STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105556	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village on the Green	500 Village Place Longwood, FL 32779

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to provide adequate supervision and maintain a secure environment to ensure vulnerable residents did not exit the facility without supervision, for 1 of 8 residents reviewed for elopement risk, out of a total sample of 8 residents, (#1). On 1/25/25 at approximately 6:20 AM, the facility failed to prevent a cognitively impaired resident from exiting the facility unsupervised. Resident #1 exited the building without knowledge of staff through an exit door at the end of the Royal Court Hall, which led to the back parking lot. The door did not have a delayed egress bar and the alarm on the door was not loud enough for staff to hear. Licensed Practical Nurse (LPN) A stated the alarm was not heard by anyone working that morning. Resident #1 left the facility wearing only a gown, no shoes, socks or undergarments in cold January weather. She was found approximately 20 feet from the exit door, lying in the grass under a light blanket approximately 25 minutes later at 6:45 AM, when a staff member arrived for work. Facility staff were unaware of resident #1's whereabouts until the staff member brought her back inside and notified the nurse. The facility failed to ensure resident #1 was adequately supervised and failed to ensure all exit doors were secure to ensure vulnerable residents did not exit the facility without staff knowledge. The facility's failure to ensure adequate supervision and maintain a secure environment put all residents who wandered at risk and resulted in Immediate Jeopardy. The facility's Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/11/25 at 1:00 PM, and provided with the Immediate Jeopardy Template. Immediate Jeopardy was determined to begin on 1/25/25 and be removed on 1/29/25 after verification of the immediate actions implemented by the facility. The scope and severity of the deficiencies were decreased to a D, no actual harm with a potential for more than minimal harm, that is not Immediate Jeopardy. Substandard Quality of Care was identified at F689. An extended survey was conducted on 3/12/25. The census at the start of the survey was 47. Findings: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was admitted to the facility on [DATE] with diagnoses that included acute bronchitis, interstitial pulmonary (lung) disease, difficulty walking, anxiety, insomnia, dementia, muscle weakness, heart failure, depression, hydrocephalus (fluid on the brain), and hypothyroidism. The Minimum Data Set (MDS) Medicare 5-day assessment with an assessment reference date of 1/28/25 revealed resident #1 had a Brief Interview for Mental Status score of 05/15 which indicated severe cognitive impairment. Resident #1 had a care plan initiated on 1/23/25 for risk for falls and injuries related to weakness, poor endurance, prescribed medications, need for assistance with transfers, and diagnosis of dementia. The only intervention was for physical therapy to evaluate and treat as ordered or as needed. She had no other care plans related to wandering, dementia or elopement risk. The Elopement Evaluation completed upon admission, 1/22/25, scored the resident a 0 which indicated she was not a risk for elopement. The evaluation section incorrectly answered,Does the resident wander? as a No, which would have scored the resident a value of 1 and indicated she was a risk for elopement. The evaluation listed foci for staff to initiate if the resident scored 1 or higher and the risk for wandering or elopement was identified which included the goal that resident did not leave the facility unattended and interventions to engage resident in purposeful activity, identify times when wandering occurs and schedule time for regular walks/appropriate activity. The evaluation did not include if family were interviewed for information used in the assessment, and there was no accompanying documentation to show resident #1's family was asked if she had a history of wandering . In a telephone interview on 3/10/25 at 9:13 AM, resident #1's daughter stated before her mother was admitted to the facility someone called and asked her if her mother had ever left the facility where she lived unattended. She recalled she told them no, she had never left the facility, but her mother frequently wandered around the building as she had dementia. Resident #1's daughter said she was told her they could care for her mother with dementia at the facility, but no one from the facility ever asked her if her mother wandered or attempted to leave once she was admitted to the facility. She recalled that sometime during the two days prior to her mother leaving the facility someone from the facility had called her to say her mother was walking around in the halls and she told them her mother frequently wandered but had not tried to leave before. She recalled the facility called her again the next day to report her mother had gone out of the building alone. The daughter said, I was very concerned because she was outside, lying in