

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Springs at Lake Pointe Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  3280 Lake Pointe Blvd Sarasota, FL 34231	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37256</p> <p>Based on record review, review of the facility's policies and procedures, and staff interviews, the facility failed to provide adequate supervision to prevent unsafe wandering and elopement for 1 (Resident #1) of 1 newly admitted cognitively impaired, confused resident exhibiting exit seeking behaviors.</p> <p>On 8/20/24 shortly after 4:15 a.m., Resident #1 who was confused, wandered and had documented exit seeking behaviors walked out of the facility through the front lobby.</p> <p>Staff was not aware of the resident's exit until 8/20/24 at 4:40 a.m.</p> <p>Resident #1 walked approximately half a mile through the parking lot, down a private road with a nearby unfenced pond, to a busy four lane main road.</p> <p>Resident #1 could have been hit by a car, assaulted, or fallen into the pond and drowned.</p> <p>The facility failure to implement adequate supervision to prevent unsafe wandering and elopement of cognitively impaired, and confused residents created a likelihood of avoidable accidents for Resident #1 and other cognitively impaired and confused residents at risk for elopement which could result in serious harm, serious injury, serious impairment or death of the residents.</p> <p>This failure resulted in the determination of Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on 8/20/24.</p> <p>On 9/19/24 after verification of an acceptable removal plan, the Immediate Jeopardy was removed as of 8/23/24.</p> <p>The findings included:</p> <p>The facility's Risk Management/Nursing Policies-Elopement Risk (undated) included, . An elopement risk evaluation will be completed as part of screening upon admission to the facility . If the resident is identified as an elopement risk based on the evaluation, a care plan will be developed to reduce elopement risk. Facility staff will provide supervision and engage the resident as needed to minimize wandering or exit seeking behavior according to the plan of care .</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Springs at Lake Pointe Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  3280 Lake Pointe Blvd Sarasota, FL 34231	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the clinical record revealed Resident #1 was admitted to the facility on [DATE] following hospitalization for a traumatic subdural hemorrhage (bleeding near the brain). Diagnoses included encephalopathy (disorder that can affect the function of the brain), and alcohol use.</p> <p>The Nursing Admission Note documented Resident #1 was alert, oriented with short term memory loss, and occasional confusion. The resident's daughter said it was her normal since the injury.</p> <p>The elopement risk evaluation used by the facility consisted in six questions. A score of 7 or higher is considered at risk.</p> <p>The Elopement Risk evaluation dated 8/19/24 at 6:27 p.m., showed question 1 (Mood/Mental Status), question 3 (Relationships), and question 6 (Elopement history) were not answered, resulting in a score of 2, indicating the resident was not an elopement risk.</p> <p>A Nursing Progress note dated 8/20/24 at 6:42 a.m., noted Resident #1 was exhibiting exit seeking behavior, going to doors and attempting to leave. The resident stated her daughter was here to pick her up and bring her home. Verbal redirection was initially effective. However, due to the resident's cognitive deficits, she forgets and attempts to leave shortly after.</p> <p>Review of the facility's incident investigations revealed that Resident #1 was last seen in bed on 8/20/24 at approximately 4:00 a.m. On 8/20/24 at approximately 4:30 a.m., the laboratory technician arrived at the facility and was not able to locate the resident on Unit C where she resided to draw her blood. Staff began to search for the resident at that time.</p> <p>Licensed Practical Nurse (LPN) Staff A said on 9/20/24 at approximately 4:15 a.m., she saw Resident #1 on Unit B. The resident asked LPN Staff A to direct her to the lobby. She said she had been visiting and needed to wait in the lobby for her daughter to pick her up. Resident #1 was dressed in sweatpants, tennis shoes, a shirt and a jacket covering her arms, so an arm band would not have been seen. She was carrying a purse. Staff A escorted Resident #1 to the front lobby where she said she would sit and wait for her daughter. LPN Staff A returned to her unit.</p> <p>The investigation noted, Unwitnessed, (Resident #1) pushed the lobby's door's red release button and left the facility for a walk.</p> <p>While searching for the resident, the laboratory technician mentioned he observed a woman in the driveway on his way to the facility.</p> <p>Facility staff, and the laboratory technician exited the facility to search for the resident. The laboratory technician located Resident #1 and the facility staff returned her to the facility at approximately 5:10 a.m.</p> <p>On 9/16/24 at 9:45 a.m., in an interview the Administrator said Resident #1 eloped from the facility in the early morning hours of 8/20/24. The Administrator provided the investigation, and actions taken to prevent recurrence.