he normally walks down the 300 hall and sits in the screened patio area. Staff A, CNA said on 4/19/25 she went to the dining room around 5:00 P.M. and that was the last time I saw [Resident #1]. Staff A, CNA, said around 5:45 P.M. she went to Resident #1's room and noticed He had not touched his food. She said she went to check the screen patio where Resident #1 usually sits and the door [to enter from the hallway] was locked. Staff A, CNA notified Staff NN, Licensed Practical Nurse (LPN) to Call Code Amber (missing resident code) because she Knew the resident was not in the building because I looked in all the usual places the resident would have been. Staff A, said most of the staff began searching for Resident #1 and searched longer than we should have, there is a time limit for the {facility name} to search for a resident before they call the police, and they searched longer. Staff A, CNA said she did not see any damage to the door in the screened patio area, because the door from the hallway was locked. She said the hallway door was locked by someone in the activity department around 5:30 P.M. Staff A, CNA said Resident #1 was an elopement risk before this event but has never tried to leave.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/29/25 at 9:09 A.M. during an interview with Staff NN, Licensed Practical Nurse (LPN), said she was assigned to Resident #1 on 4/19/25 during the elopement. Staff NN said Resident #1 Likes to walk all over the facility. Staff NN, LPN said Staff A, CNA, told her Resident #1 had not eaten his dinner. Staff NN, LPN said she administered medications to Resident #1 at approximately 4:45 P.M. and the last time she saw the resident was around 5:00 P.M. Staff NN, LPN said Staff A, CNA Came up to me around 6:40 P.M. and asked if I had seen {Resident #1} because he had not touched his dinner. Staff NN, LPN said she told Staff A, CNA to check Resident #1's usual spots, In the green room on 400 Hall. Staff NN, LPN said she was not aware They locked the porch at a specific time, but she wanted Staff A, CNA to check All the areas the resident usually walks. Staff NN, LPN said Staff A, CNA told her Resident #1 was not on the porch. She said a Code [NAME] was called around 6:48 or 6:50 P.M. Staff NN, LPN said another nurse notified Staff B, Registered Nurse (RN) Nursing Supervisor (NS). Staff B, RN, NS notified the police and Resident #1's representative. Staff NN, LPN said when the police arrived an Activity person unlocked the green room, that's when I saw the screen was cut, the police put an alert out and they found the resident on I-4. Staff NN, LPN said they Only have 10 minutes to notify police during an elopement.</p> <p>During an interview on 4/29/25 at 11:30 A.M. with Staff B, RN, NS she said on 4/19/25 she went to lunch about 7:09 P.M., while on lunch break she received a call from one of the nurses, telling her a resident [Resident #1] was missing. She said by the time she came back into the facility the code had been called, and she saw staff looking for {Resident #1}. Staff B RN, NS, said she notified the Director of Nursing (DON) and the Risk Manager (RM) to let them know the resident was missing. Then she contacted Resident #1's family member to see if {the family member} had picked up {Resident #1} from the facility. Staff B, RN, NS said she called the local police around 7:34 pm, 15 to 20 minutes after she was informed the resident was missing. She said she was familiar with Resident #1 because he walks all over the facility and the last time she saw the resident was in the morning. Staff B, RN, NS, said, As soon as management arrived at the facility, they took over the investigation.</p> <p>Review of the facility's policy titled Exit Doors, implementation date 9/1/23, showed the following:</p> <p>Definitions- Egress refers to the action of going out of or leaving a place.</p> <p>Policy Explanation and Compliance Guidelines: Check operation of magnetic door locks (if applicable) 1. Inspect door lock mounting and operation and inspect panic hardware .3. Any magnetically locked doors must automatically unlock during a fire alarm (verify this during your normal fire drill) .Check delayed egress operation (if applicable) 1. Push door release hard for a fraction of a second - door should not open and alarm should not sound 2. Apply pressure to the door release for the pre-determined nuisance period setting (normally 1-3 seconds) 3. Door should go into irreversible unlocking sequence 3 a. Door alarm will sound 3 b. Door will automatically open within 15 seconds . Ensure signs are placed on doors adjacent to the release device that read 'Push until alarm sounds. Door can be opened in 15 seconds Document results of inspection in logbook.</p> <p>Review of the facility's policy titled Elopements and Wandering, implementation date, [undated], showed the following: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Lakeland		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Lakeland Hills Blvd Lakeland, FL 33805	
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)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Definitions:</p> <p>Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit), or non-goal directed or aimless.</p> <p>Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. 4 a. Residents will be assessed. For risk of elopement and unsafe wandering upon admission and throughout their stay 4 c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. dedicate supervision will be provided to help prevent accidents or elopements. 5. Procedure for Locating Missing Resident 5 a. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g. internal alert code).</p> <p>15c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department 5 d. DON or designee shall notify the physician and family member or legal representative.</p> <p>Review of the facility's Elopement Prevention Tips, undated, showed the following:</p> <p>react to statements such as I want to go home; Observe for aimless wandering, .Review physical plant to be sure door alarms are working and that unauthorized areas are properly locked to prevent resident entry; Consider use of a chain of custody for high risk residents, develop a schedule for periodic checks on the resident; When the resident is involved in other activities or disciplines in the facility, such as dining and activity programs, the nursing assistant may give responsibility to that department for the periodic check, until the resident is returned to the assigned nursing assistant; never assume everyone knows the resident is a wanderer, make it clear to dining room aids, new staff and whoever is involved in the resident's care even for a short period of time .</p> <p>A Quality Assurance and Performance Improvement Policy was not provided at the time of the survey for review.</p>		