

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Tuskawilla Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1024 Willa Springs Dr Winter Springs, FL 32708	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646</p> <p>Based on interview, and record review, the facility failed to thoroughly investigate a possible elopement for 1 of 2 resident reviewed for elopement, of a total sample of 32 residents, (#22).</p> <p>Findings:</p> <p>Resident #22 was admitted to the facility on [DATE] with diagnoses including dementia, major depressive disorder, psychotic disorder with delusions and cognitive communication deficit.</p> <p>Review of the Minimum Data Set quarterly assessment with Assessment Reference Date 5/12/24 noted resident #22 had long-term and short-term memory problems and had severely impaired cognitive skills for daily decision making. The assessment showed resident #22 wandered 4 to 6 days out of 7 and used a wander/elopement alarming device daily.</p> <p>The medical record contained a care plan revised 11/16/23 which indicated resident #22 was at risk for elopement as evidenced by impaired safety awareness. Interventions included the use of an alerting bracelet and picture of resident to be kept in elopement binders. The most recent revision to interventions was 1/19/23.</p> <p>Review of the facility Elopement Drills revealed a drill with sign-in sheet dated 6/05/24. The drill sheet indicated a resident with a wander alert bracelet tripped the alarm at the front door. The alarm sounded and the nurse checked the alarm panel without delay. The nurse immediately directed a Certified Nursing Assistant (CNA) to go to the front door where she then observed resident #22 directly outside the front door and she returned him to the unit.</p> <p>On 6/19/24 at 3:36 PM, CNA A stated she worked the night resident #22 set off the front alarm. She recalled Registered Nurse (RN) C sent CNA F to the front door. CNA A stated she remained on the unit. She recalled the Administrator came to the facility that night because the resident had gotten out the front door and staff completed an in-service on elopement.</p> <p>On 6/19/24 at 3:41 PM, Licensed Practical Nurse (LPN) B stated she was working the night resident #22 pushed the front door and got outside the door. She stated she heard the alarm at the nurses' station, and she then checked each resident on the unit as per policy. She recalled she heard resident #22 got out the front door but not very far. She stated the Administrator came in and held an in-service and a mock drill that same day.</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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/24 at 3:47 PM, RN C confirmed she worked the night resident #22 set off the front door alarm. She recalled she gave him his medication at approximately 8:00 PM. RN C said she was at the nurses' station when she heard the alarm. She remembered she immediately turned and looked at the panel and saw it was the front door alarm. RN C explained CNA F was standing at the nurses' station and she sent CNA F to the front door at once. RN C stated the alarm was turned off and sounded again. RN C recalled she went to the front door and observed CNA F just outside the door with resident #22.</p> <p>On 6/19/24 at 3:59 PM, LPN D stated she had worked the night of 6/05/24. She recalled she heard an overhead announcement at approximately 8:30 PM, which indicated a resident was missing. She stated she immediately started checking her residents. LPN D stated a CNA got the resident and brought him back inside the building. She recalled the Administrator came in a little later and did a walk through, then had everyone sign an in-service attendance sheet.</p> <p>On 6/20/24 at 11:16 AM, CNA F confirmed she worked the night of 6/05/24. She recalled resident #22 was by the nurses' station when she went to answer a call light. When she returned to the nurses' station, resident #22 was no longer there. She stated the alarm went off and she went to the front door to check the area. She explained she saw the resident right outside the door and immediately went out to get him. CNA F stated he came back inside without any resistance. CNA F reported resident #22 did wander at times but had never seen him go to the front door previously. She stated the Administrator came to the facility that night and did an in-service with staff. CNA F recalled she told him what she knew but she was not asked to provide a written statement of what happened that night until 6/18/24.</p> <p>Review of the incident log provided by the facility revealed no record of an incident report for the possible elopement on 6/05/24.</p> <p>Review of the medical record for resident #22 revealed no progress note was documented by staff regarding the incident on 6/05/24. A new elopement risk evaluation was not completed following the incident.</p> <p>On 6/19/24 at 5:44 PM, the Administrator stated he went to the facility the night of 6/05/24 after he was notified a resident set off the exit alarm. He reported he spoke to the nurse and CNA assigned to resident #22 and got verbal statements that evening. The Administrator acknowledged he did not have statements from any other employees nor did not obtain written statements from the assigned nurse and CNA until 6/18/24. He explained he viewed video of the incident that night and created a timeline from the video but did not preserve the video itself. The Administrator reported resident #22 was considered an elopement risk but had never left the facility previously. He did not know why resident #22 tried on this date. The Administrator explained he thought questioning the two assigned staff members and watching the video was enough to determine resident #22 did not elope and therefore used the experience as a drill. The Administrator could not answer why staff did not complete a new elopement risk screening or incident report. He also could not explain why there were no progress notes relating to the incident. The Administrator acknowledged documentation of the incident including his investigation could have been better.</p> <p>The facility's policies and procedure for Resident Elopement dated 8/2023 indicated when the resident was returned to the facility, the Director of Nursing or Charge nurse would complete an Incident/Accident report, document in the resident's medical record, investigate how the resident exited and review and update care plans.</p>		