STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105399	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea Breeze Rehab and Nursing Center	3663 15th Ave Vero Beach, FL 32960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29151 Based on record review, policy review and interview, the facility failed to prevent elopement; failed to thoroughly investigate the incident; failed to implement corrective measures to minimize reoccurrence and failed to report the adverse event. The failure affected 1 of 2 sampled residents, Resident #1. The findings included: Review of the Facility policy, titled, Elopement and Wandering, dated 07/2024 documented: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Guideline: To provide care guidance for staff on the current standards of professional practice for residents who are identified as an elopement risk or wanderer upon clinical assessment Definition: A situation in which a incapacitated resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement (Ex: If the resident is observed by a staff member or a staff member is present, this would not be considered an elopement). Procedure: 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. Each resident will be assessed for wandering and elopement upon admission, re-admission, and whenever an elopement attempt or new wandering behavior is observed or identified. Assessments are also done quarterly. 3. If an employee observes a resident attempting to leaving the premises, he/she should: a. Attempt to prevent the resident from leaving in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary; and (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS), admission assessment, with reference date of 08/05/24 documented the resident BIMS (Brief Interview Mental Status) score as 03. A score of 3 indicates the resident is severely impaired for skills of daily decision making. Resident #1 exhibited wandering behavior, had one fall prior to admission and was receiving antipsychotic medications. Review of the Progress notes dated 08/05/24 documented Resident is alert and oriented with periods of confusion, resident is able to verbalized his needs, .resident is wandering back in forth down hallway needs re-direction, continue with skilled services, call light within reach. Review of the Progress notes dated 08/06/24 documented Resident is alert and oriented with periods of confusion .continue on antibiotic for metabolic toxic Encephalopathy . Resident is continue on wandering back and forth down the hallway . safety maintained. Review of the Progress notes dated 08/06/24 documented Resident has been having increase periods of confusion and exit seeking. Able to redirect however, still manages to head toward exits. Writer increased observation for this shift. Will continue to monitor. Review of the Progress notes dated 08/08/24, that has been stricken from the resident's record, documented, The leave of absence process was reviewed with the resident and/or their representative. The resident does have the ability to move about the facility independently with or without assisted devices like a walker or wheelchair. The resident does have cognitive impairment and has expressed a desire to leave the facility. The resident has exhibited exit seeking behavior including: The patient was found outside of the main entrance. The incident occurred when a visitor existing the building, and the resident followed him out through the door. A staff member promptly brought the resident back inside. The resident is at risk for elopement. The Resident does currently reside on a secure unit. Interventions include Increased staff observation, transfer to secured unit. The following people have been notified of this elopement evaluation: Resident Representative/Family Physician IDT/Care plan. Review of the Care Plan initiated on 08/08/24 documented the resident is an elopement risk / exit seeker related to Cognitive Status / Decline. The goal documented the resident will remain safe within the facility and will make no attempts to exit facility without being accompanied through next review. The interventions included: Distract resident from exit seeking by offering pleasant diversions, structured activities, food, conversation, television, book, etc; Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate; Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes as indicated and Psychological services as ordered/indicated. Review of the Progress Notes dated 08/21/24, Summary of Skilled Services, documented, Resident is alert with confusion, continue on isolation for COVID with no acute respiratory distress noted at this time, assisted with care, all medications given as ordered, tolerated well, denies pain, call light within reach, safety maintained and continue with skilled services. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes dated 08/23/24 documented the resident is alert and able to make all needs known, no distress or behavior noted on shift continue on 1:1 Certified Nursing Assistant for safety measures. Interview with the Nursing Home Administrator and the Director of Nursing, from the nursing facility located across the street, on 10/02/24 at approximately 4:00 PM confirmed a resident from Sea Breeze showed up to their door. He was asked if he wanted to visit someone and stated no, the resident was unable to verbalize why he was there and the staff recognized the resident, had an identification band and contacted Sea Breeze. The staff came in and escorted the resident back to their facility. Interview conducted with the Administrator (NHA) and the Director of Nursing (DON) on 10/03/24 at 9:20 AM confirmed the incident involving Resident #1 was not captured on the incident log but the facility completed an investigation. The NHA stated they deemed the event was not an elopement based on the fact the staff supervised him at all times. Review of the facility investigation conducted on 10/03/24 revealed on 08/22/24, Resident #1 exited the facility and ended up across the street at another nursing facility. The report documented, Resident stated that he wanted to be discharged . The discharge was held as he was COVID positive, and he decided to go LOA (leave of absence) without signing out. The resident deemed at elopement risk and exit seeker due to mentation and Metabolic Encephalopathy and was on antibiotic for UTI. Conclusion: It was an intentional LOA without signing out. The unit manager was watching him in the driveway and the resident was discharged to a lower level of care ALF [Assisted Living Facility]. Interview with the receptionist on duty on 08/22/24 was conducted on 10/03/24 at 9:25 AM. The receptionist stated she was doing receptionist duties, Resident #1 was sitting in the therapy room in his wheelchair, across from her desk. Approximately 20 minutes later, he was not there. The receptionist stated she did not see the resident go out the door, but it was a busy day, lots of visitors in and out and is possible that the resident went out with visitors. The receptionist denied being involved in the investigation, confirmed she gave a statement but did not receive any feedback or education after the event. The receptionist also denied the facility having a book or list to identify residents that may be at risk for elopement. Interview with Assistant Director of Nursing (ADON) on 10/03/24 at 9:46 AM revealed her recollection of the incident. The unit manager called her to inform her that the resident was outside, and she was following him on her vehicle. The manager then went outside, went across the street and was able to convince the resident to return to the facility. The manager was asked why the staff was not aware of his elopement risk to escort the resident back into the facility, and who notify the responsible party or family members of the events and stated she did, but was not able to locate documentation. Interview with the NHA conducted on 10/03/24 at 9:51 AM revealed the facility has surveillance video, it keeps for 30 days, and was asked if the video was reviewed to identify how the resident was able to leave the facility. The NHA stated she reviewed the video, she did not keep a copy and furthermore stated the time line provided on the investigation file was based on staff interviews estimation of time, not from the surveillance video. (continued on next page)

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