

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Anchor Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 Port Malabar Blvd NE Palm Bay, FL 32905	
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** 32131</p> <p>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect by their failure to ensure staff maintained a secure environment and implemented measures to mitigate the risk to prevent elopement for 1 of 1 resident reviewed for elopement, of a total sample of 5 residents, (#1).</p> <p>On 7/31/24 at approximately 7:48 PM, resident #1 left the facility unsupervised without the knowledge of staff. The resident walked along a busy roadway with a speed limit of 40 miles per hour and accepted a ride with strangers to get to her home. The facility staff were not aware of resident #1's whereabouts for approximately one hour and twenty minutes. Due to her cognitive deficits, and diagnosis of dementia, the elopement placed her at risk of falling, being severely injured, abducted, or hit by a motor vehicle.</p> <p>The facility's failure to provide adequate supervision and a secure environment contributed to resident #1's elopement and threatened all residents who were at risk for elopement. This failure resulted in Immediate Jeopardy which started on 7/31/24 and was removed on 8/02/24. The noncompliance at F600 and F689 was determined to be past noncompliance.</p> <p>Findings:</p> <p>Cross Reference F689</p> <p>Resident #1, an [AGE] year-old female directly admitted from home to the facility on [DATE] at approximately 1:00 PM. Her diagnoses included dementia, unspecified severity/other behavioral disturbance, diabetes mellitus type II, generalized anxiety disorder, major depressive disorder, and chronic systolic (congestive) heart failure.</p> <p>Review of the Summary notes of the resident's visit on 6/26/24 with her community Primary Care Physician, revealed the resident had, dementia with behavioral disturbances and the document read, She has some agitation she is forgetting words and she started to wander around.</p> <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105464
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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 Admit/Readmit Screener with effective date of 7/31/24 at 1 PM, revealed resident #1 arrived at the facility ambulatory from home, with admitting diagnosis of dementia, and anxiety. The document indicated the resident was oriented to person, place, time and situation, walked frequently, and had no limitation with mobility. The Elopement Risk assessment in conflict with the Summary notes from resident #1's provider on 6/26/24, indicated the resident was ambulatory, with no risk factors selected, and the selection, Not at risk for elopement was checked.</p> <p>On 8/28/24 at 12:08 PM, in an interview with resident #1 with translation provided by Receptionist F, the resident said she wanted to go back home to see her granddaughter. She stated she got anxious, so she got up and left the facility. Resident #1 explained a visitor was going out of the facility, so she followed the visitor out. She said she went out of the facility, turned right, walked up the street for about five to ten minutes then a couple gave her a ride to her home.</p> <p>On 8/28/24 at 4:06 PM, the incident was reviewed with the Administrator, the Director of Nursing (DON), and the Regional Nurse Consultant (RNC). The Administrator gave a timeline of the incident based on the facility's investigation. He said resident #1 was a direct admit to the facility on [DATE] at 1:00 PM, bought from home accompanied by her granddaughter, and son-in law. He stated that at 7:45 PM, the Licensed Practical Nurse (LPN)/ Evening Supervisor was alerted by a resident that people were in the lobby waiting to be let out. At 7: 48 PM, the Evening Supervisor entered the lobby, and observed another resident's wife, and resident #1 standing in the lobby. After asking if the visitor was there to visit her husband, the evening Supervisor entered the door code, and both the visitor, and resident #1 exited the facility. The Administrator stated the facility had cameras in the lobby and courtyards, and in review of the camera footage, resident #1 was observed on camera to exit the facility and turn to the right until she was out of range of the camera. The investigation revealed that at 8:40 PM, LPN E noticed the resident was not in her room, and when she did not locate the resident, she notified the Evening Supervisor, who called the elopement code, and a search was initiated. The Administrator recalled he was notified by the Evening Supervisor at 8:55 PM, and at approximately 9:07 PM the resident returned to the facility accompanied by her granddaughter and son-in law.