| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105733 | A. Building<br>B. Wing | 04/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Palm Garden of Pinellas | 200 16th Ave SE<br>Largo, FL 34641 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223<br><br>Based on observations, interviews and record reviews, the facility failed to protect the resident's right to be free from neglect by not ensuring one resident (#1) of six residents at risk for elopement with a known history of exit seeking behaviors, and an expressed desire to leave the facility, was provided supervision and services to prevent elopement.<br><br>Resident #1, on 3/25/2024 at approximately 4:15 p.m., exited the facility without being seen by staff members. Resident #1 exited through an ambulance side (C-Wing) entrance door of the facility, which was equipped with an electromagnetic locking device (a magnetic lock that was unlocked when de-energized and required power to remain locked). Resident #1 was able open the door by punching the security code into the keypad beside the door. She walked out of the door and around the outside of the facility for approximately 13 minutes. She traveled approximately 0.3 miles, along a 2-lane road, across this busy road and continued walking 0.5 miles down a well-traveled 6-lane road for 16 minutes. The staff at the facility did not know Resident #1 was missing. The facility staff neglected to ensure supervision or safety of Resident #1. Resident #1 was seen by a staff member who was on her way back to the facility from escorting another resident to an appointment at approximately 4:40 p.m. Resident #1 was picked up by the facility van with staff members and returned to the facility at 4:45 p.m. on 3/25/2024. The resident was not located for approximately 30 minutes.<br><br>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #1 and resulted in the determination of Immediate Jeopardy on 3/25/2024. The findings of Immediate Jeopardy were determined to be removed on 4/10/2024 and the severity and scope was reduced to a D after verification of removal of immediacy of harm.<br><br>Findings included:<br><br>Review of the facility's policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation, dated September 2023 a 15-page document shows: Policy: The center recognizes each resident's right to be free from abuse, neglect, and exploitation (ANE), misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, voluntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.<br><br>(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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | This includes the center's identification of resident's whose personal histories render them at risk for abusing other residents, and development of interventions strategies to prevent occurrences, observing for changes that would trigger abusive behavior, reassessment of the interventions on a regular basis.<br><br>On page 7, under the section titled Definitions - Neglect is defined in statute 483.5 is the failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This occurs when the center was aware of or should have been aware of, goods or services that the resident(s) required but the center failed to provide them resulting in or may result in physical harm, pain, mental anguish, or emotional distress.<br><br>This does not mean that all services must be provided by the center but that the center is responsible to ensure that the resident receives the necessary/required services. Goods and services fall into categories. Those categories are structures and processes and individual.<br><br>On page 9, under the section titled Procedures for Prevention reveals: . The center identifies, correct, and intervenes in situations of alleged abuse, neglect, and exploitation (ANE) and misappropriation of resident property and focuses on the following areas for prevention: . e. supervision of staff .<br><br>On page 14, under 7. Investigation: A thorough investigation will be conducted, as the center has a zero tolerance for abuse of any form. The DQA/designee will initiate procedures for conducting the investigation.<br><br>The investigation shall include the following but is not limited to this list:<br><br>a. The type of allegation (as defined previously in this policy and procedure) may include the following:<br><br>o Confiscating photographs and/or recordings of residents, with any type of equipment (e.g., cameras, smartphones, and other electronic devices) that contain inappropriate images or record situations such as a resident dressing or undressing, bathing, using the bathroom, having intimate relations, or any situation which breaches the resident's right to privacy. Additionally, under no circumstances should these images or recordings be kept, shared, or disseminated via any type of text, e-mail, image sharing, or social media application.<br><br>o Confiscating photographs or recordings of a resident that were obtained without the explicit written consent from the resident and/or their family.<br><br>b. What occurred, when, where and to whom? By whom? Get a physical description or identify the alleged suspect if possible.<br><br>c. Describe the injury and any treatment.<br><br>d. Interview witnesses separately; interview caregivers, roommates; get statements; observe/document demeanor; include names, and addresses, emails, and phone numbers of actual witnesses.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | e. Document cognitive status of victim, resident witnesses; document if credible/believable.<br><br>f. Obtain signed statement from alleged suspect, if possible.<br><br>g. Review alleged suspects' past performance and reputation.<br><br>h. Describe action taken to protect resident.<br><br>i. Note any bias between alleged suspect and witness.<br><br>j. If agency personnel, obtain information from agency.<br><br>k. Use observation of your own and others that may be identified during interviews.<br><br>l. If sexual abuse is alleged, document regarding physical examination; obtain copy or statement from examiner.<br><br>m. If neglect is alleged, identify team members, length of time, and outcome to resident.<br><br>n. If exploitation is alleged, identify items and value.<br><br>o. Review schedules and assignments.<br><br>p. Review any medications that may cause the resident to bruise easily or be related to the nature of the injury.<br><br>q. Review center Policy and Procedures for unsafe techniques used by the team members.<br><br>r. Review training logs to ensure abuse prevention training.<br><br>s. Review the nurse's notes and other records for information about the incident.<br><br>t. Secure all physical evidence.<br><br>It is important to complete an investigation that allows for decision making that is strongly supported.<br><br>8. Corrective Action<br><br>If an investigation verifies an allegation the center must take appropriate corrective action to protect the residents. The implementation of the corrective action should have oversight and be evaluated for effectiveness. The center Quality Assessment and Assurance Committee shall monitor the reporting and investigation of the alleged violations. All corrective actions will be documented. Acts of abuse directed towards residents are absolutely prohibited. Such acts are cause for disciplinary action, including up to termination of employment, reporting to licensing boards and possible criminal prosecution.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's preadmission Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, with a Physician Certification date of 2/25/2024, showed under Section C: Decision Making Capacity, Resident #1 required a surrogate for medical decision making. The transfer form showed under Section S: Physical Function, Resident #1 ambulated with assistance and required no assistive devices to ambulate. The transfer form showed under Section U: Mental/Cognitive Status at Transfer, Resident #1 was alert and disoriented but could follow simple instructions.