the grass and it was during that little cold snap that we had. Review of a therapy note documented by Physical Therapy Assistant C on 1/23/25 revealed on admission resident was disoriented to person, place, time and situation which per family was her baseline cognition. The therapy assistant noted resident #1 required minimal assist in completing bed mobility activity tasks but was reeducated regarding safety issues to be observed at all times due to poor safety technique related to her cognitive status. Review of a therapy note documented by Physical Therapy Assistant C on 1/24/25 at 2:59 PM, that read, . Therapist engaged with a conversation with patient (pt.) about participating with therapy. Pt. stated she is living [leaving] this place and trying to get out of here. Pt. became combative, pulling the cover and stated she's going to make a call. Therapist exited the room shortly after. There was no documentation in the record this was reported to the nurse or any other nursing staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone conversation on 3/09/25 at 3:35 PM, and an in-person interview on 3/11/25 at 9:45 AM, Certified Nursing Assistant (CNA) B stated it was dark and cold that Saturday morning, 1/25/25. She remembered she first noticed the blanket on the ground when she pulled up to the back parking lot in her car for work. She explained when she got out of her car for her day shift at the facility and approached the item on the ground, she saw a pair of bare feet sticking out from what looked like a pile of towels on the grass. She explained when she got closer she realized it was a resident under a light blanket on the ground between the light post and some poles. CNA B said she lifted the blanket, and the resident immediately looked at her. She said she did not recognize her but the resident was lying in a fetal position under the blanket. She asked resident #1 what her name was but she was not able to tell her or was she able to say how long she was outside in the cold or how she had gotten out there. CNA B explained she assisted the resident up to her feet but the resident could not walk very well so she sat her in a wheelchair that was parked outside the therapy door. CNA B recalled the resident's feet were cold so she grabbed a pair of socks off a nearby cart, put them on the resident and then took her to the nurse on Royal Court. She said the nurse was not aware that resident #1 was outside the building alone. CNA B said a little while later the Administrator and called her on the phone, to ask about the details of the incident. The temperature on 1/25/25 at 6:00 AM, was approximately 39 degrees Fahrenheit (F), and sunrise was at 7:16 AM, (retrieved on 3/11/25 from www.timeanddate.com). Hypothermia (low body temperature) occurs when your body's temperature drops below 95 degrees F and your brain and body can't function properly. If left untreated it can lead to cardiac arrest and death. Most cases of hypothermia occur at very cold temperatures under 40 degrees F, but environmental conditions such as wetness can cause a person's body to lose more heat than it can generate. Older adults are more at risk for hypothermia due to less body fat and less control of body temperature self regulation (retrieved on 3/24/25 from www.my.clevelandclinic.org). On 3/09/25 at 2:15 PM, Registered Nurse (RN) D stated the door resident #1 exited from did have an alarm and demonstrated how the alarm sounded when the door was opened. She explained the alarm sounded when the door opened but stopped alarming as soon as the door closed. The alarm at the Royal Court back door was audible, but not loud, and at that time the DON was the only staff to respond to the sound. RN D stated all staff were supposed to go to the alarm as soon as it was heard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/09/25 at 5:15 PM, in a telephone interview LPN A stated she took care of resident #1 the night she eloped. She stated when she received report from the off-going day shift nurse, she was not told that the resident was an elopement risk. She said she was told the resident needed assistance with ambulation, otherwise she would have put a wander alarm on the resident. The LPN recalled she was in the hall outside the resident's room that morning sometime after 6:00 AM, when she heard resident #1 saying hello, hello? The nurse said she went into the resident's room to see what she needed and the resident asked her where she was, why she was there and when could she get up. The nurse said she told the resident that she was there for physical therapy, and she could get up in an hour or two. The LPN said resident #1 told her okay and said that she was going back to sleep. LPN A stated she turned on the bathroom light and left her door cracked open. LPN A explained the exit doors had alarms, but she did not hear the alarm when the door opened and resident #1 went outside. She stated the alarms were not loud, it was a faint sound and only rang while the door was open. LPN A described the alarm stopped when the door closed. She said, I do not know how resident #1 walked from her room to the door, and no one saw her. LPN A