</p> <p>The DON stated that prior to the elopement, the facility's visitor process was that visitors would sign in and get a yellow visitor's badge to be worn while in the facility. She said resident #1 did not have a visitor's badge on, and the Supervisor assumed the two women were together. The facility stated their Root Cause Analysis (RCA) showed they failed to confirm that resident #1 was not a visitor and failed to adhere to the facility's visitation process.</p> <p>On 8/28/24 at 5:11 PM, the LPN/Evening Supervisor recalled that on 7/31/24 the facility had three admissions. She stated she was entering admission orders in the Electronic Medical Record (EMR), and a resident was yelling out that people were at the door that needed to leave. The Supervisor stated she went to the door, and two older women were standing there, both holding belongings in their arms. She said she was familiar with one of the women and assumed resident #1 who she did not know was assisting her to take stuff to her car. She recalled she punched in the door code and walked with them out of the facility while conversing with the familiar person. When asked if the women had visitor badges on, the Supervisor said she could not recall, stating she had seen the familiar visitor several times before, accompanied by different persons.</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 8/29/24 at 1:35 PM, resident #1's granddaughter stated she was at home when the resident was dropped off, but did not see the persons who gave her a ride. The granddaughter recalled she was told by the facility that her grandmother was talking to another resident's family member and exited the building. The granddaughter said she was not happy, and when she returned her grandmother to the facility, she asked, You have cameras how could you let a resident out who has dementia? She stated the facility said they were going to become more vigilant with ensuring that visitors signed in and out of the visitor log, and give badges to all visitors, to differentiate between visitors and residents.</p> <p>The facility policy, Elopements and Wandering Residents implemented 11/2020, and reviewed/ revised 3/16/2023, read, The facility is equipped with door locks/alarms to help avoid elopements.</p> <p>Review of the corrective actions implemented by the facility revealed the following which were verified by the surveyor:</p> <p>*On 7/31/24 at approximately 9:07 PM, resident # 1 returned to the facility from home accompanied by her granddaughter. Resident #1 was placed on one-on-one supervision and re-evaluated for elopement risk. Nurse evaluation of the resident was completed with no signs of injury or distress.</p> <p>*On 7/31/24 education was initiated related to elopement standards and guidelines, Abuse and Neglect, and visitor process to ensure residents are identified to prevent elopement. Post-tests were completed to validate competency. The Key Points on Visitors included, Visitors entering the building are required to sign in on the visitor log form. Visitors are also required to wear a visitor badge. Visitors exiting the building are required to sign out on the visitor log form. Visitors are also required to return the visitor badge. If staff is unable to verify the identity of the visitor, they are directed not to let the person exit the facility until another staff member is able to identify the visitor(s).</p> <p>*From 7/31/24 to 8/06/24, facility employees were provided education by the Leadership Team. 152 total facility employees (Nursing, Dietary, Laundry, Housekeeping, Therapy, Administrative staff, Maintenance Department employees) received the above mentioned education as follows:</p> <p>* On 8/01/24, 112 out of 152 staff members completed the education.</p> <p>* On 8/02/24, 26 out of 152 staff members completed the education.</p> <p>* On 8/03/24, 13 out of 152 staff members completed the education.</p> <p>* On 8/06/24, 1 out of 152 staff members completed the education.</p> <p>*Newly hired staff to receive the above education during orientation and prior to working an assignment.</p> <p>*On 8/01/24, Elopement Risk Binders were reviewed to ensure they contained photos and demographic information of residents evaluated to be at risk for 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 8/01/24, an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting was completed with the Medical Director, Administrator, Director of Nursing and additional IDT (Interdisciplinary Team) members related to Elopement. The Performance Improvement Plan was accepted by the committee. Root Cause Analysis completed.</p> <p>*On 8/02/24, the Front lobby receptionist hours were extended from 6:00 PM to 9:00 PM.