

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Bay Village of Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE  8400 Vamo Road Sarasota, FL 34231	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30599</p> <p>Based observation on interview record review and policy the facility failed to provide supervision to prevent the elopement of one resident (Resident #162) of one resident surveyed for elopement and failed to ensure four of four residents assessed as an elopement risk currently residing at the facility had appropriate interventions to prevent the potential for an elopement.</p> <p>Findings included:</p> <p>Resident #162 is a [AGE] year-old female who was admitted to the facility on [DATE] with a history of cognitive communication deficit, abnormal gait, lack of coordination, and hypertensive heart disease.</p> <p>Review of the Elopement/Wander Risk Screen dated 12/21/23 shows Resident #162 was assessed with being a risk for elopement. The intervention listed as being initiated on 12/21/23 was a wanderguard was put in place at that time.</p> <p>According to the timeline provided in the facility's investigation, on 12/24/23 at approximately 9:30 a.m., Resident #162 was last seen in her room by staff who were attempting to administer her morning medication.</p> <p>On 12/24/23 at 10:15 a.m, a facility camera captured Resident #162 eloping from the facility through the front guarded gate.</p> <p>According to the timeline, Resident #162 was not seen again by facility staff until 12:45 p.m. when the resident was brought back to the facility by Resident #162's daughter. Resident #162 had traveled to an area in shopping mall approximately 0.4 miles from the facility. Resident #162 had provided contact information to the police and the police had notified Resident #162's daughter that she had left the facility.</p> <p>On 12/24/23 at 1:33 p.m., the staff nurse assigned to the resident documented Resident #162 had cut the wanderguard off her walker and was able to exit the building though the 2nd floor elevator without the wanderguard system alarming.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The analysis of the facility's investigation was Resident #162 had become confused due to a visit from an estranged family member and a potential urinary tract infection. The facility policy was changed to include a silver alert with the room number announced over radio communication. The Guard shack was to also be provided with an updated elopement book weekly.</p> <p>The facility investigation showed Resident #162 was able to remove the Wanderguard device and enter into the second floor elevator without the Wanderguard system alarming, and then exit the building and the guarded gate at the facility without staff being aware the resident had left the premises.</p> <p>On 4/17/24 at 8:15 a.m., the Security Guard at the front gate said he was not aware of an elopement book. He stated he would have to find out about the elopement book from his supervisor.</p> <p>On 4/17/24 at 10:15 a.m., the Assistant Director of Nursing provided an example of the Wandergaurd device, and the plastic bracelet currently being used on 4 residents assessed as being an elopement risk by the facility. The plastic bracelet provided was observed to be easily snapped in two pieces by applying very little force at both ends.</p> <p>On 4/17/24 at 11:20 a.m., Resident #52 was observed in her room with the Wanderguard device attached to her wrist with the same type of plastic bracelet observed to be easily broken with very little force.</p> <p>On 4/17/24 at 11:25 a.m., Resident #18 was observed sitting in a recliner in his room with a Wanderguard device attached to his left ankle with the same type of plastic bracelet.</p> <p>On 4/17/24 at 12:15 a.m., Resident #29 was observed in the dining room with the Wanderguard device attached to her wrist with the same type of plastic bracelet.</p> <p>On 4/17/24 at 12:30 p.m., Resident #17 was observed in her room with the plastic bracelet attaching the wandergaurd device to her ankle.</p> <p>On 4/17/24 at 1:15 p.m., the Director of Nursing (DON) said she had the bracelets which had come with wandergaurd device. She said she was in the process of applying the wandergaurd devices to the residents who were assessed by the facility to be an elopement risk. The bracelets the DON provided at this time were grey in color and were observed to be stronger. They could not be broken by applying force at both ends of the bracelet. The DON could not explain why the appropriate bracelets were not being used to attach the wandergard devices. She said that from now on they would be and she had ordered more of the grey bracelets to be used in the future.</p> <p>On 4/17/24 at 1;20 p.m., the DON said she had not implemented putting a elopement book at the guard shack. She felt the issue had to due with communication, and by implementing a policy for announcing a Silver Alert when a resident eloped it would be communicated to staff.</p> <p>On 4/17/24 at 3:04 p.m., the Receptionist on the first floor of the facility in the front of the doors leading in and out of the building said she was not aware of who the residents were on the second floor who were at risk to elope from the building. The Receptionist said she did not know the code (Silver Alert) that would be called over the walkie talkie if a resident eloped from the second floor. She said she had had an email about elopement a while ago, but she was not aware of what the email had addressed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/17/24 at 3:09 p.m., the Guard at the guard shack at the front gate of the building said he was not aware of what residents were at risk for elopement on the second floor of the facility. He verified he was stationed at the only open gate that residents could go through to get off the facility grounds. He said there was one other closed gate that could be opened by pushing a button and it was not a guarded gate.</p> <p>On 4/17/24 at 3:15 p.m., the Receptionist at the station directly in front of the elevators on the second-floor skilled nursing unit said she did not know the code (Silver Alert) that would be called on the walkie talkie if a resident had eloped and could not be found.</p> <p>On 4/17/24 at 3:35 p.m., Certified Nursing Assistant, Staff G said she did not know the Code ([NAME] Alert) that would be called over the walkie talkie if a resident could not be found on the second floor. Staff G said they use the telephone to communicate if residents could not be found.</p> <p>On 4/17/24 at 2:59 p.m., The DON verified Resident #162 had exited the second floor by removing her wandergaurd device. She said staff were not aware the resident had left the premises for over 2 hours when the resident's daughter returned the resident to the facility. The DON verified how resident #162 was able to remove the wandergaurd and go off the premises through the guarded gate had not been addressed.</p>		