STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105635	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Melbourne Terrace Rehabilitation Center	251 Florida Ave Melbourne, FL 32901

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview, and record review, the facility failed to protect the resident's right to be free from neglect by not ensuring staff implemented measures to mitigate the risk to prevent elopement for 1 of 5 residents reviewed for elopement, of a total sample of 5 residents, (#1). These failures contributed to the elopement of resident #1 and placed her at risk for serious injury, impairment, and/or death. While resident #1 was out of the facility unsupervised, there was likelihood she could have fallen, been accosted by unknown persons, become lost or been hit by a vehicle. On 8/04/24 at approximately 7:45 PM, the facility failed to prevent resident #1, a newly admitted female with a documented risk of elopement from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts for approximately 13 hours until law enforcement located her at an Assisted Living Facility approximately 8 miles away at 9:00 AM the next morning. The resident was transported to a local hospital for minor injuries and dehydration. The route resident #1 likely traveled was along heavily trafficked roads noted to have uneven pavement, retention ponds, train tracks, and ran along a large body of water. The facility failed to ensure resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility unsupervised. The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to resident #1's elopement and placed all residents who wandered at risk. This failure resulted in Immediate Jeopardy starting on 8/04/24. The Immediate Jeopardy was determined to be removed on 8/06/24 after verification of the immediate actions implemented by the facility. The Immediate Jeopardy was determined to be past noncompliance as of 8/20/24 after verification of the facility's corrective actions. Findings: Cross reference F689 Review of the medical record revealed resident #1 was admitted to the facility from an acute care hospital on 8/02/24 with diagnoses including cerebrovascular disease, type 2 diabetes mellitus, hypertension, major depressive disorder and dementia without behaviors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated 8/02/24 revealed the resident was admitted with a diagnosis of altered mental status and urinary tract infection. The form listed the resident as needing a surrogate for making healthcare decisions, and as alert, but disoriented. Under the section Patient risk alert the options of fall risk and elopement risk were checked by hospital staff. A Physical Therapy Evaluation dated 8/03/24 revealed resident #1's level of function prior to being at the facility was independent for indoor mobility. Her level of functional cognition prior to being at the facility was dependent. The assessment summary for cognition was listed as severely impaired for decision making ability for routine activities. Her reasons for needing physical therapy were listed as decreased balance, decreased functional capacity, decreased insight, and decreased safety awareness. An Occupation Therapy Evaluation dated 8/03/24 revealed the resident walked too fast and could be unsteady on her feet. Under the section cognitive and communication assessment it described resident #1 as moderately impaired in decision making ability for routine activities, and as having impaired safety awareness. Resident #1's admission assessment dated [DATE] indicated the resident was unable to ambulate and needed the use of a manual wheelchair. Review of the fall risk section indicated resident #1 as a possible fall risk. Review of the elopement section revealed the resident was listed as alert and oriented to person, place, time and situation in contrast with the Hospital transfer form completed the same day. The assessment described resident #1 as independent with a wheelchair. The elopement score indicated resident #1 was not a risk for elopement. Resident #1 had a care plan initiated on 8/03/24 for a risk for falls related to poor safety awareness as well as gait and balance problems. There were no care plans in place for risk for elopement, wandering, or other related behaviors. Review of the medical record revealed physician orders for Memantine 5 milligrams (mg) twice a day for dementia and Risperidone 0.5 mg once a day for psychosis. Both had a start date of 8/02/24. There were no physician orders for an electronic wander prevention bracelet or other elopement prevention measures such as increased supervision in the medical record. Namenda (Memantine is a drug used to treat moderate to severe Alzheimer's type dementia, (retrieved on 10/02/24 from www.drugs.com). (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's hospital discharge record from 8/02/24 revealed she was brought to the emergency roiagnom on [DATE] due to resident being confused and disoriented. The record revealed she had a Geriatric Consult on 7/25/24 for dementia with behavioral disturbances. The history of present illness noted the resident was recently diagnosed with dementia and started on Namenda (Memantine). The record indicated the resident's daughter, who was the resident's legal guardian, was the main historian. The resident previously had lived with her son but had not been taking her medications including the dementia medication. The history described the resident as combative and irritable, and at risk for wandering, for falls and for elopement. The physician documented the resident had a diagnosis of major