</p> <p>*On 8/02/24, as part of the ongoing QAA (Quality Assessment and Assurance) process, an ad hoc QAPI was conducted that included the Medical Director, Administrator, Director of Nursing and additional IDT members to review the plan viability on elopement. No additional recommendations were made at that time.</p> <p>*Additional QAPI meetings were held on 8/06/24, 8/13/24, and 8/16/24, to review PIP (Performance Improvement Plan) progress related to the elopement. No concerns were identified during ongoing quality reviews.</p> <p>*Ongoing Quality Reviews were completed by the DON/designee to review visitor process with staff weekly x 4 weeks, then once every 2 weeks, then monthly to ensure staff were able to verbalize the visitor process. 100 reviews were completed during Week 1 (8/04/24), 110 reviews were completed during Week 2 (8/11/24) with 100% compliance.</p> <p>* Administrator/designee to review 10 residents in LOA (Leave of Absence) book weekly x 4 weeks, then once every 2 weeks, then monthly to ensure LOA process is followed. Reviews were completed on 8/06/24 and 8/13/24 with 100% compliance.</p> <p>Review of the in-service attendance sheets revealed staff signatures to reflect participation in education on Elopement Process, Visitor Process, and Abuse/Neglect Education.</p> <p>Review of audits revealed Visitor process/Leave of Absence Process were reviewed with staff weekly x 4 weeks, then 1 x every 2 weeks, then monthly. Results were reported to QAPI: 8/2/24, 8/05/24, 8/06/24, 8/07/24, 8/08/24, 8/09/24,8/10/24, 8/11/24,8/12/24, 8/13/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/21/24, 8/23/24, 8/25/24, and 8/27/24.</p> <p>On 8/28/24 through 8/30/24 interviews were conducted with 5 Registered Nurses, 7 Licensed Practical Nurses, 13 Certified Nursing Assistants, 1 Rehabilitation staff, 2 Receptionists, and 1 Housekeeping staff. All verbalized understanding of the education provided.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131</p> <p>Based on interview, and record review, the facility failed to ensure the Admission process was thoroughly completed by accurately evaluating and providing needed supervision to prevent elopement for 1 of 5 residents at risk for elopement, of a total sample of 5 residents, (#1).</p> <p>On 7/31/24 at approximately 7:48 PM, resident #1 left the facility unsupervised without the knowledge of staff. The resident walked along a busy roadway with a speed limit of 40 miles per hour and accepted a ride with strangers to get to her home. The facility staff were not aware of resident #1's whereabouts for approximately one hour and twenty minutes. Due to her cognitive deficits, and diagnosis of dementia, the elopement placed her at risk of falling, being severely injured, abducted, or hit by a motor vehicle. The driving distance from the facility to resident #1's home was 2.7 to 3.0 miles away from the facility depending on the route taken. (retrieved on 9/16/24 from www.googlemaps.com). The temperature in Palm Bay on 7/31/24 at 7:53 PM, was 85 degrees Fahrenheit (F), and at 8:53 PM it was 84 F, (retrieved on 9/10/24 from www.wunderground.com).</p> <p>The facility's failure to provide adequate supervision and a secure environment contributed to resident #1's elopement and threatened all residents who were at risk for elopement. This failure resulted in Immediate Jeopardy which started on 7/31/24 and was removed on 8/02/24. The noncompliance at F600 and F689 was determined to be past noncompliance.</p> <p>Findings:</p> <p>Cross reference F600</p> <p>Resident #1, an [AGE] year-old female directly admitted from home to the facility on [DATE] at approximately 1:00 PM. Her diagnoses included dementia, unspecified severity/other behavioral disturbance, diabetes mellitus type II, generalized anxiety disorder, major depressive disorder, and chronic systolic (congestive) heart failure.</p> <p>Review of the Medical Certification For Medicaid Long-Term Care Services And Patient Transfer Form (3008) dated 3/11/24 revealed the resident's primary diagnoses were dementia, anxiety, and depression. The document revealed the resident ambulated independently, and was alert, oriented, and followed instructions.</p> <p>Review of the Summary notes of the resident's visit on 6/26/24 to her community Primary Care Physician, revealed the resident had dementia with behavioral disturbances and the document read, She has some agitation she is forgetting words and she started to wander around.