STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105611	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Greenacres	6414 13th Rd S Green Acres, FL 33415

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142 Based on record review, the facility failed to appropriately care plan for monitoring of a resident as an elopement risk, for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE]. On 04/05/24, Resident #1 was identified as an elopement risk. A comprehensive care plan was initiated for that problem. The focus on the care plan stated the following: The resident is an elopement risk/wanderer r/t [related to] exit seeking. The goal states: The resident's safety will be maintained through the review date. Interventions included the following: Electronic monitoring device q [every] shift. 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. The above interventions were initiated on 04/05/24. When the resident was determined to be actively exit seeking on 06/27/24 the following interventions were put in place: Wanderguard Check Q [every] shift. Monitoring: Wanderguard - Expiration Date. Wanderguard - check for function each day. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These revisions were initiated when Resident #1 was noted to have verbalized exit seeking behaviors. These verbalizations included expressing he was going to another country and expressing he was going to Canada on two separate occasions. These were documented in nurses' progress notes on 06/27/24. It was not until after the elopement of 7/26/24 that actively monitoring the resident every 30 minutes was added. On 08/01/24 the intervention of one-to-one (1:1) observation was added.

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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** 39142 Based on interview, observation, and record review, the facility failed to provide appropriate supervision to prevent an elopement, which resulted in a resident who was able to leave the facility and travel along a busy roadway with a likelihood of being hurt, killed or lost, for 1 of 1 sampled resident reviewed for elopement risk (Resident #1). The deficient practice allowed Resident #1 to exit the facility from between 07/25/24 at 9:00 PM to 07/26/24 at 5:45 AM without supervision. Resident #1 walked approximately 3 miles away from the facility, before being stopped by staff. Resident #1 was transported back to the facility by the same staff. Census was 94 at the time of the survey. Seven residents were identified at risk of elopement or wandering. Resident #1 remains in the facility with one-to-one (1:1) supervision. The facility's Administrator was notified of Immediate Jeopardy and given the Immediate Jeopardy (IJ) Template on 08/14/24 at 3:30 PM. The Immediate Jeopardy was removed at the time of the facility exit on 08/16/24. The findings included: Review of the facility policy, titled, Elopement/Wandering Risk Guideline, Revision Date 08/01/20, documented in the section labeled Process, a bullet point that states Initiate individualized interventions based on Patient/Residents' risk. Record review revealed Resident #1 is vulnerable, adult male, who was admitted to the facility on [DATE]. Resident # 1 had his most recent Minimum Data Set (MDS) Quarterly Assessment on 07/10/24. At that time, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated a moderate cognitive deficit. Resident #1 was identified as a elopement risk upon his initial evaluation at admission on 04/02/24. On 06/27/24, Resident #1 was re-evaluated as an elopement risk when he began exhibiting signs of exit seeking. The resident's diagnoses included the following: Cardiomegaly (enlarged heart), generalized muscle weakness, anxiety disorder, acute kidney failure, insomnia, altered mental status, cognitive communication deficit and encephalopathy. The primary diagnosis for the admission was encephalopathy (damage or disease that affects the brain). From the facility's report, on 07/26/24 at 6:39 AM, the Director of Nursing (DON), who is no longer on staff at the facility, reported to the Administrator that Resident #1 was missing from the facility. Resident #1 was out of the facility for an unknown amount of time, he left either late at night or in the early morning, and walked 3 miles, before he was found. The distance was determined by Google Maps and verified by this writer, on 08/12/24, using his car's trip odometer. When Resident #1 was brought back to the facility, he was asked how he got out and he stated he loosened the screws in the window lock placed on the bottom inside track. He then was able to remove the device, open the window, remove the screen and climb out the window. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/12/24 at 1:13 PM, an interview with Staff A, a facility Housekeeper, was conducted. Staff A stated that she was off duty and on her way to a store when she saw Resident #1. Staff A stated that the time was around 7:30 AM. Staff A stated she saw Resident #1 as he was walking Northbound on a busy 6-lane divided roadway, with a 45 Mile Per Hour (MPH) speed limit, near the entrance ramp to the 4-lane Florida's Turnpike with a speed limit of 70 MPH. Staff A stated she made a U-turn, pulled over to the side of the road with her hazard lights on and spoke to Resident #1. Resident #1 told Staff A that he was going to his family. Staff A called the facility to inform them she found Resident #1 near the Turnpike ramp, and she was going to try to get Resident #1 into her car. Staff A stated she offered Resident #1 a ride, letting him believe she was taking him to his family, and he accepted the ride. Resident #1 was then returned to the facility by Staff A. Record review was conducted of a nurse's progress note dated 06/27/24 at 6:58 AM indicated Resident #1 informed the nurse that someone called him through the television, and he needed to be somewhere. The nurse documented that Resident #1 was monitored closely and the oncoming nurse was notified to continue. A progress note dated 06/27/24 at 7:15 AM indicated an order was received to place a wanderguard device on Resident #1. The nurse documented the wander guard was placed on Resident #1's right foot and the Staff monitored him closely. On 06/27/24 at 8:37 AM, Psychiatry was notified of the exit seeking behavior. The Resident was noted to have been standing at the front door and expressing he was leaving that morning. The same note stipulated that the Assistant Director of Nursing (ADON) told the nurse that Resident #1 was expressing he was going to another country. The nurse documented that Resident #1 had told the nurse the week prior that he, Resident #1, was going to Canada. The investigative report, dated 08/01/24, revealed that the resident was last seen by his primary nurse on 07/25/24 between 8 and 9 PM. The nurse stated she did not see Resident #1 at 5:45 AM, when she was passing medications. On 08/13/24 at approximately 2:15 PM, an interview conducted with the primary nurse, Staff L, who worked the 7:00 PM to 7:00 AM shift, starting on 07/25/24, on the North Wing. Staff L stated she did not remember when she last saw Resident #1, but she did notice he was missing at around 5:45 AM on 07/26/24. Staff L stated she reported the resident missing to Staff B (nurse on South Wing). At that time the elopement protocol was started. On 08/13/24 at 9:37 AM, an interview was conducted with Staff C, Certified Nursing Assistant (CNA). Staff C stated that she works the 11:00 PM - 7:00 AM shift. Staff C stated that when she first came on shift and looked in the resident's room, she noted the bed was made as if there was no one assigned to the bed. Staff C stated she did not see the resident, and she never laid eyes on him. Staff C stated she normally works the South Unit and Resident #1 was on the North unit. Staff C stated when she works the South unit, she is more familiar with the residents and would ask the nurse about a missing resident. Staff C stated she did not ask the nurse about the resident not being there. Staff C stated she just did not ask about the resident. Staff C stated that there is no communication between shifts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/13/2024 at 8:24 AM, an interview was conducted with Staff B, Registered Nurse (RN), who worked on the South Wing from 7:00 PM to 7:00 AM on the day of the elopement. Staff B stated that she was the weekend supervisor for her shift. Resident #1's room was on the North Wing. Staff B stated that at approximately 6:00 AM the nurse who was primary for Resident #1 informed Staff B that Resident #1 was missing. Staff B stated she immediately initiated the elopement protocol and had the staff search the facility and grounds for Resident #1. Staff B stated she was present when Resident #1 was returned to the facility. Staff B stated Resident #1 appeared to be in good spirits and unharmed. Staff B remembered that the weather that morning was overcast but it was not raining at the time. Staff B stated Resident #1 was dressed in a T-shirt, either in long shorts or pants, and he had a jacket or sweater with a hood over his shoulder. On 08/13/24 at approximately 4:00 PM, an interview was conducted with Resident #1. Resident #1 explained that he got out by loosening the screws on the (window blocking) device, removed it, opened the window, pushed out the screen and climbed out the window. Resident #1 stated he put it all back together so no one would see. Resident #1 was unsure of the time he got out. **An onsite IJ Removal Plan verification was conducted on 08/16/24. The following is verification that the IJ Removal Plan was implemented and the Immediate Jeopardy had been removed: On 08/16/24 at 9:00 AM, the IJ Removal plan was reviewed with Administrator present. The criteria section 1 included items already reviewed during the initial investigation. The Elopement policy and procedure were not changed as no changes were thought to be necessary. Resident #1 remained in the facility with continuous 1:1 observation. The Executive Director led a Quality Assurance and Performance Improvement meeting on 07/26/24 with the Medical Director, Director of Clinical Services, Plant Operations, Dietary Supervisor, MDS Coordinator, Business Development Director, Business Office Manager and Assistant Director of Nursing. The Elopement Policy was reviewed, and the root cause of the elopement was discussed. The meeting included a Root