cognitive disorder for approximately 2 to 3 years, now with worsening behavioral symptoms. The resident was noted to have a history of abnormal brain imaging and possible lesions to the brain. Review of the hospital progress note from 7/28/24 revealed the resident continued to be confused and lacked capacity. On 9/17/24 at 10:02 AM, video footage obtained from the evening of 8/04/24 was reviewed with the Administrator. Two visitors were seen walking into the front lobby, up to the reception desk to sign out on the electronic visitor system after their visit. Receptionist D was noted to be looking up towards the two visitors who were signing out instead of towards resident #1 who then entered the lobby a few seconds behind the two visitors. Resident #1 was seen to hesitate for a minute, then took a few steps to the right of the reception desk, toward the Administrator's office. She was seen to quickly change course and walk out the front of the unlocked lobby door. The resident did not use any assistive devices, and was dressed in a long sleeve shirt, pants and shoes. In a telephone interview on 9/18/24, with receptionist D she stated she assumed the resident was accompanying the two visitors who were signing out. She explained that often when visitors left the facility, one visitor signed out for all of them and the other visitors hung back by the door until it opened. The receptionist assumed that any residents who were an elopement risk would have an electronic wander prevention bracelet on, and the alarm would have alerted her to their presence. She said she also presumed all elopement risk residents would look confused, disheveled and more than likely use a wheelchair. The receptionist described resident #1 as relatively young looking. Review of the disciplinary action form dated 8/05/24, the receptionist acknowledged she had understood the protocol for checking visitors in and out of the facility but did not follow the procedure. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interviews with the Director of Nursing (DON) and the Administrator on 9/16/24 at 9:58 AM, and continued at 10:22 AM, the Administrator explained the resident's daughter who previously worked at the facility as an Advanced Practice Registered Nurse (APRN) told them her mother would not leave the building and must be hiding somewhere due to the thunderstorms. The DON said the daughter did not feel the resident was an elopement risk. The Administrator revealed they were aware of the hospital discharge paperwork from 8/02/24 which showed in multiple places that resident #1 was an elopement risk prior to her being admitted to the facility. They described resident #1's daughter had recently become her legal guardian, and the DON stated she discussed the resident being labeled as an elopement risk throughout the hospital paperwork with her daughter, but she insisted she was just an, avid walker, and not an elopement risk. The DON stated resident #1's daughter was present during admission to the facility and on the following days, and did not report any instances where she thought her mother was an elopement risk. The DON stated upon admission nurses performed an elopement assessment, and her score was a 3 which meant she was not a risk for elopement, based on the information provided by her daughter. When asked if resident #1 was evaluated by the facility's in house physician to determine cognition and elopement risk, they replied that she was admitted on a Friday night and would not have been seen by the physician until Monday. She explained all orders and hospital paperwork were reviewed and verified by on-call provider at that time. In a phone interview with Registered Nurse (RN) A on 9/18/24 at 2:50 PM, he confirmed resident #1 was on his assignment the night of 8/04/24 on the evening shift. He stated he had not been informed that resident #1 had a history of being an elopement risk. He stated he did not read the hospital discharge paperwork or any of the documents sent from the hospital at time of admission, so he did not know she was at risk for elopement. He explained he typically only read that paperwork if he was the admitting nurse, which he was not. He explained, as a floor nurse, he did not have time to sit and read through the charts and paperwork due to his workload. He would typically rely on the off-going nurse to pass along any behaviors or risks in shift report. Nurse A described when new patients arrive and the nurse has a full patient load, things can get rushed. He stated sometimes they didn't have the time they would like to spend on assessments of the new residents. He stated there were multiple interventions that could have been put into place to prevent resident #1's elopement, if he knew the risk such as a wanderguard or 48-hour checks. He explained 48-hour checks were hourly checks staff perform on the resident for a total of 48-hours. The facility's policy and procedure titled, Resident Mistreatment, Abuse and Neglect Prohibition dated 2017 revealed that, Neglect is failure to provide goods and services necessary to avoid physical harm, metal anguish or mental illness. Review of the facility's corrective actions were verified by the survey team and included the following: * Resident #1 identified to have exited the facility on 8/04/24 and located on 8/05/24 at a local Assisted Living Facility, she was transported to the hospital. * Missing Resident Process initiated by the weekend supervisor on 8/04/24. * The weekend supervisor and Director of Nursing verified 159 of 160 residents to be in the facility on 8/04/24 (the one resident not present was resident #1). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* 10 of 10 door guardians and 12 of 12 screamer alarms inspected by the Maintenance Assistant, with proper function verified on 8/04/24. * The Administrator and Director of Nursing verified staffing level appropriate: licensed nurses (1.51) and certified nursing assistants (2.42) on 8/04/24. * On 8/05/24 facility Administrator notified the Department of Children and Families of resident #1's elopement. * A Federal; Immediate Report was also submitted on 8/05/24. * Identified receptionist provided education by the Administrator related to responsibilities/functions of a receptionist on 8/05/24 and subsequently suspended on 8/05/24. * With census of 160, 157 residents were assessed and deemed not at risk for elopement. Reviewed for accuracy of evaluation and care plan verified by the Director of Nursing on 8/05/24. * 2 of 2 residents deemed at risk for elopement reviewed for accuracy of evaluation and care plan verified by the Director of Nursing on 8/05/24. * 11 of 12 facility employees who function as receptionist provided education by the Administrator related to the responsibilities and functions of receptionists including but not limited to sign-in/sign-out process initiated 8/05/24 and completed 8/06/24. One employee was currently on maternity leave, to be educated upon return. *210 of 333 facility employees received education provided by the Director of Nursing and the Staff Development Coordinator related to abuse, neglect, and misappropriation. Education includes but is not limited to 8/04/24 up until 8/06/24. * 49 of 67 current facility nurses were educated to review transfer paperwork to ensure elopement prevention intervention (electronic wander prevention bracelet) implemented if indicated to prevent neglect. Education initiated 8/04/24 and completed by 8/06/24. * 3 of 3 admission employees have received education provided by the facility Administrator related to accurately reflecting resident conditions including but not limited to history of wandering/elopement on 8/06/24. * 11 of 12 facility employees who function as a receptionist provided education by the Administrator related to responsibilities/functions of receptionist including but not limited to sign/in-sign/out process initiated 8/05/24 and completed 8/06/24. One employee who functions as receptionist is currently on maternity leave and will have competency verified prior to return. Review of the in-service attendance sheets noted staff participated in education on the topics listed above. From 9/15/24 until 9/19/24, interviews were conducted with 20 staff members across all shifts. This included 8 Licensed nurses, 6 Certified Nursing Assistants, 2 receptionists, 2 housekeepers, 1 Dietary aide, and 1 Physical therapist who verbalized their understanding of the education provided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident sample was expanded to include 4 additional residents identified as at risk for elopement. Observations, interviews, and record reviews revealed no concerns related to elopement for residents #2, #3, and #4.

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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** 51023 Based on interview, and record review, the facility failed to provide adequate supervision and a secure environment to prevent elopement of 1 of 5 residents reviewed for elopement, of a total sample of 5 residents, (resident #1). On 8/02/24 resident #1 a cognitively impaired [AGE] year-old female was admitted to the facility from the hospital. While at the hospital she was determined to be at risk of falls, wandering, and elopement. On 8/04/24, at approximately 7:45 PM, resident #1, exited the facility's front entrance when the receptionist, distracted by other departing visitors unlocked the front door and allowed her to leave from the facility unsupervised. The facility was unaware of her whereabouts overnight, for approximately 13 hours. Due to her cognitive deficits and diagnosis of dementia, the elopement placed her at risk of serious injury, being abducted, or hit by a motor vehicle and die. The walking distance from the facility to the Assisted Living Facility (ALF) where she was found was approximately 8 miles from the facility, depending on the route taken, (retrieved on 10/02/24 from www.googlemaps.com). The temperature in [NAME] on the evening of 8/04/24 was approximately 81 degrees Fahrenheit, with a relative humidity of 80 percent, (retrieved on 10/02/24 from www.timeanddate.com). The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to resident #1's elopement and placed all residents who wandered or were at risk for elopement at risk. This failure resulted in Immediate Jeopardy starting on 8/04/24. The Immediate Jeopardy was determined to be removed on 8/06/24 after verification of the immediate actions implemented by the facility. The Immediate Jeopardy was determined to be past noncompliance as of 8/20/24 after verification of the facility's corrective actions. There were a total of 4 residents who were identified as at risk for elopement. Findings: Cross reference F600 Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease, type 2 diabetes mellitus, hypertension, major depressive disorder and dementia without behaviors. The Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form dated 8/02/24 revealed the resident was admitted with a diagnosis of altered mental status and urinary tract infection. The form listed the resident as needing a surrogate for making healthcare decisions, and as alert, but disoriented. Under the section Patient risk alert the options of fall risk and elopement risk were checked by hospital staff. (continued on next page)