explained at that time in the morning, the CNAs and nurses were busy in the halls doing rounds. She said she was not aware that resident #1 left the building until the CNA brought her back inside. LPN A recalled when the CNA brought resident #1 back into the facility, she did a head-to-toe assessment including neurological checks and vital signs and found no injuries. She remembered the resident's gown was damp on the side where she was lying in the grass, and they changed her into dry clothes. She said she called the physician, the resident's daughter and the DON to inform them of what happened. In interviews on 3/09/25 at 4:20 PM, and 3/10/25 at 10:45 AM, the Administrator and Director of Nursing (DON), stated the elopement happened at shift change. The DON said the nurse saw resident #1 at approximately 6:20 AM in bed. The Administrator added the CNA found her at approximately 6:45 AM outside in the back and brought her back inside. They both expressed they thought resident #1 fell off the sidewalk on to the grass. The DON explained resident #1 had only been here a few days before the elopement and if she would have had a electronic wander bracelet the door alarm would have been very loud. They acknowledged the door alarm was not loud without the electronic wander bracelet present and that the door resident #1 left from could be easily opened by pushing on it as it did not have a delay to open. The Administrator and DON stated they had workers at the facility last week to put egress push bars on all of the exit doors to prevent a confused resident to be able to push the door open easily. The Administrator added that resident #1 was only in the facility for a couple of days when it happened, and she had not been assessed an elopement risk upon admission. They did not explain why resident #1 was not assessed an elopement risk if she was confused and known to frequently wander per her daughter. The Administrator acknowledged the nurse's statement read she did not believe the resident had fallen but based on her physical therapy evaluation, and the way the grass was where she was found, they confirmed it was possible she fell into the grass. On 3/10/25 at 12:00 PM, the Director of Rehabilitation stated resident #1 had her initial evaluation with therapy on 1/23/25. He summarized her therapy care as needing minimum assistance for transfer and she was able to walk 15 feet with a walker with minimum assistance per Physical Therapy (PT) evaluation. The Director of Rehabilitation indicated on 1/24/25 the PT assistant noted the resident was combative and pulled the covers over her head until the therapist left. The Director of Rehabilitation did not say whether nursing staff were notified of resident #1's behaviors on 1/24/25. He continued that on 1/25/25, after the incident, Occupational Therapy indicated resident #1 needed minimal assistance to get out of bed or for toileting and on 1/27/25 PT assessed she could walk over 100 feet with her walker, but needed to be redirected multiple times. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/10/25 at 2:30 PM, the DON stated there were no working cameras in the area where resident #1 eloped. On 3/12/25 at 10:30 AM, the Medical Director (MD) stated he was informed of the elopement the morning it happened. He said he was surprised resident #1 could walk that far because she had not walked that far prior to the incident. The Medical Director said the facility had an ad hoc Quality Improvement meeting the Monday morning after the incident and discussed what needed to be done to prevent future elopements. He stated we reviewed everything again on 1/31/25, which was our regular meeting. The Medical Director stated he spoke with the Administrator last night to see how things were going with education of staff and the new doors the facility was installing. He felt new doors would help prevent residents from leaving the facility unsupervised in the future. Review of the policy and procedure, Elopement, Unsupervised Absence, Hazardous Wandering and Missing Residents revised 2/18/20, revealed an elopement occurred when a resident receiving health care exited the Health Center, licensed healthcare provider or exited the community's property and was no longer under the supervision or line-of-sight of a team member, volunteer or family member. Review of the Facility Assessment Tool revealed the facility accepted and could provide care for residents with Psychiatric/Mood disorders to include impaired cognition, anxiety disorder, behavior that needs interventions, behavioral and psychological symptoms of dementia. Review of corrective measures to remove Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team: *Resident #1 is not a current resident in the community. *On 1/25/25 at 6:45 AM resident #1 was brought back to the room and assessed by Licensed Nurse - no injuries or changes in condition noted. Physician and family were notified on 1/25/25 by Licensed Nurse and DON. *On 1/25/25 DON/Designee completed full head count in Health Center - no other residents were unaccounted for. *On 1/25/25 DON/Designee reviewed plan of care interventions, completed Elopement Risk Assessment