<br><br>Review of Resident #1's Admission record showed Resident #1 was admitted to the facility on [DATE] with diagnoses of presence of left artificial shoulder joint, aftercare following joint replacement surgery; presence of cardiac pacemaker; hypertension; anxiety disorder; atherosclerotic heart disease without angina; muscle weakness; and cognitive communication deficit.<br><br>Review of Resident #1's progress notes dated 2/26/2024 at 1:20 p.m., authored by Staff G, Licensed Practical Nurse (LPN) showed a note under Type: Clinical Admission, under the section titled: Mental Status: Resident #1's level of cognitive impairment: Mild impairment (some confusion). The evaluation showed under Mood and Behavior: Resident is agitated. Resident is anxious. Anxious - Unknown if change in mood. Agitated - Unknown if change in mood. Resident is currently experiencing unwanted behavior(s).<br><br>Review of Resident #1's progress notes dated 2/26/24 at 4:13 p.m., the Social Service Director wrote, Spoke with case manager from the senior apartments where she lives. The case manager reported that she has been off her medications for a while and is not well mentally. Resident has been confused for a while.<br><br>Review of Resident #1's Elopement Evaluation dated 2/27/2024 at 7:31 a.m., showed a Score of 6. A score value of 1 or higher indicated at Risk of Elopement.<br><br>Review of Resident #1's care plan showed a problem area date initiated 2/27/2024, Resident #1 is at risk for elopement related to wandering/desire to go home.<br><br>Goal: Will not have any unsafe elopement episodes through review, date initiated: 2/28/2024. The resident will not leave facility unattended, date initiated 2/27/2024. The resident's safety will be maintained, date initiated 2/27/2024.<br><br>Interventions included: Engage resident with purposeful activities date initiated: 2/27/2024.<br><br>Provide reorientation to surroundings, environment, date initiated 2/27/2024. Resident added to elopement book, date initiated 2/27/2024.<br><br>1:1 due to high elopement risk, date initiated 3/25/2024.<br><br>Review of the Initial Plan of Care Summary dated 2/28/2024, on admission showed under the section titled, Summary of Care Plan Goals, Resident is an Elopement risk of 6 (add to elopement).<br><br>A review of Resident #1's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/3/2024, showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 8/15, which indicated moderate impaired cognition.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's progress notes dated 3/22/2024 at 2:38 p.m., authored by Staff N, Registered Nurse (RN) showed a note Type: COMMUNICATION - with Physician. A telephone call with the Advanced Practiced Registered Nurse (APRN) revealed that resident has had an increase in wandering since her fall on this week. Resident has started wandering into other resident rooms over the past couple of days and today repeatedly got into other residents' beds. Resident is usually easy to redirect but has become belligerent over the course of the day. CNA reports that resident is urinating more frequently today. New order received for UA C&S (urinalysis with a culture and sensitivity) to rule out UTI (urinary tract infection).<br><br>Review of Resident #1's progress notes dated 3/25/2024 at 5:00 p.m. and authored by the Director of Nursing (DON), showed LATE ENTRY, notified by staff that resident was observed off the property and on the sidewalk that runs in front of the church across the street. A Certified Nursing Assistant (CNA) that was on an escort was returning from an appointment with another resident and observed the resident. CNA immediately came into the facility to notify staff and staff went to bring resident back. Resident was on the sidewalk with her cell phone and her bowl of ice cream she got from Life Enrichment (activities). When asked where she was going, she said to get more ice cream because hers was melted. She was placed on 1:1. When she spoke to another staff member, she reported she was out looking at apartments. Resident #1 was not noted to be in any distress. CNA provided her with a shower. CNA and resident sitting together and conversing.<br><br>Review of Resident #1's progress notes dated 3/26/2024 at 6:29 p.m., and authored by Staff P, LPN showed Resident discharged with meds and belongings to another Skilled Nursing Facility at 6 pm. Transferred via wheelchair van with one attendant. Vital signs stable. No skin issues noted at this time. Resident has no complaints and is looking forward to transfer.<br><br>An interview was conducted on 4/8/2024 at 2:37 p.m., with Staff F, CNA. Staff F stated, I was not [Resident #1's] assigned CNA; I am the one who found [Resident #1]. I routinely work on the front hall, so I don't see exit doors, unless I go over to them. I recall [Resident #1] wandering consistently throughout the building. I do not recall her going into the lobby, those are the only doors I can see on my assignment. [Resident #1] would wander the facility, go into other resident rooms, lay down and sleep in other's beds. On the day of the event, 3/25/2024 at approximately 4:45 p.m., I was coming back with another resident from an appointment, in a non-facility van. I just happened to look out the van window and saw a person with a red shirt on. I said to the van driver, 'I think that is our residents'. The van driver refused to stop. As soon as we pulled up to the facility, I ran out of the van to the receptionist and asked her if Resident #1 was here. The receptionist called 'Code Green' which is a missing resident. The business office manager (BOM) overheard me with the receptionist and came out of the office. The BOM and I ran out of the facility to where I had seen the resident. I saw the resident on Seminole Boulevard past the church. When we got to the resident, we waited for the [facility] van to pick us up. Resident #1 was fine, asked us for more ice cream. The van arrived shortly after we reached the resident. We all got in the van and the van driver returned us to the facility. Resident #1 was wearing a short sleeve red t-shirt, shorts, socks, and sneakers.<br><br>An interview was conducted on 4/8/2024 at 2:08 p.m., with Staff G, LPN who was Resident #1's routine nurse for the 7:00 a.m. to 3:00 p.m. shift. Staff G recalled Resident #1 and stated [she] was very confused, argumentative, always exit seeking. [Resident #1] continuously stated desire to go home and carried a purse. [Resident #1] walked around the whole building, not just this unit. Staff G continued, [Resident #1] would go up to (exit) doors, push on the door. The door would be locked, and [Resident #1] would turn around and continue walking another way.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on 4/8/2024 at 2:15 p.m., with Staff H, CNA. Staff H recalled Resident #1. Staff H stated, [Resident #1] would walk around a lot. I've seen [Resident #1] at the doors trying to exit and would become upset when I would tell her that she should not be there (near the door) and to come over to where I am and go to activities. [Resident #1] would shout at me, 'no one is going to tell me what to do.'<br><br>An interview was conducted on 4/8/2024 at 2:30 p.m., with Staff I, CNA. Staff I regularly worked with Resident #1 and stated [Resident #1] was very sociable and liked to go to activities. [Resident #1] wandered around the facility on a regular basis, always going into other resident rooms, would lay down in their beds, always carried her purse. [Resident #1] would not stop talking about going home, she definitely did not want to be here.<br><br>An interview was conducted on 4/9/2024 at 10:30 a.m. with Staff L, CNA. Staff L confirmed being assigned to Resident #1 regularly and was assigned to Resident #1 the evening of the elopement. Staff L stated, she recalled seeing Resident #1 the evening of 3/25/2024 when she came on shift. Staff L stated I thought [Resident #1] was in activities. I did not realize she was gone until after the 'Code Green' was called.