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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	Review of resident #1's hospital discharge record from 8/02/24 revealed she was brought to the emergency roiagnom on [DATE] due to resident being confused and disoriented. The record revealed she had a Geriatric Consult on 7/25/24 for dementia with behavioral disturbances. The history of present illness noted the resident was recently diagnosed with dementia and started on Namenda (Memantine). The record indicated the resident's daughter, who was the resident's legal guardian, was the main historian. The resident previously had lived with her son but had not been taking her medications including the dementia medication. The history described the resident as combative and irritable, and at risk for wandering, for falls and for elopement. The physician documented the resident had a diagnosis of major cognitive disorder for approximately 2 to 3 years, now with worsening behavioral symptoms. The resident was noted to have a history of abnormal brain imaging and possible lesions to the brain. Review of the hospital progress note from 7/28/24 revealed the resident continued to be confused and lacked capacity. Resident #1's admission assessment dated [DATE] indicated the resident was unable to ambulate and needed the use of a manual wheelchair. Review of the fall risk section indicated resident #1 as a possible fall risk. Review of the elopement section revealed the resident was listed as alert and oriented to person, place, time and situation in contrast with the Hospital transfer form completed the same day. The assessment described resident #1 as independent with a wheelchair. The elopement score indicated resident #1 was not a risk for elopement. Resident #1 had a care plan initiated on 8/03/24 for a risk for falls related to poor safety awareness as well as gait and balance problems. There were no care plans or interventions in place for risk for elopement, wandering, or other related behaviors. Review of the medical record revealed physician orders for Memantine 5 milligrams (mg) twice a day for dementia and Risperidone 0.5 mg once a day for psychosis. Both had a start date of 8/02/24. There were no physician orders for an electronic wander prevention bracelet or other elopement prevention measures such as increased supervision in the medical record. Namenda (Memantine is a drug used to treat moderate to severe Alzheimer's type dementia, (retrieved on 10/02/24 from www.drugs.com). A Physical Therapy Evaluation dated 8/03/24 revealed resident #1's level of function prior to being at the facility was independent for indoor mobility. Her level of functional cognition prior to being at the facility was dependent. The assessment summary for cognition was listed as severely impaired for decision making ability for routine activities. Her reasons for needing physical therapy were listed as decreased balance, decreased functional capacity, decreased insight, and decreased safety awareness. Occupation Therapy Evaluation from 8/3/24 revealed the resident walks too fast and could be unsteady on her feet. Under the section cognitive and communication assessment it was revealed that the resident was moderately impaired in decision making ability for routine activities, and as having impaired safety awareness. An Occupational Therapy Evaluation dated 8/03/24 revealed the resident walked too fast and could be unsteady on her feet. Under the section cognitive and communication assessment it described resident #1 as moderately impaired in decision making ability for routine activities, and as having impaired safety awareness. (continued on next page)

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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	On 9/17/24 at 10:02 AM, video footage obtained from the evening of 8/04/24 was reviewed with the Administrator. Two visitors were seen walking into the front lobby, up to the reception desk to sign out on the electronic visitor system after their visit. Receptionist D was noted to be looking up towards the two visitors who were signing out instead of towards resident #1 who then entered the lobby a few seconds behind the two visitors. Resident #1 was seen to hesitate for a minute, then took a few steps to the right of the reception desk, toward the Administrator's office. She was seen to quickly change course and walk out the front of the unlocked lobby door. The resident did not use any assistive devices, and was dressed in a long sleeve shirt, pants and shoes. The video footage did not capture which direction the resident proceeded after she left the facility. In a telephone interview with receptionist D on 9/18/24 at 2:26 PM, she recalled speaking with two visitors who were signing out on the electronic system the facility uses for visitors to the facility on the evening of 8/04/24. She explained when she saw resident #1 by the door, she assumed she accompanied the two departing visitors. Receptionist D described that often when visitors are leaving, one visitor signed out while the other visitors hung back by the door, waiting for them. Receptionist D stated she had assumed any residents who were an elopement risk would have an electronic wander prevention bracelet on, which would alert her if they came near the door. She explained she had assumed that any residents with elopement risk would look confused, disheveled and more than likely would use a wheelchair. The