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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105618	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Winter Park	558 N Semoran Blvd Winter Park, FL 32792

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 45646 Based on observation, interview, and record review, the facility failed to provide adequate supervision to maintain a secure environment to ensure vulnerable residents did not exit the facility without supervision and failed to respond appropriately to a door alarm for 1 of 15 residents reviewed for elopement, of a total sample of 15 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury/impairment/death. While resident #1 was out of the facility unsupervised, there was reasonable likelihood he could have fallen, become lost, been accosted/harmed by a stranger or been hit by a car. On 7/25/24 at approximately 5:15 AM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until staff located him across from an assisted living facility (ALF) approximately 0.2 miles away at 5:53 AM. The facility failed to ensure resident #1 was adequately supervised and failed to monitor the front lobby door to ensure vulnerable residents did not exit the facility without knowledge. There was a total of 15 residents who were identified as at risk for elopement. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy. The Immediate Jeopardy began on 7/25/24 and was removed on 7/26/24. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings: Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses t included encephalopathy, unspecified dementia, heart failure, type 2 diabetes mellitus, adult failure to thrive and depression. Review of the Minimum Data Set quarterly assessment with assessment reference date of 7/07/24 revealed resident #1 had a Brief Interview for Mental Status score of 03/15 which indicated he had severe cognitive impairment. The document indicated resident #1 used a wheelchair for mobility and was able to propel his self independently. The assessment did not indicate resident #1 wandered or exhibited other behaviors during the look-back period but used a wander/elopement alarm daily. (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	Review of physician orders revealed a current active order for electronic wander bracelet dated 11/20/23. Review of the psychiatric progress notes revealed resident #1 was recently seen by the provider on 4/03/24, 4/24/24, 5/29/24, 6/19/24 and 7/03/24. Each progress note indicated resident #1 had a history of exit-seeking behavior, was cognitively impaired with poor long-term and short-term memory, lacked insight concerning matters of self and lacked judgement regarding everyday activities. Review of the medical record revealed elopement risk evaluations dated 11/20/23, 12/04/23, 12/11/23, 12/20/23 and 3/04/24 indicated resident #1 was at risk for elopement. An elopement risk evaluation dated 5/03/24 indicated resident #1 was not at risk for elopement. Review of progress notes revealed resident #1 was considered to be at high risk for elopement on 11/20/23 and a wander bracelet was placed on his right arm. A progress noted dated 5/03/24 read, Resident elopement risk performed, no longer risk for elopement. [Electronic wander bracelet] removed. A care plan for elopement risk initiated 11/20/23 indicated resident #1 was at risk for elopement. Interventions included use of wander bracelet, check placement every shift, place resident information in elopement risk notebook, monitor for exit seeking behaviors and use verbal cues to redirect. The care plan was resolved on 5/03/24, when the electronic wander bracelet was removed and was reinitiated 7/25/24. Review of the Treatment Administration Record for May, June and July 2024 revealed staff continued to document on placement and function of the electronic wander alarm bracelet even though it had been removed on 5/03/24. In a phone interview on 8/07/24 at 6:23 AM, Certified Nursing Assistant (CNA) F verified resident #1 was on her assignment on 7/25/24. She recalled providing care to resident #1 with the assistance of another CNA between 4:00 and 4:30 AM. CNA F stated she then went to get another resident dressed for an appointment. She recalled as she escorted the other resident to the transportation pick-up area, Licensed Practical Nurse (LPN) D told her, Make sure you close that door so he [resident #1] can't get out. CNA F stated she closed the door and proceeded to the transportation area. On 8/06/24 at 5:37 AM, CNA B confirmed she assisted CNA F with providing care for resident #1 and then went back to her assignment. She recalled as she came out of a resident room around 5:00 AM, she saw resident #1 at the nurse's station with CNA A. CNA A informed her resident #1 was walking in the hallway without his wheelchair. CNA B stated she stayed with resident #1 while CNA A retrieved a wheelchair from the dayroom. She stated she went back to her assignment and did not see resident #1 again until after the event. She stated she did not hear an alarm go off and did not know the resident was missing until LPN D asked her to look for him. On 8/06/24 at 5:28 AM, CNA A stated she was not assigned to resident #1 but she saw him standing at the nurse's station. She asked CNA B to help her locate a wheelchair for resident #1. She explained she located a wheelchair in the day room, and they assisted the resident to sit in the chair. CNA A then went back to her assignment. She recalled LPN D later asked her if she knew where resident #1 was, so she started looking for him. She went up front and saw one of his shirts on the ground outside. She went back into the building and headed toward the back to see if she could find him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/06/24 at 11:16 AM, LPN D - stated she saw resident #1 at the nurse's station between 5:00 - 5:10 AM. She recalled CNA F needed to escort another resident to the transportation area and asked LPN D if resident #1 was going somewhere as he was not usually up so early. LPN D stated she told CNA F to just close the doors when she went through, and LPN D continued her rounds. LPN D recalled at approximately 5:30 AM she came out of a resident's room and no longer saw resident #1 at the nurse's station. She stated she started looking around the unit for him and asked other staff to assist. LPN D reported Registered Nurse (RN) C called her and told her about the shirt found outside. LPN D stated she went