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Springs at Lake Pointe Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  3280 Lake Pointe Blvd Sarasota, FL 34231	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/16/24 at 6:15 p.m., in an interview Licensed Practical Nurse (LPN) Staff C said she was working the night Resident #1 eloped. She said she saw Resident #1 walking by with a pillow and bags and thought maybe she was a dialysis resident. She said they began looking for the resident when the laboratory technician could not locate Resident #1 to draw her blood. LPN Staff C said the laboratory technician and her got in their car to search for the resident. The laboratory technician found her. Staff C said she brought the resident back to the facility. Resident #1 was pleasant and had no visible injuries.</p> <p>On 9/16/24 at 3:00 p.m., in an interview the Director of Nursing (DON) said she interviewed staff on duty the night Resident #1 eloped. She said when Resident #1 approached LPN Staff A, said she was a visitor and asked for assistance to exit the facility, Staff A did not verify the resident's identity. The DON said staff needed to be aware of new admissions and verify whether they are a visitor or resident before allowing them to leave. The DON said Staff A and Staff B (Charge nurse on Unit C where Resident #1 resided) were no longer employed at the facility.</p> <p>On 9/18/24 at 10:20 a.m., in a meeting with the DON and Administrator they said after Resident #1 eloped, she was fitted with a wander alert bracelet (wearable device that alerts staff when a resident leaves a designated safe area). Resident #1 was also placed on checks every 15 minutes until she was safely discharged to a secured facility on 8/22/24. The DON and Administrator said they in-serviced staff on elopement policies, conducted numerous elopement drills on all shifts and continued to audit to prevent further elopement incidents.</p> <p>The facility submitted an acceptable Immediate Jeopardy Removal Plan on 9/19/24, and the Immediate Actions implemented by the facility and verified by the surveyor included:</p> <p>All exterior doors were checked by the Director of Nursing, Administrator, and Maintenance Technician. All were in good working order with no deficiencies noted. The maintenance department conducts routine door inspections during their work shifts.</p> <p>On 9/16/24 at 12:20 p.m., the surveyor conducted a tour with the DON and verified all doors were functioning properly.</p> <p>Resident #1 was placed on enhanced monitoring on 8/20/24 with continuous 15-minute checks for supervision in addition to wander management bracelet until discharge date of [DATE].</p> <p>On 9/16/24 the surveyor verified through review of the monitoring documentation beginning on 8/20/24 at 6:00 a.m., until 8/22/24 at 2:15 p.m., when Resident #1 was discharged to a secured facility.</p> <p>Exit button used by Resident #1 in front lobby to exit front door was disabled by the Administrator. Secured lock box was placed over exit button. A sign was placed on the lock box to see nurse to exit facility after hours on 8/20/24. The front door is monitored by the receptionist from 8 AM to 6:30 PM. The front door automatically locks at 6:30 PM and automatically unlocks at 8 AM.</p> <p>On 9/16/24 the surveyor verified through observation of the sign located over the exit button. On 9/16/24 a receptionist was observed at the desk during the day. On 9/16/24 after 6:30 p.m., the door was locked. A staff member had to open the door for the surveyor to exit the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Springs at Lake Pointe Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  3280 Lake Pointe Blvd Sarasota, FL 34231	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Elopement education for staff began on 8/20/24 with 6:00 a.m., to 2:00 p.m., 2:00 p.m., to 10:00 p.m., and subsequent shifts on elopement policy and procedure, wander management devices, identifying residents at risk for elopement, and steps to identify a resident versus a visitor. Education was completed with 100% participation of current staff on 8/23/24. There were 173 staff members trained out of 173 current staff members.</p> <p>On 9/19/24 the surveyor verified participation through review of the sign-in sheets for the education provided. On 9/19/24, interviews with staff member corroborated trainings.</p> <p>Ninety-one of 99 direct care staff have participated in one of more elopement drills. Staff members have participated in one or more elopement drills related to performance improvement plan initiated by this resident event. Elopement drills were conducted by the Assistant Director of Nursing, RN Unit Supervisors, the Administrator, and the Infection Preventionist.</p> <p>Those staff members who did not participate in an elopement drill will not work until participation in an elopement drill is completed.</p> <p>On 9/19/24 the surveyor verified through review of sign-in sheets for elopement drills. On 9/19/24 interviews with staff corroborated multiple elopement drills held on all shifts.</p> <p>QAPI (Quality Assurance and Performance Improvement) meeting was held with QAPI committee members on 8/20/24 at 10:00 a.m., to review resident elopement performance improvement plan. The Medical Director participated in the QAPI meeting as well as all facility members. All members approved the performance improvement plan as written.</p> <p>On 9/16/24 the surveyor verified through review of minutes from the QAPI meeting held on 8/20/24 and ad hoc (unplanned) follow up held on 9/16/24.