

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2024
NAME OF PROVIDER OR SUPPLIER Davenport Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 206 W Orange St Davenport, FL 33837	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223</p> <p>Based on interview and record review the facility failed to report an allegation of neglect related to an elopement for one resident (#4) out of three residents reviewed for elopement risk.</p> <p>Findings included:</p> <p>An interview was conducted on 12/8/24 at 11:04 a.m. with the Director of Nursing (DON) and Nursing Home Administrator (NHA). The DON stated on 6/15/24 around 11:00 a.m. she was notified Resident #4 could not be found. The DON stated she had instructed staff to continue the search and notified the NHA. The NHA stated she instructed staff to notify the police.</p> <p>Review of the timeline prepared by the NHA at the time of the event showed:</p> <ul style="list-style-type: none"> - On 6/15/24 at 11:00 a.m. notified by the facility Resident #4 was unable to be located. - A family member reported to the facility they saw Resident #4 sitting on the outside bench at the front of the facility. When staff went to the bench, Resident #4 was not there. The facility continued to search the building and surrounding areas. - At approximately 11:10 a.m. the facility contacted the police department for the missing resident. - At approximately 11:20 a.m. NHA arrived to the facility and an officer who was on site stated the police department would deploy a helicopter, drone and scent dogs. - At approximately 12:00 p.m. the police department contacted the facility and stated Resident #4 was found and unharmed. The police stated they would be taking Resident #4 to the local hospital per protocol. <p>Review of the admission record of Resident #4 showed an admitted [DATE] with diagnoses including malignant neoplasm of the lung and bones, congestive heart failure, hemiplegia and hemiparesis following cerebral infarction affecting the right side and other co-morbidities.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #4's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (AHCA Form 5000-3008) dated 6/11/24 revealed in section C - Decision Making Capacity Patient [Resident #4] required a surrogate.</p> <p>Review of Resident #4's medical records showed a care plan with a focus dated 6/14/24, showing Resident #4 was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 10. Resident #4 makes needs known but has impaired decision making due to alcohol abuse. Another focus dated 6/14/24 showed Resident #4 had a mood problem related to Admission, alcohol abuse, anxiety and disease process of adult failure to thrive.</p> <p>A baseline care plan for Resident #4 dated 6/11/24 showed, Summary long term care admitted . Diagnosis of lung cancer with metastasis to bone and spine. Malnutrition severe. Adult failure to thrive. Neurocognitive disorder. Receiving anti-psychotropic medications. Chronic pain. Fall while in the hospital. History of substance abuse and suicidal comments .</p> <p>Review of Resident #4's progress notes dated 6/13/24 showed, BIMS summary score: 10 meaning resident is moderately impaired. Resident stated knowing family unable to care for him. Resident #4 states owning a house, but family cannot assist. Resident is mildly depressed and will be seen by psych.</p> <p>Review of the facility's Reportable Log did not show any reports related to Resident #4. On 12/8/24 at 10:30 a.m. the Nursing Home Administrator (NHA) confirmed this was a complete list of reported incidents.</p> <p>An interview was conducted on 12/8/24 at 11:04 a.m. with the DON and the NHA. The NHA stated an elopement would meet the requirements of needing to be reported.</p> <p>On 12/8/24 at 10:30 a.m. the NHA stated the facility did not have a policy specific to Elopement.</p> <p>Review of a facility policy titled, Reporting Abuse to Facility Management dated revised February 2014, revealed: Policy Statement: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident of or suspected incidents of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. Policy interpretation and implementation: . (f.) Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p>		