outside with RN C and RN E to search for resident #1. She explained RN E located him between the two parking lots at the adjacent assisted living facility and they escorted him back into the facility through the back entrance. On 8/06/24 at 11:45 AM, RN E stated she was doing rounds and went to the unit resident #1 was on at approximately 5:00 AM on 7/25/24. She recalled seeing him in a wheelchair in front of the nurse's station. RN E reported she sat at the nurse's station to complete some documentation. She explained she left the unit at approximately 5:20 AM to go to the other unit but could not recall whether resident #1 was still near the nurse's station. She stated LPN D called her a short time later and asked if resident #1 followed her to the other unit. RN E informed LPN D he had not followed her and was not on that unit. RN E stated she told the staff to search for resident #1 and a code for missing resident was paged overhead. She recalled hearing the front door alarm as she was headed back to resident #1's unit. RN E stated when she entered the front lobby she saw RN C at the front door. RN C informed her resident #1 may have gone outside because they found a shirt on the ground that belonged to him. RN E stated she proceeded out the front door and walked down the pathway to the parking lot to search for resident #1. She recalled LPN D was ahead of her and when they reached the employee parking lot, RN E stated she got in her car to drive up toward the ALF to see if he was further up the road. She stated she saw resident #1 his wheelchair under a lamp post across from the ALF parking lot next to the enclosed retention pond. RN E stopped her car and called LPN D as she wheeled resident #1 back toward the facility. RN E reported RN C and LPN D took the resident back inside the facility as she retrieved her car. She explained he was placed on one-to-one supervision, and she applied a wander alarm bracelet on his ankle. RN E could not recall if resident #1 had a wander alarm bracelet previously. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 8/06/24 at 9:09 AM, RN C stated she was at the nurse's station around 5:00 AM the morning of 7/25/24. She recalled resident #1 wanted to use the phone. RN C asked resident #1 if he could make his call a little later and he agreed. She stated she left to use the restroom before she began to pass medications. RN C recalled LPN D was near resident #1 when she left. As she returned down the hallway approximately 10 minutes later, she heard a door alarm coming from the front lobby. RN C explained she entered the lobby and went to the front door. She recalled she pulled the door toward herself to ensure it was engaged and looked out the glass door. RN C stated it was dark outside and she did not see anyone, so she turned off the alarm and returned to her work station. She explained she did not think about the alarm again until later when LPN D came to her and asked if she had seen resident #1. She then remembered the front door alarm and went back to the front lobby with CNA A. RN C stated she held the front door open while CNA A went outside. She recalled the CNA found a shirt on the ground which she recognized as the shirt resident #1 had on his lap in the wheelchair. RN C stated she told the CNA to come back inside and she paged overhead for LPN D and RN E to come to the front lobby. She explained the three of them went out together to search for resident #1. She reported that RN E located him and returned him to facility through the back entrance. RN C expressed she felt CNA F and LPN D should have provided closer supervision for resident #1. She explained CNA F told LPN D to watch resident #1 while she escorted a resident to the transportation area. RN C stated LPN D told CNA F to just shut the doors to the unit when she went out. RN C acknowledged when she heard the door alarm, she did not go outside to search, nor did she notify any other staff of the alarm and instead she turned it off and returned to her duties. On 8/06/24, resident #1's wife confirmed she was notified her husband eloped from the facility. She stated she was not sure how he managed to get outside. She explained they had been married for [AGE] years and had always been together. Resident #1's wife stated she was concerned he got out of the facility unsupervised, but she was looking forward to taking him home. On 8/06/24 at 12:06 PM, the Director of Nursing (DON) acknowledged resident #1 had history of elopement but had a decline in mobility in May 2024. She explained he was assessed at that time and was not considered an elopement risk. She clarified the wander/elopement alarm bracelet was removed and the care plan was resolved at that time. The DON recalled he progressed approximately 4-6 weeks later with improved mobility but did not exhibit any exit-seeking behaviors. She explained resident #1 regularly accompanied his wife to the front door, kissed her before she left and returned to his room without incident. The DON reported she was not aware of any exit-seeking behavior. In a meeting with the Administrator, DON and Regional Nurse Consultant (RNC) on 8/07/24 at 10:58 AM, the Administrator stated the Quality Assurance and Performance Improvement (QAPI) Committee met and reviewed the event and investigation. She stated the committee identified RN C should have opened the door and looked outside when she responded to the door alarm and should have notified staff of the alarm. The Administrator acknowledged staff should have been more aware of resident #1's movement through the facility. She stated the committee noted several areas of opportunity for improvement and began education on several topics which included abuse and neglect, elopement standards and guidelines, accuracy of documentation, increased supervision and appropriate response to door alarms. The Administrator stated the QAPI Committee conducted a root cause analysis and determined the facility failed to respond appropriately to a door alarm and failed to provide appropriate supervision. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Review of the policy and procedure Elopements and Wandering Residents revised 3/16/23 revealed an elopement occurred when a resident left the premises or a safe area without authorization and/or necessary supervision to do so. The document indicated that alarms were not a replacement for necessary supervision. Staff were directed to be vigilant in responding to alarms in a timely manner.