</p> <p>Review of the Admit/Readmit Screener with effective date of 7/31/24 at 1 PM, revealed resident #1 arrived at the facility ambulatory from home, with an admitting diagnosis of dementia, and anxiety. The document indicated the resident was oriented to person, place, time and situation, walked frequently, and had no limitation with mobility. The Elopement Risk assessment indicated the resident was ambulatory, but contrary to the information in the Primary Care Physician's Summary notes of 6/26/24, none of the elopement risk factors were selected, and Not at risk for elopement was checked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 12:08 PM, an interview was conducted with resident #1 with translation provided by Receptionist F. The resident was sitting on the side of her bed finishing her lunch. When asked what happened when she left the facility on [DATE], the resident said she wanted to go back to see her granddaughter. She explained she got anxious so she got up and left the facility. Resident #1 explained a visitor was going out of the facility, and she followed the visitor out. She said she went out of the facility, turned right, walked up the street for about five to ten minutes until a couple gave her a ride. She stated she gave the Latino couple who picked her up from the side of the road her address, and confirmed she did not know the couple previously. She recalled the incident happened in the evening, and said it was, not that dark, but it was hot, and she was sweating.</p> <p>The Interview Statement from resident #1 dated 8/01/24 conducted by the Director of Nursing (DON), revealed the resident said she ate dinner, went to the bathroom, and then wanted to go home. The resident stated she used her walker and started to walk down the street, a young couple picked her up, and she gave them her address. The resident could not recall where the couple picked her up, and she reported that when she got home, she sat for a little bit, then her granddaughter brought her back to the facility.</p> <p>On 8/28/24 at 1:14 PM, Certified Nursing Assistant (CNA) B confirmed she was resident #1's assigned CNA on 7/31/24. CNA B recalled when she came on for the 2:00 PM to 10:00 PM shift, the off going CNA reported she had a new resident. The CNA recalled she went into the resident's room and introduced herself to the resident. She stated she tried to talk with the resident, but communication was hard, she served her dinner, checked on her sporadically, and walked with her to the bathroom. CNA B recalled when she returned to the unit from her lunch break, resident #1 and her roommate who also spoke Spanish were having some disagreement regarding whether to close or open the room door. The CNA verbalized she went to give another resident a bath, and heard the code for elopement paged for the room resident #1 was in. She recalled she went into the room, and noted resident #1's bed was made up as if it was never laid on, and everything was gone. CNA B stated staff were given specific areas to search, and she left in her car along with another CNA to conduct a search. She verbalized that when she came back to the facility, she saw the resident walking through the facility's parking lot, with some keys in her hand. CNA B said when she asked the resident where she went, the resident started laughing, and she took her inside. The CNA recalled the resident's son and granddaughter were in the building, and they explained the resident caught a ride home with strangers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 4:06 PM, the incident was reviewed with the Administrator, the DON, and the Regional Nurse Consultant (RNC). The Administrator gave a timeline of the incident based on the facility's investigation. He said resident #1 was a direct admit to the facility on [DATE] at 1:00 PM, brought from home accompanied by her granddaughter, and son-in law. The Administrator said reports from the family were they had no concerns regarding wandering, or elopement risk, and the family described the resident as, low maintenance, not needing much care, was independent in activities of daily living, and they were looking for Long-term Care placement. At 1:30 PM, CNA C introduced herself to the resident, and no concerns were voiced. At 1:45 PM, the admission evaluation was completed with assistance from the family members present. During the 2:00 PM shift to shift rounding by CNAs, the resident was observed sitting on her bed. The resident had dinner at approximately 5:00 PM, and Registered Nurse (RN) A was in the room administering medications to the resident's roommate. At 6:00 PM, RN A observed the resident sitting on her bed, she was calm, and no concerns were identified. Walking rounds were completed by off going and on-coming nurses at 7:00 PM, and the resident was again observed in her room at that time. At 7:30 PM, Licensed Practical Nurse (LPN) E introduced herself to the resident who was ambulating around her room. At 7:45 PM, the LPN/ Evening Supervisor was alerted by a resident that people were in the lobby waiting to be let out. At 7: 48 PM, the Evening Supervisor entered the lobby, and observed another resident's wife, and a woman (resident #1) standing in the