<br><br>An interview was conducted on 4/9/2024 at 3:30 p.m. with Staff E, LPN. Staff E stated [Resident #1] continuously walked around the building. I usually worked here (A Wing), and she lived on the other (C Wing). I would redirect her to go back to her wing. The evening of the elopement, I remember seeing [Resident #1] here on A wing and redirected her over to C wing. I did not know she was missing until the 'Code Green'. I don't recall any door alarms sounding that evening until after [Resident #1] had returned.<br><br>A telephone interview was conducted on 4/9/2024 at 3:10 p.m., with Resident #1's primary care Advanced Practice Registered Nurse (APRN). The APRN stated he was quite familiar with Resident #1, as he had seen her several times. The APRN stated [Resident #1] was admitted to the hospital for a shoulder replacement, with expectation of discharge to home the same day. The resident had no record of dementia or cognition issues in the medical records prior to the surgery. The anesthesia affected her cognition and caused a decline, as well as an infection developed in the incision. [Resident #1] showed an improvement in the hospital and was discharged to this facility for short term rehabilitation. During the course of treatment, [Resident #1's] cognition was improving 'quite a bit'. Although, she still lacked the safety awareness to make an informed decision regarding her surroundings. The facility did call me regarding the resident's increase in behaviors. The APRN continued to state, an order for a UA was ordered on 3/22/24 and resulted on 3/26/24. He said the results were not of concern, and he suggested the facility follow up with the physician at the new facility. The APRN stated, I was made aware of the situation (elopement) upon my visit the following day, actually they could have told the answering service the night before.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A telephone interview was conducted on 4/9/24 at 4:12 p.m. with the Resident Representative (RR) of Resident #1. The RR stated the facility told him Resident #1 went outside. He found out later through the resident's good friend, that Resident #1 walked about a 1/4 mile down the road. The facility did not tell the RR any specifics of the incident. The RR stated he had no problems until he found that out. The RR stated Resident #1 lived on her own prior to admission to the hospital for surgery. The RR stated Resident #1's memory problems had been getting worse prior to entering the facility over the past couple of months. The RR stated Resident #1 had a little case of dementia going on but was not sure if she had been diagnosed with dementia. The RR stated Resident #1 was great when on her meds but 'just isn't right' when she doesn't take them. The RR did not know what medications Resident #1 was routinely on. The facility did not communicate any sort of increase in behaviors. Just stated your mother walked out of the building, and we need to find her a new place within the next 12 hours.<br><br>A telephone interview was attempted on 4/9/2024 at 3:30 p.m., with Resident #1's friend (RF) who visited her daily. RF did not answer the phone call and a message was left. On 4/11/2024 at 3:02 p.m., the RF returned the call. The RF stated, She visited her friend every day. She stated [Resident #1] went to the hospital for an elective shoulder replacement. The RF stated, [Resident #1] was fine with just a little memory issue prior to surgery. She was supposed to come home right after surgery. Although, she had some sort of reaction to the anesthesia and was in recovery for a while. When [Resident #1] woke up from anesthesia her memory was awful and had not come back yet. She is doing better but not great. The facility really was good to us. [Resident #1] really improved while at the facility. We even went to lunch but that turned out to instigate her desire to go home. She became fixated on going home. After that experience, I did not take her out of the facility. One day I went home and when I returned the next, [Resident #1] was on 1:1. She had a staff companion that did not leave her. The staff member told me she got out. [Resident #1] admitted to me that she left because she wanted to go home. Later that night, [Resident #1's] (family member) called and told me she had eloped. The facility told him [Resident #1] is not safe in their facility and had to find another. The RF stated the facility had found [Resident #1] another place that had a better environment where Resident #1 would be safer.<br><br>An interview was conducted on 4/8/2024 at 12:20 p.m. with the Director of Quality Assurance (DQA) and DON. The DON and DQA stated, Resident #1 eloped from the facility on 3/25/2024. During the investigation into Resident #1's elopement, the facility developed the following timeline of events through staff interviews and indoor and outdoor video camera observations. The DQA and DON said they determined Resident #1's most likely route determined was: Resident #1 exited the facility via the C wing ambulance entrance. Resident #1 walked around the facility and crossed the road out front of the facility and down the sidewalk of the main road near the facility. They stated, We picked her up with the facility van at the Assisted Living Facility just past the church. The DON stated [Resident #1] refused to tell us how she exited. [Resident #1] stated, I wouldn't be able to get out again if I told you. We (the facility) had a couple of staff ask [Resident #1] the question. [Resident #1] never did tell us. [Name of another state oversight agency] investigator told us [Resident #1] told him she had the code. We (facility) determined [Resident #1] heard the code given to Staff D, CNA when she exited the facility.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the facility's investigation showed interviews were conducted with numerous staff members. None of the interviews showed a staff member observed Resident #1 leave the facility. Nor did the interviews reveal a staff member heard the door alarm. Review of the facility's interview with Staff D, Agency CNA showed she was new to the facility and did not know where staff were supposed to enter/exit. Staff D added that there were several codes given to her to get into the different areas of the facility. The interview showed: When Staff D was asked how she was able to leave through the C-Wing side door, she said someone gave her the code when she was leaving.<br><br>A telephone interview was attempted on 4/9/2024 at 1:20 p.m., 4/10/2024 at 9:05 a.m. and 3:00 p.m. with Staff D, CNA. Staff D, CNA was the agency staff member who exited the facility via the C wing ambulance entrance/exit on 3/25/2024 at 4:11 p.m. The phone call was not returned by Staff D, CNA.<br><br>During review of the facility's staff interviews the Regional Maintenance Assistant's (RMA) interview showed, the RMA saw Resident #1 in the back of the building but was under the impression Resident #1 was a guest. The facility conducted a root cause analysis of the elopement and determined Resident #1 was able to leave the facility due to unauthorized use of C wing ambulance entry/exit by door, codes being shared with non-staff individuals, and staff failing to recognize signs of elopement as evidence by Resident #1's increased elopement seeking behavior prior to the event.<br><br>The Regional Maintenance Assistant was unavailable for interview during the time of the survey.<br><br>On 4/9/2024 at 2:25 p.m., an observation of the route traveled by Resident #1 from the facility to the Assisted Living Facility down the road, showed Resident #1 walked approximately 1 mile away from the facility:<br><br>Resident #1 exited the C wing entrance/exit door.<br><br>- Turned right and continued to walk on the sidewalk around the facility passing the Outpatient Therapy entrance. The sidewalk continued toward the back of the facility, passing the back of the Therapy Department. Located here were therapy steps with handrail on each side.<br><br>- The sidewalk brought you to the back of the facility, near a small building structure and parking lot to the left and the facility to the right. The resident continued to walk off the sidewalk, on broken pavers to the parking lot behind the building near the kitchen entrance/exit and dumpsters. The parking lot was uneven and cracked.<br><br>- Resident #1 exited the facility property onto the 2-lane road with a speed limit of 35 mph (miles per hour).<br><br>- She turned right onto a 4-lane road with a large median in the middle, the road enters a large apartment complex, speed limit 35 mph and walks 0.2 miles.<br><br>- She turned right onto a busy 2-lane subdivision road with a speed limit of 35 mph and Resident #1 was then seen at the A wing ambulance entrance/exit (via camera) sidewalk proceeding to main driveway of the facility. Resident #1 exited the facility parking lot.<br><br>(continued on next page) |