Cause Analysis, which was reviewed with the Administrator. The facility determined Resident #1 strongly wanted to go home to his family. Resident #1 determined that the windows did not have alarms and that was probably the easiest way to escape the building without being noticed. Resident #1 was evaluated by the psychiatric services on 07/26/24 with recommendation for continued 1:1 observation and new orders for lab work. Interview, record review, and observation confirmed this to be true during the initial investigation. Lab orders were received from the attending physician. The results were obtained 07/27/24, 07/29/24 and 08/01/24 and reviewed by attending physician with no new orders. Record review confirmed these orders were received and acted upon. The lab results showed the resident had normal or near normal values. There were no indicators that would point to confusion, or a change of cognition as would be related to infection or other disease processes. Under criteria two, the following was reviewed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o On 07/26/24, a facility wide head count was conducted to verify all residents present in the facility. Documentation provided included a copy of the Midnight Census used to check the presence of all residents on both wings. o On 07/26/24, the Plant Operations Manager rounded in the facility to validate all exit door alarms were functioning properly and windows were secured. Documentation examples were provided to show the doors and windows were being checked daily. o On 07/26/24, the Director of Clinical Services and/or designee checked all residents with the wanderguard for functioning and placement. The wander guard checks were recorded in the Treatment Administration Record (TAR). The checks were done for each shift. The checks involved checking for placement and checking for functioning. Functioning checks were done with a device that has a green light that turns on if the device is good. If the green light does not go on, the wanderguard is replaced. On 07/26/24, the Director of Clinical Services and/or designee reviewed and updated all the elopement risk books. Elopement evaluation for 5 remaining elopement risk residents were reviewed. Elopement evaluation for 2 residents not at risk were reviewed. The evaluations matched to the documentation kept in the Elopement Binders, which were found at the two nurses' station and the front desk. On 07/26/24 daily window checks initiated. See above (Operations Manager). On 08/15/24, Maintenance director conducted a new inspection of all flip locks on windows to ensure locking mechanism is working and all windows were locked. No corrections needed. Observations were made of the window lock tests. The locks were checked to ensure they could unlock in an emergency. Under criteria three, the following were verified: Facility staff were educated by clinical leadership and executive director beginning 07/26/24 on missing persons, abuse/neglect, elopement, midnight census head count, accounting for residents on assignment, identifying residents on assignment, identifying residents with increase exit seeking behavior - implement 1:1 accordingly. Education was validated with post testing and elopement drill participation. Copies of sign-in sheets for all shifts were provided for the education provided. An Elopement drill was observed. The staff appeared competent in responding to the drill. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As of 08/02/24 a total of 117 of 120 staff, including contracted staff members, had received elopement education, and participated in elopement drills. New hires will receive education in orientation. Certified letters were sent out to those staff members that were unable to attend the education. Staff include: Therapy Housekeeping laundry Dietary CNA Nurses All department heads and administrative staff. Newly hired staff will receive education in orientation. A list of employees with the date of the education provided was secured by the surveyor. Current facility nurses were educated by the Director of Clinical Services or designee, on the importance of providing thorough supervision for residents with signs and symptoms of wandering or exit seeking behaviors. This included how to monitor, and screen generalized statements and conversations even on admission for risk of elopement. Reinforced education included how to monitor and identify different residents for increased sign and symptoms of elopement risk in the SNF settings. Key components included how to search interior and exterior of rooms and corridors to increase the accuracy and effectiveness of elopement drills. As of 08/02/24, 35 out of 35 nurses had received education from the Director of Nursing/designee. One of the 35 nurses had not completed an elopement drill due to being out on maternity leave at this time. A certified letter has been sent to notify of ineligibility to work until elopement drills have been completed with posttest. Documentation was provided as part of the education documentation noted above. The Director of Nursing and/or designee conducted elopement drills on each shift daily starting on 07/26/24 continued daily through 08/07/2024 including