lobby. After asking if the visitor was there to visit her husband, the evening Supervisor entered the door code, and both the visitor, and the woman (resident #1) exited the facility. The Administrator stated the facility had cameras in the lobby and courtyards, and in review of the camera footage, resident #1 was observed on camera to exit the facility and turn to the right until she was out of range of the camera. At 8:40 PM, LPN E noticed the resident was not in her room, and when asked, the roommate said she had left the room. LPN E did not locate the resident, and she notified the Evening Supervisor, who called the elopement code, and a search was initiated. The Administrator recalled he was notified by the Evening Supervisor at 8:55 PM, and at approximately 9:07 PM, the resident returned to the facility accompanied by her granddaughter and son-in law. The Administrator stated he arrived in the facility shortly after the resident returned with her family. He shared that in an interview with the resident's family members, they reported having a general telephone conversation with the resident at approximately 5:00 PM, and there was no mention of her wanting to leave the facility. He recalled the resident's granddaughter said she went into the living room, and the resident was sitting on the couch watching television. When she asked the resident what she was doing there, the resident said she wanted to come home, and a nice Spanish couple bought her home. The granddaughter did not see who dropped the resident off but verified the time resident #1 arrived home via a ring doorbell camera was 8:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 5:11 PM, the LPN /Evening Supervisor recalled that on 7/31/24 the facility had three admissions. She stated she was entering admission orders in the Electronic Medical Record (EMR), and a resident was yelling out that people were at the front door and needed to leave. The Supervisor stated she went to the door, and two older women were standing there, both holding belongings in their arms. She said she was familiar with one of the women and assumed the other woman (resident #1) was assisting her to take stuff to her car. She recalled she entered the door code and walked with them out of the facility while conversing with the familiar person. When asked if the women had visitor badges on, the Supervisor said she could not recall, but stated she had seen the familiar visitor several times before, accompanied by different people. The Evening Supervisor could not recall how long after the women exited the facility that resident #1's assigned nurse came and said they could not find resident #1. She called a code silver for elopement and initiated a search. The Evening Supervisor said when they could not locate the resident after the second search, she called the Administrator to notify him of what was going on. She recalled the resident's family then came to the facility and said the resident had come home, and she had a set of keys to the house, so she opened the door and let herself in.</p> <p>On 8/28/24 at 5:46 PM, in a telephone interview RN A confirmed she worked on the 7:00 AM to 7:00 PM shift and was resident #1's assigned nurse on 7/31/24. She verified she completed the admission process for resident #1. RN A recalled the resident was awake and alert, and the resident's family members helped the resident to understand the admission paperwork she signed. The RN recalled the family said the resident was, low maintenance and would settle into the facility well. She said she, did not dig any deeper, as she did not think there would be any elopement risk when the family indicated the resident was, low maintenance. RN A stated she did not actually ask the family about any prior elopement risk/ wandering by the resident and recalled when she returned to work the following day, she was made aware of the resident's elopement. The RN said she heard after the elopement, that information in the resident's history and physical indicated she had a previous, wandering situation. She said she should have asked more probing questions when she was told the resident was low maintenance. She verbalized the resident responded appropriately, and so she thought she was okay.