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| | 105733 | A. Building<br>B. Wing | 04/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Palm Garden of Pinellas | 200 16th Ave SE<br>Largo, FL 34641 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - She turned right back onto a busy 2-lane subdivision road with a speed limit of 35 mph and walked 0.3 miles, crossed the subdivision street, speed limit of 35 mph (numerous apartments/business'/homes, located on this busy street).<br><br>- She turned left onto the main highway near the facility for 0.5 miles. This main highway was a heavily traveled road, 6-lanes of traffic (3 each way with a median separating the lanes, plus turn lanes) Speed limit 45 mph. (Photographic Evidence Obtained)<br><br>On 4/8/24 at 4:05 p.m., an observation was conducted of the main road and the road where the facility was located. The traffic was heavy. Numerous cars were seen on both sides of the main road. Three cars on the main road were waiting to turn onto the road the facility was on. Two cars were waiting to turn onto the main road from the road the facility was located on. (Photographic Evidence Obtained)<br><br>On 4/9/2024 at 4:00 p.m., an observation was conducted of all the roads Resident #1 had traveled. The roads were highly traveled with busy traffic, uneven terrain, and obstacles like curbs and parking bumpers. (Photographic Evidence Obtained)<br><br>The weather in [NAME], Florida according to localconditions.com on 3/25/2024 was clear with a temperature range between 78- and 80-degrees F when Resident #1 eloped.<br><br>An interview was conducted on 4/8/2024 at 12:20 p.m. with the DQA and DON. The DQA stated Resident #1's return to the facility, a skin assessment was performed, and Resident #1 had no injuries from the elopement. The DON stated Resident #1 was in good spirits and requested more ice cream.<br><br>An interview was conducted on 4/9/2024 at 2:30 p.m. with the NHA. The NHA stated a third-party vendor was contacted on 3/26/2024 to inspect all exit/entry doors for proper function. The third-party vendor completed inspection on 3/29/2024 noting all doors work as they should at this time.<br><br>During an interview with the DON and the DQA on 4/8/2024 at 12:20 p.m. The DON stated the facility had changed all the door codes. Only staff members being permitted to have the exit codes for the facility. The DON stated all facility staff had in-service education related to elopement and the elopement policy, abuse, neglect, and exploitation, the leave of absence (LOA) policy, and identification of wandering/elopement behaviors, which was started on 3/26/2024 and continue.<br><br>Facility's immediate actions to remove the Immediate Jeopardy included:<br><br>- 3/25/2024, Resident #1 was returned to the facility and a body audit was completed with no new findings. Resident #1's PCP was notified, and no new orders were given.<br><br>- 3/25/2024, Resident #1 was placed on 1:1.<br><br>- 3/25/2024, an updated elopement risk evaluation was completed for Resident #1 by DON.<br><br>- 3/25/2024 Resident #1's care plan and Kardex (CNAs key resident information from the care plan) reviewed to include 1:1 supervision.<br><br>- 3/25/2024 facility wide resident count occurred; all residents were accounted for.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - 3/26/24: DON/designee initiated 100% audit of all residents to identify for at risk for wandering. All assessments were completed, one resident was added to the log. Orders, care plans, Kardex, and elopement binders were updated for all identified residents.<br><br>- 3/26/24: Maintenace completed 100% audit of all entrance/exit doors in the facility to ensure all doors were locked and functioning properly for delayed egress.<br><br>- 3/26/24: Education initiated for CNA staff related to exit seeking behaviors, place resident on 1:1 then call supervisor.<br><br>- 3/26/24: Education initiated for all staff related to elopement policy and elopement drill, Elopement risk, utilization of what door staff are to use and no sharing codes with non-staff.<br><br>- 3/26/24: Education initiated for all staff related to abuse, neglect, and exploitation.<br><br>- 3/25/2024 Quality Assurance & Performance Improvement (QAPI) implanted.<br><br>- 3/26/2024 Ad Hoc QAPI, meeting held to review plan.<br><br>- 4/3/2024 Ad Hoc QAPI, meeting held to review plan and progress. Changes made to plan (codes).<br><br>- 4/8/2024 Ad Hoc QAPI, meeting held to review plan and progress.<br><br>Verification of the facility's removal actions was conducted by the survey team on 4/10/2024. Review of facility education was conducted. Staff roster provided by NHA and DON. 142 total staff members. All staff members were educated related to abuse, neglect, and exploitation, elopement policy and protocols (focus on supervision), LOA policy, and elopement risk/exit seeking behaviors and notification, place resident with new/increased exit seeking behaviors on 1:1 notify supervisor, which was completed on 4/3/2024.<br><br>A sample of two residents at risk for elopement were reviewed for verification of elopement evaluations, care plans/Kardex and pictures present in the elopement books at all locations. Review of the two residents showed elopement evaluations were completed, care plans/Kardex updated, and pictures were present in the electronic medical record and elopement risk books. A sample of seven of the entry/exit doors were reviewed to verify functioning of electronic Mag Lock devices. Review of the seven doors showed proper placement and functioning of electronic Mag Lock devices and code keypads at time of visit.<br><br>Interviews were conducted with 68 staff members, including 13 Licensed Nurses, 23 CNAs, 6 dietary staff, 7 therapy staff, 6 housekeeping staff, and 13 other staff members. The staff members were able to state that they had been trained and were knowledgeable about the policies and procedures.<br><br>Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be removed on 4/10/2024 and the non-compliance was reduced to a scope and severity of D. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223<br><br>Based on observations, interviews, and record review, the facility failed to ensure one resident (#1) of six residents at risk for elopement, was provided with supervision and services related to the resident's cognitive deficits, lack of safety awareness, and confusion before admission to the facility.<br><br>The facility staff failed to ensure the supervision and safety of Resident #1 on 3/25/2024 at approximately 4:15 p.m. Resident #1 exited the facility through an ambulance side (C Wing) entrance door that was equipped with an electromagnetic locking device (a magnetic lock that unlocked when de-energized and required power to remain locked). Resident #1 was able open the door by punching the security code into the keypad beside the door. She walked out of the door and around the outside of the facility for approximately 13 minutes and then traveled approximately 0.3 miles along a 2-lane road, crossed this busy road and continued walking 0.5 miles down a well-traveled 6-lane road for 16 minutes. Resident #1 was seen by another staff member who was on the way back to the facility from escorting another resident to an appointment at approximately 4:40 p.m. Resident #1 was picked up by the facility van by staff members and returned to the facility at 4:45 p.m. on 3/25/2024. The resident was not located for approximately 30 minutes.