On 8/07/24, resident #1's likely elopement route was retraced. He exited the facility's front lobby door and wheeled himself in the dark along an uneven sidewalk with four-inch curbs, from the front door to the parking lot. Resident #1 proceeded through the parking lot and down a paved driveway approximately 0.2 miles to an adjacent ALF. He was located under a lamp post across the street from the ALF's front parking lot next to a fenced retention pond. Along the route, he passed several metal drainage grates, a drainage ditch with water, a downed lamp post with exposed wires and two parking lots with dumpsters and electrical equipment.

Historical weather data revealed on the morning resident #1 eloped, 7/25/24, the temperature at 5:53 AM was 78 degrees Fahrenheit and mostly cloudy. Sunrise occurred at 6:44 AM, (retrieved on 8/07/24 from www. wunderground.com).

Review of the Facility Assessment Tool revealed the facility accepted and could care for residents with psychiatric and mood disorders including psychosis, impaired cognition, depression, anxiety, and behaviors that needed intervention. The document indicated the facility provided person-centered care which included identifying and implementing interventions to help support individuals with cognitive impairment.

Review of corrective measures to remove Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team:

*On 7/25/24 at 5:30 AM, resident #1 was discovered to be missing and the facility implemented its elopement policy and procedures.

*On 7/25/24 at 5:53 AM, resident #1 returned to the facility with facility staff. He was assessed on return to the facility and had no injuries. A head count was conducted to verify the safety of all residents. The required notifications were made to the physician and family. Resident #1 was placed on 1:1 supervision.

*On 7/25/24, resident #1 was re-evaluated for elopement risk and the elopement risk care plan was re-initiated due to his increased risk.

*On 7/25/24, the facility re-evaluated all residents' elopement risk and identified a total of 15 residents as at risk for elopement. The elopement risk binders were reviewed to ensure they contained photos and demographic information for all identified residents.

*On 7/25/24, electronic wander alarm bracelets were checked for all residents identified as at risk for elopement.

*On 7/25/24, the Maintenance Director checked all doors and alarms center wide for proper functioning. No issues were identified.

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