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/29/24 at 1:35 PM, in a telephone interview with resident #1's granddaughter, she recalled she was at home when the resident was dropped off, but did not see the persons who gave her a ride. She recalled she was told by the facility her grandmother was talking to another resident's family member, exited the building, and started walking down the road, when a random person picked her up and took her home. She stated her neighbor has a door camera, and gave her a copy of the footage, and she did not recognize/know any of the persons in the car. The granddaughter said she was not happy about the elopement, and when she returned the resident to the facility, she said to them, You have cameras, how could you let a resident who has dementia out? She stated the Administrator said they reviewed the camera footage, which showed her grandmother had all her stuff with her, and a nurse put in the code to the door and let her out. The granddaughter said she felt, Bad, scared, and was stressed out. She verbalized she was scared for her grandmother's health. Resident #1's granddaughter stated that before her admission to the facility, the resident had wandered away from home multiple times, had walked in the main road, and neighbors and others that knew her would call and let her know she had wandered out of the house again. She explained she lived about seven to eight minutes away from the facility, and shared when resident #1 came home that night, she was, sweaty, frantic, and was, under the impression that the granddaughter had left her at the facility to get checked out by the doctor, then return home. The granddaughter said the resident got frustrated, and said no one came in to see her, so she left the facility. She stated the resident had issues with balance, had vertigo, and dizziness, and had previously fallen a number of times. She said it was dark at the time the resident came home, and she was thankful her grandmother arrived home safely.</p> <p>On 8/30/24 at 7:50 AM, in a telephone interview LPN E recalled she worked on 7/31/24 on the 7:00 PM to 7:00 AM shift and was resident # 1's assigned nurse. She stated she received shift report from the resident's off going nurse RN A, who reported the resident was, a bit confused. LPN E stated they did the narcotic count, did a walk around to put faces to names, and she introduced herself to resident #1. The LPN stated the resident seemed put together and she noted no agitation, or behaviors. She recalled she went to do medication administration on the opposite hall, which took approximately twenty to thirty minutes. She recalled when she started medication administration on the hall the resident was on, she went in to give the resident's roommate her medications, and did not see resident #1, her bed was made, and she did not see a purse/bag. LPN E said she started looking around, she looked in the hallways since resident #1 could ambulate, and when she did not locate the resident, she notified the Evening Supervisor, and the code green for elopement was called. LPN E stated the Evening Supervisor assigned staff to search different areas, and approximately one hour after the search was started, the resident came back to the facility with her family. The LPN said that during the time she observed the resident, she did not notice any signs/symptoms of agitation/exit seeking behaviors. She stated the resident spoke English as well as Spanish, and had instructed the resident to call if she needed anything. She explained that an elopement risk assessment would be done by the admitting nurse.</p> <p>The resident's baseline care plan with admitted [DATE], signed by the resident, and RN A dated 7/31/24 did not select at risk for elopement/exit seeking as a, Potential Concern.</p> <p>An Elopement Risk Evaluation dated 7/31/24 at 11:29 PM, after the incident, revealed a score of 1.0 indicating the resident was now assessed as At Risk for Elopement.</p> <p>Review of a Brief Interview for Mental Status assessment dated [DATE] revealed the resident's cognition was severely impaired with a score of 06 out of 15.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Anchor Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 Port Malabar Blvd NE Palm Bay, FL 32905	
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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Although there was no baseline care plan for elopement risk, a care plan for risk for elopement related to history of wandering, unauthorized leave of absence, newly admitted to nursing facility, accustomed to living at home, independently ambulatory with assisted device, impaired safety awareness was initiated on 8/01/24 after the incident, with revision on 8/07/24. Interventions included, observe resident for, tailgating when visitors are in the building.</p> <p>The facility's policy, Elopements and Wandering Residents implemented on 11/2020 and reviewed/ revised on 3/16/2023 read, 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 . Residents will be assessed for risk of elopement and unsafe wandering upon admission.</p> <p>The policy Admission of a Resident implemented on 11/03/20, and revised on 11/16/23 read, The admission process is intended to obtain all the information possible about the resident, for the development of comprehensive plans of care .Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol.</p> <p>Review of the corrective actions implemented by the facility revealed the following which were verified by the surveyor:</p> <p>*On 7/31/24 at approximately 9:07 PM, resident #1 was returned to the facility from home, accompanied by her granddaughter.</p> <p>*Resident #1 was placed on one-on-one supervision and re-evaluated for elopement risk. Nurse evaluation of the resident was completed with no signs of injury or distress.</p> <p>*On 7/31/24, education was initiated related to elopement standards and guidelines, Abuse and Neglect. Post-tests were completed to validate competency.</p> <p>*From 7/31/24 to 8/03/24, licensed nurses were educated on elopement standards and guidelines to include how to accurately conduct an elopement risk evaluation and implementation of appropriate immediate interventions to prevent the risk for elopement.</p> <p>* On 8/01/24, 22 out of 33 licensed nurses completed the education.</p> <p>* On 8/02/24, 5 out of 33 licensed nurses completed the education.</p> <p>*On 8/03/24, 6 out of 33 licensed nurses completed the education.</p> <p>* As of 8/03/24, 100 % of licensed nurses completed the education.</p> <p>*Newly hired licensed nurses will receive education on elopement standards and guidelines to include how to accurately conduct an elopement risk evaluation and implementation of appropriate immediate interventions to prevent the risk for elopement during orientation and prior to working on an assignment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*On 8/01/24, current residents were re-evaluated for elopement risk to ensure assessments were current and accurate. No additional residents were newly identified at risk for elopement. Care plans for current residents at Risk for Elopement were reviewed to validate appropriate interventions were in place related to Elopement Risk.</p> <p>*On 8/01/24, Elopement Risk Binders were reviewed to ensure they contained photos and demographic information of residents evaluated to be at risk for elopement.</p> <p>*On 8/01/24, the facility created and implemented a Community Admission Worksheet to include review for behaviors and history of wandering/elopement risk. Visual meet and greet to occur with perspective admissions from the community. The Administrator educated admission team on the new process.</p> <p>*From 8/01/24 to 8/07/24, Elopement drills were conducted on every shift. Drills continued weekly. As of 8/16/24, 25 Elopement drills had been conducted.</p> <p>* On 8/01/24, an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting was completed with the Medical Director, Administrator, Director of Nursing and additional IDT (Interdisciplinary Team) members related to Elopement. The Performance Improvement Plan (PIP) was accepted by the committee. Root Cause Analysis (RCA) completed.</p> <p>*On 8/02/24, an ad hoc QAPI was conducted that included the Medical Director, Administrator, Director of Nursing and additional IDT members to review the plan viability on elopement. No additional recommendations were made at that time.</p> <p>*On 8/02/24, an additional review was completed by the IDT on current residents at risk for elopement. Hourly safety checks were initiated for residents at risk for elopement. Care plans were reviewed/updated.</p> <p>*Additional QAPI meetings were held on 8/06/24, 8/13/24, and 8/16/24, to review the PIP progress related to the elopement. No concerns were identified during the ongoing quality reviews.</p> <p>*Ongoing Quality Reviews: DON/designee to review new admissions/re-admissions and residents with significant change in condition for Elopement Risk Status twice weekly x 4 weeks, then weekly x 1 month, then monthly to ensure elopement risk evaluation is current and accurate for residents identified at risk, the resident's care plan reflects the risk with appropriate/person-centered interventions. Reviews were completed on 8/06/24, 8/09/24, 8/13/24, and 8/16/24 with 100% compliance.</p> <p>Review of the in-service attendance sheets revealed staff signatures to reflect participation in education on Evaluating Resident for Elopement Risk, safety checks, and Abuse and Neglect.</p> <p>Review of the audit titled, Resident Elopement Risk, revealed a Quality Indicator was to identify if the elopement risk evaluation was current and accurate for residents reviewed. Audits were conducted and reviewed and modified by the facility's QAPI committee based on findings.</p> <p>On 8/28/24 through 8/30/24, interviews were conducted with 5 Registered Nurses, 7 Licensed Practical Nurses, 13 Certified Nursing Assistants, 1 Rehabilitation staff, 2 Receptionist, and 1 Housekeeping staff. All verbalized understanding of the education provided.</p>		