</p> <p>Root Cause Analysis (RCA) was completed on 8/20/24. RCA determined the individual nurse did not follow facility practice in identifying residents. Facility nurse was educated on elopement procedure prior to the event.</p> <p>On 9/16/24 the surveyor verified through review of the education on elopement procedure prior to 8/20/24.</p> <p>All residents currently identified at risk for elopement were verified to have their wander management device in place and was functioning properly on 8/20/24. Residents who are at risk for elopement are audited twice daily by nurses for device placement and function. Nurses document in the resident Treatment Administration Record (TAR) that device is present and functioning. Elopement books are brought to clinical meeting to verify list of residents are correct, all resident sheets are in the book, and device placement is correct.</p> <p>On 9/16/24 the surveyor verified through observation of residents at risk for elopement wearing a wander alarm band during tour with the DON and documentation of placement and function of the wander alert band in the Treatment Administration Record. Elopement books were reviewed and contained the current information.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Springs at Lake Pointe Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  3280 Lake Pointe Blvd Sarasota, FL 34231	
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The elopement risk binders located at nurses' stations, front desk, and risk manager office were verified as current and accurate on 8/20/24. Audits conducted weekly by Risk Manager with no identified areas of concern noted.</p> <p>On 9/16/24 the surveyor verified through review of the information in the elopement books for accuracy.</p> <p>Current residents were re-evaluated for elopement risk and documented in PCC (Point Click Care) electronic clinical record by nurse managers. All evaluations were found to be accurate with no changes indicated on 8/21/24.</p> <p>On 9/16/24 the surveyor verified through review of the elopement risk re-evaluation.</p> <p>Staff Elopement drills were initiated on the 6:00 a.m. to 2:00 p.m. shift on 8/20/24. They continued every eight hours for the next seven days. These drills were completed by nurse managers and Administrator. After the initial seven days, elopement drills have been conducted weekly and will continue weekly until 9/27/24. After 9/27 they will be completed twice monthly per facility protocol.</p> <p>On 9/16/24 the surveyor verified through review of the elopement drills.</p> <p>Director of nursing/designee has been auditing elopement evaluations in morning clinical meeting daily on new/readmission residents. No new residents have been identified at risk since the incident.</p> <p>On 9/16/24 the surveyor verified through review of the completed audits.</p> <p>Twenty-three of 25 licensed nurses were educated on 8/23/24 regarding taking new admission photos and uploading them into Point Click Care upon admission. This is verified in morning clinical meeting audits by nurse leadership and/or Administrator. Those PRN (as needed) nurses who have not been educated will not work until education is completed.</p> <p>On 9/19/24 the surveyor verified through review of the documentation of the education. A total of 26 nurses have been educated.</p> <p>On 8/28/24, a 15 day Adverse Incident was completed by DON and submitted to AHCA (Agency for Health Care Administration), (State Survey Agency).</p> <p>On 9/16/24 the surveyor verified through review of the Adverse Incident submitted.</p> <p>New staff are educated/oriented to elopement/missing resident policy and procedures upon general orientation which occurs prior to working in their assigned department.</p> <p>On 9/18/24 the surveyor verified through review of eight personnel files. All eight randomly selected staff received training.</p> <p>Employees receive education annually on elopement/missing resident policy and procedures.</p> <p>On 9/18/24 the surveyor verified through review of eight personnel files. All eight staff selected received training.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Springs at Lake Pointe Woods		STREET ADDRESS, CITY, STATE, ZIP CODE  3280 Lake Pointe Blvd Sarasota, FL 34231	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Residents at risk for elopement are supervised by multiple interventions:</p> <p>Encouraged to participate in activities offered on units in Avalon rooms. These rooms are monitored by staff assigned to area for increased supervision.</p> <p>Encouraged to eat in Avalon rooms with other residents or in the main dining room for a higher level of supervision.</p> <p>Encouraged to attend group activities in supervised areas provided by the activity department.</p> <p>On off hour shifts, increased supervision is provided for those residents at risk by nurses during room rounds, medication pass, wound care treatments. Increased supervision is also provided by Certified Nursing Assistants (CNAs) by increased room rounds and monitoring. Staff are encouraged to provide 1:1 (one to one) or group activities if needed for residents with wandering behaviors.</p> <p>CNAs have Kardex (Provides instructions for care) and pocket care guides to have information on residents at risk for elopement.</p> <p>On 9/16/24 through 9/18/24 the surveyor verified through observation of residents at risk for elopement and review of Kardex and pocket care guides.</p>