post drill education based on response. On 08/07/24, Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting held. After a review of the elopement drills revealed 100% compliance with responses every shift, the committee has determined the drills will be conducted 3 times a week for 4 weeks. Elopement risk evaluations on new admissions will be reviewed at the morning clinical meeting. On 08/14/24, the Director of Nursing initiated education to CNA and licensed nurses on nurse-to-nurse verbal report, nurse to CNA verbal report, and CNA to CNA verbal report. Interviews and record review conducted with no concerns noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Under criteria 4, the following was noted: The Executive Director led an additional Quality Assurance and Performance Improvement meeting on 07/31/24 with the Medical Director, Director of Clinical Services (DCS), Social Services Director, Assistant Director of Nursing, Plant Operations, Activities, Dietary Supervisor, MDS Coordinator, Therapy Director. The Elopement Policy and Procedure was reviewed, and the root cause of elopement was discussed. DCS and/or designee will continue weekly quality reviews times 3 months of residents at risk for elopement to ensure policy and procedures in place. New admissions audited by DCS/designee to ensure accurate elopement risk identification, appropriate interventions in place as required and care plan in place as necessary. Oversight will be provided by the Regional Nurse Consultant. The Plant Operations Manager and/or designee will be responsible for conducting elopement drills weekly for 4 weeks and monthly for 3 months. The results will be reviewed during the Quality Assurance Committee meeting. The above points were covered with previous documentation review. On 08/16/24 at 2:50 PM, an interview was conducted with Staff F, RN, relating to reporting at change of shift. Staff F stated that communication between staff is important so the oncoming shift knows of any changes from the previous shift. Staff F also stated, if someone notices a resident is not where they should be, it gives the staff more time to follow the elopement policy to locate the resident. The nurse stated that communication is supposed to happen between the nurse going off and the nurse coming on, between the CNA going off and the CNA coming on and between the Nurse and CNA to make sure the team is involved. On 08/16/24 at 3:02 PM, an interview was conducted with Staff G, RN, who stated that when she gets report, she includes the CNA she is working with because she wants the CNA to know the resident in case there are changes in condition. On 08/16/2024 at 3:08 PM, an interview was conducted with Staff H, CNA, who stated when she first comes in, she and the off going CNA first do a head count to make sure no-one is missing. The off going CNA also informs the oncoming CNA if there have been changes to the residents. The nurse then tells the CNA if there are changes in the residents' status or other information the CNA needs to know. Staff H stated she usually cares for 10 to 12 residents on her shift. On 08/16/24 at 3:14 PM, an interview was conducted with Staff I, CNA, who stated if a resident who eloped is not on 1:1 or if the resident is at risk for elopement, then she and the other CNAs check on the resident every 30 minutes. The CNA stated that at the beginning of her shift she does rounds with the off going CNA to make sure the residents are present and to offer help if needed. Then Staff I would get report from the off going CNA. Staff I stated she also gets report from the nurse as well. She stated this is how she finds out if there are any changes or special instructions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/16/24 at 4:02 PM, an interview was conducted with Staff J, CNA, who works the 7:00 AM to 3:00 PM and the 3:00 PM to 11:00 PM shifts. Staff J explained that if there is a missing person then she would notify the nurse immediately. She stated then they are assigned to search inside and outside the facility to try and find the resident. Staff J stated that they (CNAs) round on the residents who are elopement risk every 30 minutes. Staff J stated that there is a sheet where they place a check mark and initials next to the time the resident check is performed. On 08/16/24 at 4:10 PM, an interview was conducted with Staff K, CNA, who works 3:00 PM to 11:00 PM. Staff K expressed that if a resident has an elopement, then the resident is placed on 1:1 observation. Staff K stated that when there is an elopement then the nurses tell the CNAs who to look for and if the CNA is to look outside or inside. Staff K stated that they do rounding with the CNA from the last shift to make sure there were no changes. Staff K state she also gets report from the nurse about anything new regarding the resident. The scope and severity of F689, was lowered to a (D) for no actual harm with a potential for more than minimal harm that is not immediate jeopardy as of 08/16/24. The scope and severity were lowered because of the facility's corrective actions implemented. These corrective actions were verified by the surveyor through observations, interviews, and record review on 08/16/24.