<br><br>The facility failed to take action to prevent the resident from exiting the facility by not determining and providing the necessary level of supervision, and not distinguishing the resident from visitors of the facility.<br><br>This failure created a situation that resulted in the likelihood of a worsened condition, serious injury and or death to Resident #1 and resulted in the determination of Immediate Jeopardy on 3/25/2024. The findings of Immediate Jeopardy were determined to be removed on 4/10/2024 and the severity and scope was reduced to a D after verification of removal of the immediacy.<br><br>Findings included:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on 4/8/2024 at 2:37 p.m., with Staff F, Certified Nursing Assistant (CNA). Staff F stated, I was not [Resident #1's] assigned CNA; I am the one who found [Resident #1]. I routinely work on the front hall, so I don't see exit doors, unless I go over to them. I recall [Resident #1] wandering consistently throughout the building. I do not recall her going into the lobby, those are the only doors I can see on my assignment. [Resident #1] would wander the facility, go into other resident rooms, lay down and sleep in other's beds. On the day of the event, 3/25/2024 at approximately 4:45 p.m., I was coming back with another resident from an appointment, in a non-facility van. I just happened to look out the van window and saw a person with a red shirt on. I said to the van driver, 'I think that is our resident'. The van driver refused to stop. As soon as we pulled up to the facility, I ran out of the van to the receptionist and asked her if [Resident #1] was here. The receptionist called Code Green, which is a missing resident. The business office manager (BOM) overheard me with the receptionist and came out of the office. The BOM and I ran out of the facility to where I had seen the resident. I saw the resident on Seminole Boulevard past the church. When we got to the resident, we waited for the facility van to pick us up. [Resident #1] was fine, asked us for more ice cream. The van arrived shortly after we reached the resident. We all got on the van and the van returned us to the facility. [Resident #1] was wearing a short sleeve red t-shirt, shorts, socks, and sneakers.<br><br>Review of Resident #1's progress note, dated 3/25/2024 at 5:00 p.m. and authored by the Director of Nursing (DON), showed: LATE ENTRY, notified by staff that resident was observed off the property and on the sidewalk that runs in front of the church across the street. A Certified Nursing Assistant (CNA) that was on an escort was returning from an appointment with another resident and observed the resident. CNA immediately came into the facility to notify staff and staff went to bring resident back. Resident was on the sidewalk with her cell phone and her bowl of ice cream she got from Life Enrichment [Activities]. When asked where she was going, she said to get more ice cream because hers was melted. She was placed on 1:1. When she spoke to another staff member, she reported she was out looking at apartments. [Resident #1] was not noted to be in any distress. CNA provided her with a shower. CNA and resident sitting together and conversing.<br><br>On 4/8/24 at 4:05 p.m., an observation was conducted of the main road and the road where the facility was located. The traffic was heavy. Numerous cars were seen on both sides of the main road. Three cars on the main road were waiting to turn onto the road the facility was on. Two cars were waiting to turn onto the main road from the road the facility was located on. (Photographic Evidence Obtained)<br><br>On 4/9/2024 at 4:00 p.m., an observation was conducted of all the roads Resident #1 had traveled. The roads were highly traveled with busy traffic, uneven terrain, and obstacles like curbs and parking bumpers. (Photographic Evidence Obtained)<br><br>The weather in [NAME], Florida according to localconditions.com on 3/25/2024 was clear with a temperature range between 78- and 80-degrees F when Resident #1 eloped.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's progress note, dated 3/22/2024 at 2:38 p.m. and authored by Staff N, Registered Nurse (RN), showed: Type: COMMUNICATION - with Physician. A telephone call with the Advanced Practiced Registered Nurse (APRN) revealed that resident has had an increase in wandering since her fall on this week. Resident has started wandering into other resident rooms over the past couple of days and today repeatedly got into other residents' beds. Resident is usually easy to redirect but has become belligerent over the course of the day. CNA reports that resident is urinating more frequently today. New order received for UA C&S (urinalysis with a culture and sensitivity) to rule out UTI (urinary tract infection).<br><br>Review of Resident #1's progress note, dated 3/26/2024 at 5:17 p.m. and authored by Staff O, Licensed Practical Nurse (LPN), showed: spoke with APRN, ok to collect urine via straight catheter and send it to lab stat for analysis, this writer was able to obtain urine via straight catheter, no distress to resident, lab called and stat pick up for urine given to technician, lab will be out within 2 hours to pick up specimen.<br><br>Review of Resident #1's care plan showed a Problem, initiated 2/27/2024, as (Resident #1) is at risk for elopement related to wandering/desire to go home.<br><br>Goal: Will not have any unsafe elopement episodes through review, initiated: 2/28/2024. The resident will not leave facility unattended, initiated 2/27/2024. The resident's safety will be maintained, initiated 2/27/2024.<br><br>Interventions included: Engage resident with purposeful activities initiated: 2/27/2024.<br><br>Provide reorientation to surroundings, environment, initiated 2/27/2024. Resident added to elopement book, initiated 2/27/2024.<br><br>1:1 due to high elopement risk, initiated 3/25/2024.<br><br>Review of Resident #1's preadmission Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, with a Physician Certification date of 2/25/2024, showed under Section C: Decision Making Capacity, Resident #1 required a surrogate for medical decision making. The transfer form showed under Section S: Physical Function, Resident #1 ambulated with assistance and required no assistive devices to ambulate. The transfer form showed under Section U: Mental/Cognitive Status at Transfer, Resident #1 was alert and disoriented but could follow simple instructions.<br><br>Review of Resident #1's Admission Record showed Resident #1 was admitted to the facility on [DATE] with diagnoses of presence of left artificial shoulder joint, aftercare following joint replacement surgery; presence of cardiac pacemaker; hypertension; anxiety disorder; atherosclerotic heart disease without angina; muscle weakness; and cognitive communication deficit.<br><br>Review of Resident #1's progress note, dated 2/26/2024 at 1:20 p.m. and authored by Staff G, LPN, showed a note under Type: Clinical Admission, under the section titled: Mental Status: Resident #1's level of cognitive impairment: Mild impairment (some confusion). The evaluation showed under Mood and Behavior: Resident is agitated. Resident is anxious. Anxious - Unknown if change in mood. Agitated - Unknown if change in mood. Resident is currently experiencing unwanted behavior(s).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Social Service Director's progress note, dated 2/26/24 at 4:13 p.m., revealed, Spoke with case manager from the senior apartments where she lives. The case manager reported that she has been off her medications for a while and is not well mentally. Resident has been confused for a while.