and implemented interventions for resident now At Risk for Elopement - Electronic wander bracelet order obtained and applied, resident added to Community Elopement Book, resident #1 placed on 1:1 supervision until she was discharged (planned) on 1/28/2025 to community. *On 1/25/25 all residents' records were reviewed for Risk of Elopement by Administrator and DON - no other residents were identified for risk of elopement. MD notified of the audit - no further orders or modifications to plan of care. *On 1/25/25 all exit doors in Health Center were checked by Plant Operations Director for functioning - no Maintenance concerns noted. *On 1/25/25 Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was completed with Administrator, Director of Nursing, and Medical Director. A Plan of Correction was initiated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On 1/25/25 Administrator initiated investigation and in-services for nursing staff on resident interventions and elopement prevention policy. Nursing Staff education was completed on for regular staff on 1/25/25 (8 out of 34 CNAs/Nurses), 1/27/25 (3 out of 34 CNAs/Nurses) 1/29/25 (10 out of 34 CNAs/Nurses) and ongoing. Education Topics included Elopement Policy and Procedures, Elopement Assessment and Family Notification. *On 1/27/25 an elopement Drill was conducted by Administrator at the Health Center to include Director of Nursing, ADON, Social Service Director, Director of Therapy, RNs, LPNs, CNAs, MDS Coordinator, Admission Assistant, Environmental Service Lead, Therapy Director, Admission Director and Maintenance Lead. *On 1/27/24 all doors were noted with a functioning audible alarm. *On Ad Hoc 1/27/25 QAPI Meeting was held with Interdisciplinary Team including Administrator, DON, MDS Coordinator, Therapy Director, Lifestyles Director, Maintenance, Social Worker, Medical Records, to review the alleged deficiencies, policy and procedure, and plan of correction. *On 1/27/25 Director of Nursing or designee monitor compliance daily (Monday through Friday) and Administrator/DON (Saturday and Sunday) by checking new admissions records for Elopement Risk and appropriate interventions. The facility presented additional information on corrective actions which were verified by the survey team and included the following: *All new admission records are reviewed daily for Elopement Risk. Any residents noted at risk; interventions are in place. *On 1/31/25 monthly QAPI Meeting was held with Administrator, DON, Medical Director, Social Service Director, MDS, Therapy Director, Registered Dietician, Environmental Services, and Health Information Practitioner and reviewed the alleged deficiencies, policy and procedure, and plan of correction. Audit findings were reviewed at the monthly QAPI Meeting. Reviewed new doors with delayed egress with team. *In-services were provided by Administrator/Designee all team members on the facility Elopement Policy and Procedures, Elopement Screening Tool and Notification of family. In-services were provided on 2/05/25, 2/12/25, 2/26/2012, 3/04/25, 3/05/25, 3/07/2025. Education will be continued to ensure compliance. Any team member who has not received education will be provided with education prior to reporting to work. All New hires will receive education. *On 2/21/25 monthly QAPI Meeting held Administrator, DON, Medical Director, MDS, Therapy Director, Registered Dietician, ADON, Environmental Services, Lifestyles Director and Health Information Practitioner and reviewed the alleged deficiencies, policy and procedure, and plan of correction. Audit findings were reviewed at the monthly QAPI Meeting. No areas noted out of compliance. Reviewed new doors with delayed egress, plan and specifications for doors have been submitted to county for permitting. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On 3/05/2025 on 7:00 AM-3:00 PM & 3:00 PM-11:00 PM elopement Drill with CNAs and Nurses was conducted by the Administrator at the Health Center. Monthly Elopement Drills will be continued to ensure compliance. *The Administrator/Designee will continue to monitor compliance by completing a random audit of three residents twice per week monthly for the next three months, checking residents medical records for elopement risk and appropriate interventions. Audits were initiated on 1/29/25 and audits will be continued to ensure compliance. *The Executive Director provided oversight of the Administrator to ensure that the items on the plan of removal were reviewed and completed. Interviews were conducted from 3/09/25 to 3/12/25 with 29 staff members (18 CNAs representing all shifts, 9 nurses representing all shifts, 1 therapist, and 1 dietary staff). Staff interviews revealed they were knowledgeable of the elopement policy and procedures, appropriate response to alarms and supervision of all residents to include those at risk for elopement. The resident sample was expanded during the survey to include five additional residents at risk for elopement. Observations, interviews, and record reviews conducted revealed no concerns related to elopement risk evaluations, care plans and physician orders for residents #2, #3, #4, #5, and #6.