receptionist described resident #1 as looking relatively young and wearing regular clothes, so she didn't take her to be a resident. Review of the Police Case Report and Incident Details dated 8/05/24 revealed an officer was called to an ALF on 8/05/24 at 9:00 AM. An unknown caller to 911 reported the resident was found at the door of the facility. The Incident Details indicated the call response was changed from missing person in progress to found. The report described for the County Sheriff's office to Call off the bloodhounds (search dogs). The document also described Emergency Medical Personnel were requested as the resident was, Wet, cold and has been out, possibly on foot all night. The reporting officer documented that resident #1 told him she was in bed all night and lived at home with her daughter. He reported resident #1 did not know what year it was, how many quarters in a dollar or her date of birth. She was transported to the hospital by Emergency Medical Personnel for treatment. Review of the hospital Emergency Department documentation dated 8/05/24 noted the resident to be shivering and her clothing soaking wet. The documentation showed Resident #1 had facial trauma including abrasions to her forehead and nose as well as bruises to her bilateral knees. Further hospital workup revealed a diagnosis of pneumonia. Resident #1 was noted to have no recollection of the events leading up to the hospitalization . (continued on next page)

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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	In interviews with the Director of Nursing (DON) and the Administrator on 9/16/24 at 9:58 AM, and continued at 10:22 AM, the Administrator stated once she was alerted, she immediately drove over to the facility to help with the search. She explained the resident's daughter who previously worked at the facility as an Advanced Practice Registered Nurse (APRN) told them her mother would not leave the building and must be hiding somewhere due to the thunderstorms. The DON stated they repeatedly searched inside the building for the resident at the daughter's insistence. She said the daughter never mentioned the resident was an elopement risk. The Administrator said then she looked at the cameras and saw the resident walk out the front door. She stated that was when she called 911. The Administrator explained the resident was not brought back to the facility. She revealed they were aware of the hospital discharge paperwork from 8/02/24 which showed in multiple places that resident #1 was an elopement risk prior to her being admitted to the facility. They described resident #1's daughter had recently become her legal guardian, and the DON stated she discussed the resident being labeled as an elopement risk throughout the hospital paperwork with her, but the daughter insisted she was just an, avid walker, and not an elopement risk. She stated resident #1's daughter was present during admission to the facility and on the following days, and did not report any instances where she thought her mother was an elopement risk. The DON stated that upon admission nurses performed an elopement assessment, and her score was a 3 which meant she was not a risk for elopement, based on the information provided by her daughter. When asked if resident #1 was evaluated by the facility's in house physician to determine cognition and elopement risk, they replied that she was admitted on a Friday night and would not have been seen by the physician until Monday. She explained all orders and hospital paperwork were reviewed and verified by on-call provider at that time. On 9/16/24 at 1:08 PM, the Regional [NAME] President stated he was familiar with resident #1's daughter who was an APRN and had reached out to him regarding the resident being admitted to the facility. He stated the resident had previously been denied admission to the facility for insurance reasons. He explained he had asked the DON to talk to the daughter related to the medical side of the admission and asked the daughter to do the same. He stated the daughter told him she was aware of what the hospital documented in the resident's chart about her mother being an elopement risk. The Regional [NAME] President stated the daughter explained by saying providers at the hospital just copied and pasted the information and did not write accurate notes. The Regional [NAME] President explained the daughter discussed some family conflicts and told them she had just recently become her mother's legal guardian. In a telephone interview with resident #1's daughter on 9/17/24 at 8:47 AM, she confirmed she was an APRN at the facility about 5 years ago and she left on good terms to pursue her specialty. She explained her mother had short term memory loss, but she did not consider her to be an elopement risk. She confirmed she had told the facility that she felt the hospital documentation was inaccurate because she felt the providers did not properly assess the patients and often copied and pasted the information. She stated she felt the most devastating part was that the receptionist had not paid attention when she unlocked the front doors, and let her mother slip out. (continued on next page)