<br><br>Review of Resident #1's Elopement Evaluation, dated 2/27/2024 at 7:31 a.m., showed a score of 6. A score value of 1 or higher indicated at Risk of Elopement.<br><br>Review of Resident #1's progress note, dated 3/26/2024 at 6:29 p.m. and authored by Staff P, LPN showed: Resident discharged with meds and belongings to another Skilled Nursing Facility at 6 pm. Transferred via wheelchair van with one attendant. Vital signs stable. No skin issues noted at this time. Resident has no complaints and is looking forward to transfer.<br><br>A review of Resident #1's physician's orders showed the following:<br><br>- An order dated 2/26/2024 for Buspirone 10 mg (milligrams) by mouth twice a day for diagnosis of anxiety.<br><br>- An order dated 2/26/2024 for Paroxetine 20 mg by mouth at night for diagnosis of depression.<br><br>- An order dated 2/27/2024 for Hydroxyzine 25 mg by mouth once daily as needed for diagnosis of anxiety.<br><br>- An order dated 2/26/2024 for Trihexyphenidyl 5 mg by mouth twice a day for diagnosis of Parkinson's.<br><br>Review of the Initial Plan of Care Summary, dated 2/28/2024, showed under the section titled, Summary of Care Plan Goals, Resident is an Elopement risk of 6 (add to elopement).<br><br>A review of Resident #1's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/3/2024, showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 8/15, which indicated moderate impaired cognition.<br><br>According to the National Institutes of Health, wandering behavior is one of the most important and challenging management aspects in persons with dementia. Wandering behavior in people with dementia is associated with an increased risk of falls, injuries, and fractures, as well as going missing or being lost from a facility. This causes increased distress in caregivers at home and in healthcare facilities. The approach to the comprehensive evaluation of the risk assessment, prevention, and treatment needs more strengthening and effective measures as the prevalence of wandering remains high in the community. Both the caregiver and clinicians need a clear understanding and responsibility of ethical and legal issues while managing and restraining the people with Dementia. The consequences of the wandering can vary from minor injury on the body to severe injury and death. The persistent wandering behavior and weak gait and balance have been shown to increase the risk of falls, fractures, and accidents in people with dementia.<br><br>(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8543604/#:~:text=Outcome%20of%20Wandering%20in%20Dementia,to%20severe%20injury%20and%20death.&text=The%20persistent%20wandering%20behavior%20and,fractures%2C%20and%20accidents%20in%20PwD.)<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on 4/8/2024 at 2:08 p.m. with Staff G, LPN, who was Resident #1's routine nurse for the 7:00 a.m. to 3:00 p.m. shift. Staff G recalled Resident #1 and stated, [she] was very confused, argumentative, always exit seeking. [Resident #1] continuously stated desire to go home and carried a purse. [Resident #1] walked around the whole building, not just this unit. Staff G continued, [Resident #1] would go up to (exit) doors, push on the door. The door would be locked, and [Resident #1] would turn around and continue walking another way.<br><br>An interview was conducted on 4/8/2024 at 2:15 p.m. with Staff H, CNA. Staff H recalled Resident #1. Staff H stated, [Resident #1] would walk around a lot. I've seen [Resident #1] at the doors trying to exit and would become upset when I would tell her that she should not be there (near the door) and to come over to where I am and go to activities. [Resident #1] would shout at me, 'no one is going to tell me what to do.'<br><br>An interview was conducted on 4/8/2024 at 2:30 p.m. with Staff I, CNA. Staff I regularly worked with Resident #1 and stated [Resident #1] was very sociable and liked to go to activities. [Resident #1] wandered around the facility on a regular basis, always going into other resident rooms, would lay down in their beds, always carried her purse. [Resident #1] would not stop talking about going home, she definitely did not want to be here.<br><br>An interview was conducted on 4/8/2024 at 2:50 p.m. with Staff M, CNA. Staff M stated, I remember [Resident #1], mostly nice, always carried her purse, would go in others' (residents) rooms, and was frequently found in their beds. [Resident #1] would try to get out the door but would just walk around when she noticed it would not open. I was not assigned to [Resident #1], but we all would redirect her.<br><br>An interview was conducted on 4/8/2024 at 3:20 p.m. with Staff K, CNA. Staff K stated, .took care of her sometimes, I was not responsible for her on the day she eloped. I remember working that day. I did not even know [Resident #1] was missing until the Code Green was called. I don't recall hearing an alarm going off, until after the resident's return. Then they (management) started testing the doors.<br><br>An interview was conducted on 4/9/2024 at 10:30 a.m. with Staff L, CNA. Staff L confirmed being assigned to Resident #1 regularly and was assigned to Resident #1 the evening of the elopement. Staff L stated, she recalled seeing Resident #1 the evening of 3/25/2024 when she came on shift. Staff L stated, I thought [Resident #1] was in activities. I did not realize she was gone until after the Code Green was called.<br><br>An interview was conducted on 4/9/2024 at 3:30 p.m. with Staff E, LPN. Staff E stated, [Resident #1] continuously walked around the building. I usually worked here (A Wing), and she lived on the other (C Wing). I would redirect her to go back to her wing. The evening of the elopement, I remember seeing [Resident #1] here on A Wing and redirected her over to C Wing. I did not know she was missing until the Code Green. I don't recall any door alarms sounding that evening until after [Resident #1] had returned.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A telephone interview was conducted on 4/9/2024 at 3:10 p.m. with Resident #1's primary care APRN. The APRN stated he was quite familiar with Resident #1, as he had seen her several times. The APRN stated, [Resident #1] was admitted to the hospital for a shoulder replacement, with expectation of discharge to home the same day. The resident had no record of dementia or cognition issues in the medical records prior to the surgery. The anesthesia affected her cognition and caused a decline, as well as an infection developed in the incision. [Resident #1] showed an improvement in the hospital and was discharged to this facility for short term rehabilitation. During the course of treatment, [Resident #1's] cognition was improving 'quite a bit'. Although, she still lacked the safety awareness to make an informed decision regarding her surroundings. The facility did call me regarding the resident's increase in behaviors. The APRN continued to state, an order for a UA was ordered on 3/22/24 and resulted on 3/26/24. He said the results were not of concern, and he suggested the facility follow up with the physician at the new facility. The APRN stated, I was made aware of the situation (elopement) upon my visit the following day, actually they could have told the answering service the night before.<br><br>A telephone interview was conducted on 4/9/24 at 4:12 p.m. with the Resident Representative (RR) of Resident #1. The RR stated the facility told him Resident #1 went outside. He found out later, through the resident's good friend, that Resident #1 walked about a 1/4 mile down the road. The facility did not tell the RR any specifics of the incident. The RR stated he had no problems until he found that out. The RR stated Resident #1 lived on her own prior to admission to the hospital for surgery. The RR stated Resident #1's memory problems had been getting worse prior to entering the facility over the past couple of months. The RR stated Resident #1 had a little case of dementia going on but was not sure if she had been diagnosed with dementia. The RR stated Resident #1 was great when on her meds but just isn't right when she doesn't take them. The RR did not know what medications Resident #1 was routinely on. The facility did not communicate any sort of increase in behaviors. Just stated your mother walked out of the building, and we need to find her a new place within the next 12 hours.<br><br>A telephone interview was attempted on 4/9/2024 at 3:30 p.m. with Resident #1's friend (RF) who visited her daily. RF did not answer the phone call and a message was left. On 4/11/2024 at 3:02 p.m. the RF returned the call. The RF stated, She visited her friend [Resident #1] every day. She stated [Resident #1] went to the hospital for an elective shoulder replacement. The RF stated, [Resident #1] was fine with just a little memory issue prior to surgery. She was supposed to come home right after surgery. Although, she had some sort of reaction to the anesthesia and was in recovery for a while. When [Resident #1] woke up from anesthesia her memory was awful and had not come back yet. She is doing better, but not great. The facility really was good to us. [Resident #1] really improved while at the facility. We even went to lunch, but that turned out to instigate her desire to go home. She became fixated on going home. After that experience, I did not take her out of the facility. One day I went home and when I returned the next (day), [Resident #1] was on 1:1. She had a staff companion that did not leave her. The staff member told me she got out. [Resident #1] admitted to me that she left because she wanted to go home. Later that night, [Resident #1's] (family member) called and told me she had eloped. The facility told him [Resident #1] is not safe in their facility and had to find another. The RF stated the facility found Resident #1 another place that had a better environment where Resident #1 would be safer.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Palm Garden of Pinellas | 200 16th Ave SE<br>Largo, FL 34641 |

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on 4/8/2024 at 12:20 p.m. with the Director of Quality Assurance (DQA) and DON. The DON and DQA stated, Resident #1 eloped from the facility on 3/25/2024. During the investigation into Resident #1's elopement, the facility developed the following timeline of events through staff interviews and review of the indoor and outdoor video camera observations:<br><br>- 4:08 p.m. via interview with Staff E, LPN Resident #1 seen inside facility on A Wing and was redirected back to C Wing.<br><br>- 4:11 p.m. Staff D, CNA was captured by camera footage outside the C Wing camera (ambulance entrance) walking toward parking lot, this is in the front of building. Staff D, CNA was leaving the facility at the end of her shift.<br><br>- 4:11 p.m. Resident #1 was captured by camera footage inside the building on C Wing by the nurse's station facing the C Wing hall. At the end of this hallway is the exit door to the parking lot (C Wing ambulance entrance/exit).<br><br>- 4:14 p.m. Resident #1 was captured by camera footage outside the C Wing ambulance entrance facing the parking lot.<br><br>- 4:16 p.m. Resident #1 was captured by camera footage outside the therapy department's back door, near the outside therapy steps (rear of facility).<br><br>- 4:18 p.m. Resident #1 was captured by camera footage by the kitchen, near the construction area, witnessed by the Regional Maintenance Director.<br><br>- 4:19 p.m. Resident #1 was captured by camera footage outside by the dumpster walking toward the rear of the building.<br><br>- 4:27 p.m. Resident #1 was captured by camera footage outside the A Wing ambulance entrance/exit walking away from the building toward the front parking lot.<br><br>- 4:27 p.m. Resident #1 was captured by camera footage outside the A Wing ambulance entrance/exit walking on the sidewalk toward the main entrance of the front parking lot.<br><br>- 4:37 p.m. Staff F, CNA observed Resident #1 on the sidewalk of the main road, past the church on the corner.<br><br>- 4:40 p.m. Staff F, CNA was captured by camera footage in the portico of the front lobby entrance.<br><br>- 4:43 p.m. the facility van was captured by camera footage driving away from the facility on 16th Ave.<br><br>- 4:45 p.m. the facility van was captured by camera footage in the portion of the front lobby entrance.<br><br>- 4:45 p.m. Resident #1 was back in the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DQA and DON continued to state they determined Resident #1's most likely route determined was: Resident #1 exited the facility via the C Wing ambulance entrance. Resident #1 walked around the facility and crossed the road out front of the facility and down the sidewalk of the main road near the facility. They stated, We picked her up with the facility van at the assisted living facility just past the church. The DON stated, [Resident #1] refused to tell us how she exited. [Resident #1] stated, I wouldn't be able to get out again if I told you. We (the facility) had a couple of staff ask [Resident #1] the question. [Resident #1] never did tell us. The [name of another regulatory agency] investigator told us [Resident #1] told him she had the code. We (facility) determined [Resident #1] heard the code given to [Staff D, CNA] when she exited the facility.<br><br>During the continued interview with the DQA and DON, the DQA stated Resident #1's return to the facility, a skin assessment was performed, and Resident #1 had no injuries from the elopement. The DON stated Resident #1 was in good spirits and requested more ice cream. The DON stated the facility had changed all the door codes. Only staff members were permitted to have the exit codes for the facility. The DON stated all facility staff had in-service education related to elopement and the elopement policy, abuse, neglect, and exploitation, the leave of absence (LOA) policy, and identification of wandering/elopement behaviors, which was started on 3/26/2024 and continues.<br><br>On 4/9/2024 at 2:25 p.m. an observation of the route traveled by Resident #1 from the facility to the assisted living facility down the road, showed Resident #1 walked approximately 1 mile away from the facility:<br><br>- Resident #1 exited the C Wing entrance/exit door.<br><br>- Turned right and continued to walk on the sidewalk around the facility passing the Outpatient Therapy entrance. The sidewalk continued toward the back of the facility, passing the back of the Therapy Department. Located here were therapy steps with handrail on each side.<br><br>- The sidewalk brought you to the back of the facility, near a small building structure and parking lot to the left and the facility to the right. The resident continued to walk off the sidewalk, on broken pavers to the parking lot behind the building near the kitchen entrance/exit and dumpsters. The parking lot was uneven and cracked.<br><br>- Resident #1 exited the facility property onto the 2-lane road with a speed limit of 35 mph (miles per hour).<br><br>- She turned right onto a 4-lane road with a large median in the middle, the road enters a large apartment complex, speed limit of 35 mph, and walked 0.2 miles.<br><br>- She turned right onto a busy 2-lane subdivision road with a speed limit of 35 mph and Resident #1 was then seen at the A Wing ambulance entrance/exit (via camera) sidewalk proceeding to the main driveway of the facility. Resident #1 exited the facility parking lot.<br><br>- She turned right back onto a busy 2-lane subdivision road with a speed limit of 35 mph and walked 0.3 miles, crossed the subdivision street, speed limit of 35 mph (numerous apartments/business'/homes, located on this busy street).