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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	In a phone interview with Registered Nurse (RN) A on 9/18/24 at 2:50 PM, he confirmed resident #1 was on his assignment the night of 8/04/24 on the evening shift. He stated he had not been informed that resident #1 had a history of being an elopement risk. He stated he did not read the hospital discharge paperwork or any of the documents sent from the hospital at time of admission, so he did not know she was at risk for elopement. He explained he typically only read that paperwork if he was the admitting nurse, which he was not. He explained, as a floor nurse, he did not have time to sit and read through the charts and paperwork due to his workload. He would typically rely on the off-going nurse to pass along any behaviors or risks in shift report. Nurse A described when new patients arrive and the nurse has a full patient load, things can get rushed. He stated sometimes they didn't have the time they would like to spend on assessments of the new residents. He stated there were multiple interventions that could have been put into place to prevent resident #1's elopement, if he knew the risk such as a wanderguard or 48-hour checks. He explained 48-hour checks were hourly checks staff perform on the resident for a total of 48-hours. In a telephone interview with RN B on 9/18/24 at 1:09 PM, she described after RN A informed her of the missing resident around 8:45 PM, she checked the Bistro and the Tavern where many residents tended to congregate. She continued when she did not find her in those areas, she alerted the team to start a search including places such as the courtyard. She then paged the resident's name overhead three times and returned to her room to check for the resident. When she still could not be found, she notified the DON. Nurse B stated she did not have access to the camera so she could not check those. She stated she continued to check inside the facility and in the surrounding areas. Review of the facility's standards and guidelines dated 2017 titled Resident Elopement Risk Management Guidelines revealed the facility will strive to provide a safe environment for residents and implement measures to identify residents at risk for elopement, as well as preventative to ensure to minimize elopement occurrences. The Facility Assessment updated 2024 revealed the facility maintained it would consistently look for ways to enhance their skilled nursing and rehabilitation services. The facility would have approved guidelines for various diseases including Dementia. The assessment described the facility took an individualized and personalized approach to care and services. The assessment indicated the facility would develop an individualized plan of care focused on patient safety and skill level. The assessment also described staff competencies related to elopement were given to all staff upon hire and annually. Elopement individualized training would occur as the need arose. Review of the facility's corrective actions were verified by the survey team and included the following: * Resident #1 identified to have exited the facility on 8/04/24 and located on 8/05/24 at a local Assisted Living Facility, she was transported to the hospital. * Missing Resident Process initiated by the weekend supervisor on 8/04/24. * The Weekend Supervisor and Director of Nursing verified 159 of 160 residents to be in the facility on 8/04/24 (the one resident not present was resident #1). * 10 of 10 door guardians and 12 of 12 screamer alarms inspected by the Maintenance Assistant, with proper function verified on 8/04/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105635	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Melbourne Terrace Rehabilitation Center	251 Florida Ave Melbourne, FL 32901

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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	* The Administrator and Director of Nursing verified staffing level appropriate: licensed nurses (1.51) and certified nursing assistants (2.42) on 8/04/24. * Identified receptionist provided education by the Administrator related to responsibilities/functions of a receptionist on 8/05/24 and subsequently suspended on 8/05/24. * With census of 160, 157 residents were assessed and deemed not at risk for elopement. Reviewed for accuracy of evaluation and care plan verified by the Director of Nursing on 8/05/24. * 2 of 2 residents deemed at risk for elopement reviewed for accuracy of evaluation and care plan verified by the Director of Nursing on 8/05/24. * 11 of 12 facility employees who function as receptionist provided education by the Administrator related to the responsibilities and functions of receptionists including but not limited to sign-in/sign-out process initiated 8/05/24 and completed 8/06/24. One employee was currently on maternity leave, to be educated upon return. * 210 of 333 facility employees received education provided by the Director of Nursing and the Staff Development Coordinator related to sign-in/sign-out process, leave of absence/pink card process and elopement/wander process, including but not limited to review of transfer paperwork to ensure elopement prevention intervention (electronic wander prevention bracelet), implemented if indicated. Education initiated 8/04/24 and completed 8/06/24. Review of the in-service attendance sheets noted staff participated in education on the topics listed above. From 9/15/24 until 9/19/24, interviews were conducted with 20 staff members across all shifts. This included 8 Licensed nurses, 6 Certified Nursing Assistants, 2 receptionists, 2 housekeepers, 1 Dietary aide, and 1 Physical therapist who verbalized their understanding of the education provided. The resident sample was expanded to include 4 additional residents identified as at risk for elopement. Observations, interviews, and record reviews revealed no concerns related to elopement for residents #2, #3, and #4.