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - She turned left onto the main highway near the facility for 0.5 miles. This main highway was a heavily traveled road, 6-lanes of traffic (3 each way with a median separating the lanes, plus turn lanes), speed limit of 45 mph. (Photographic Evidence Obtained)<br><br>Review of the facility's investigation showed interviews were conducted with numerous staff members. None of the interviews showed a staff member observed Resident #1 leave the facility. Nor did the interviews reveal a staff member heard the door alarm. Review of the facility's interview with Staff D, CNA showed she was new to the facility and did not know where staff were supposed to enter/exit. Staff D, CNA added that there were several codes that were given to her to get into the different areas of the facility. The interview showed: When [Staff D, CNA] asked how she was able leave through the C-Wing side door, she said someone gave her the code when she was leaving. The interview reviewed showed Staff D, CNA was not able to tell the name of the person given her the code nor if she was a center's staff member.<br><br>During review of the facility's staff interviews the Regional Maintenance Assistant's (RMA) interview showed, the RMA saw Resident #1 in the back of the building but was under the impression Resident #1 was a guest. The facility conducted a root cause analysis of the elopement and determined Resident #1 was able to leave the facility due to unauthorized use of C Wing ambulance entry/exit by door, codes being shared with non-staff individuals, and staff failing to recognize signs of elopement as evidence by Resident #1's increased elopement seeking behavior prior to the event.<br><br>A telephone interview was attempted on 4/9/2024 at 1:20 p.m., 4/10/2024 at 9:05 a.m. and 3:00 p.m. with Staff D, CNA. Staff D, CNA was the agency staff member who exited the facility via the C wing ambulance entrance/exit on 3/25/2024 at 4:11 p.m. The phone call was not returned by Staff D, CNA.<br><br>The Regional Maintenance Director was unavailable for interview during the time of the survey.<br><br>An interview was conducted on 4/9/2024 at 2:30 p.m. with the Nursing Home Administrator (NHA). The NHA stated a third-party vendor was contacted on 3/26/2024 to inspect all exit/entry doors to check for proper function. The third-party vendor completed the inspection on 3/29/2024, noting all doors work as they should at this time.<br><br>Review of the facility's policy and procedure titled, Risk Management - Elopement, dated November 2022, showed: Policy: It is the policy of this center that an elopement risk evaluation is completed upon admission. All guest/residents will be evaluated for elopement risk upon admission, quarterly, and with the change in condition or significant event. An elopement risk identification notebook will be maintained at key locations in the center to alert team members of those guests/residents deemed at risk for elopement.<br><br>Procedure:<br><br>1. If the guest/resident is identified as an elopement risk based on the evaluation, a care plan will be developed to reduce elopement risk. Center team members will provide supervision and engage the guest/resident as needed to minimize wandering or exit seeking behavior according to the plan of care.<br><br>2. Guests/residents identified at risk for elopement will have a Resident Identification Sheet completed, and a copy of a recent color photograph of the guest/resident will be attached.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | a. The photo should be taken when the guest/resident is awake and dressed for the day.<br><br>b. Pertinent information will be included to assist the search activities.<br><br>3. The completed Resident Identification Sheet will be added to the Elopement Risk notebooks located at each Nurse's Station and at the front desk. The DQA will be responsible for maintaining and updating the Elopement Risk Notebooks.<br><br>Review of the facility's policy and procedure titled, Risk Management - Missing Guest/Resident, dated November 2022, showed: Policy: The purpose of this policy is to clearly define guest/resident elopement and to provide guidance and management of all reports of missing guest/residents. Definition of Elopement: Elopement occurs when a guest/resident leaves the premises or a safe area without the center's knowledge and supervision, if necessary. If any guest/resident should leave the premises at any time without following the center's procedures for a voluntary leave, the missing guest/resident procedure should begin immediately. If a guest/resident attempts to leave the center or a safe area and a team member is aware of the occurrence/visualizes the guest/resident and immediately accompanies the guest/resident and returns the guest/resident to the center, it will not be considered an elopement, as the guest/resident in this case was always under a team member supervision. If an alert guest/resident leaves the property without signing out, they will be encouraged to return to the center and will be reeducated on the center's Leave of Absence (LOA) process. Repeated failures to follow the center's process for LOA may lead to formal discharge notice.<br><br>Procedure:<br><br>1. It is the responsibility of all team members to report any guest/resident attempting to leave the premises, or suspected of being missing, to the Charged Nurse immediately who will then notify others (see below).<br><br>2. Should a team member observe a guest/resident leaving the premises without authorization, he/she should:<br><br>a. Attempt to prevent the departure.<br><br>b. Obtain assistance from other team members in the immediate vicinity, if necessary.<br><br>c. Instruct other team members to inform Charge Nurse or Director of Clinical Services that a guest/resident is attempting to leave or has left the premises.<br><br>d. Be courteous in preventing the departure and in returning the guest/resident to the center.<br><br>e. If possible, the team member should stay with the guest/resident until additional help responds if the guest/resident is refusing to return to the center.<br><br>3. Upon return of the guest/resident to the center, the director of Clinical Services or Charge Nurse should:<br><br>a. Examine the guest/resident for injuries.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | b. Contact the attending physician and report what happened.<br><br>c. Contact the guest/resident's legal representative and inform them of the incident.<br><br>d. Make appropriate notification in the resident's medical record.<br><br>4. Should a team member discover the guest/resident is missing from the center he/she should:<br><br>a. Determine if the guest/resident is out on an authorized leave or pass. If not:<br><br>b. Make center announcement designating missing guest/resident.<br><br>c. Begin timeline to document pertinent information.<br><br>d. Make a thorough search of the building(s) and premises. Including all closed doors, bathrooms, common spaces, offices, and outdoor areas. If not located:<br><br>e. Notify the Executive Director and Director of Clinical Services.<br><br>f. Notify the Police Department.<br><br>g. Notify the guest/resident's legal representative.<br><br>h. Notify the attending physician.<br><br>i. If necessary, notify volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.).<br><br>j. Provide search teams with guest/resident identification information, including photo.<br><br>k. Make extension extensive search of surrounding area.<br><br>l. Conduct head count to ensure all other guest/residents are accounted for in the center.<br><br>m. Attempt to identify exit door to assist with search and to identify if door/alarm were functioning properly.<br><br>n. Check all other exit doors to ensure proper functioning alarms.<br><br>5. Upon return of the guest/resident to the center, the Director of Clinical Services and Charge Nurse should:<br><br>a. Examine the gas resident for injuries.<br><br>b. Contact the attending physician and report findings and conditions of the guest/resid [TRUNCATED] |