STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106089	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at the Conch Republic Nursing and Rehab	5860 W Junior College Rd Key West, FL 33040

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to provide adequate supervision to prevent unsafe wandering and elopement of 1 cognitively impaired Resident for 1 (Resident #1) of 1 resident reviewed for elopement. The facility also failed to implement care planned elopement intervention for 1 (Resident #2) of 5 residents reviewed for elopement.The findings included:Review of the facility policy titled Elopements and Wandering Residents with a revision date of 3/16/23 indicated Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. C. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the residents care plan and communicated to appropriate staff. Ie: diversional activities, wander guard placement. E. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.Review of the clinical record for Resident #1 revealed diagnoses included Alzheimer's disease.Review of the care plan for cognition initiated on 2/24/24 noted Resident #1 scored 4 on the Brief Interview for Mental Status, indicating severe cognitive impairment.On 9/16/25 at 9:37 a.m., in an interview Staff A Registered Nurse (RN) said on 9/5/25 around 9:37 p.m., she noticed Resident #1 was missing. She had given him his medications and went to the room next door to give another resident eye drops. When she exited into the hallway, she noticed the light was on in Resident #1's room. She went to check on him, but he wasn't there. She said she asked Staff B Certified Nurse Assistant who said she had seen him shortly before. They called an elopement alert and began searching inside and outside the building. They received a call from the hospital notifying them they had found Resident #1 in their parking lot and had him at the hospital. Resident #1 returned from the hospital a few hours later with no injuries. RN Staff A said she did not know how Resident #1 got out of the building. Staff A said at the time Resident #1 had not been identified as an elopement risk and wasn't wearing a wander alert bracelet. She said since the elopement a wander alert bracelet had been applied to Resident #1. A wander alert bracelet triggers an alarm when near an exit door. On 9/16/25 at 11:05 a.m., in an interview the Assistant Director of Nursing (ADON) said she investigated Resident #1's elopement. She said prior to the incident, Resident #1 had not been identified as an elopement risk. Since the incident, they had placed a wander alert bracelet on him to notify staff if he approaches the exit doors. She said after the incident all the alarms in the building worked when checked and it was her opinion that Resident #1 followed a family member out of the side door. She said another resident's son usually left around that time, and Resident #1 probably followed him out. She explained family members have a code to let themselves out the side door in the dining room. The ADON said she had just found out after the incident that another resident's son had the code because of his late hours. She said they will be looking into changing codes, but she was pretty sure it was tied to the Fire/EMS (Emergency Medical Services), so there would be a whole process involved. She said she was not sure how he got the code, and he was the only one that she knew of that comes and goes that late.On 9/16/25 at 12:04 p.m., in an interview the Director of Nursing (DON) said no family member should have the code to get in or out the door. She said it was not policy to have the code handed out and if that had been the case, they needed to change it. The DON said if a family member is visiting after hours, they should ring the doorbell to get in or get a staff member to let them out.On 9/16/25 the facility provided list of 5 residents (including Resident #2) who were identified as elopement risk and wore a wander alert bracelet. On 9/16/25 at 11:16 a.m., observation of residents with wander alert bracelets with the ADON revealed Resident #2 did not have a wander guard on. Resident #2 was unable to say where the wander alert bracelet was when asked.On 9/16/25 review of the clinical record for Resident #2 revealed no documentation verifying the wander alert bracelet was on and functioning. On 9/16/25 at 12:04 p.m., in an interview the DON said the placement and functioning of the wander alert bracelets should be checked every day. She said there was no official wander alert policy, or policy for checking it during shift change. On 9/16/25 at 12:04 p.m., in an interview the ADON said wander alert bracelets placement and functioning should be documented on the Treatment Administration Record (TAR) daily. She said she recently found out that the box to document the wander alert bracelets had somehow dropped off the TARS and they hadn't been documented on. She said she could not say how long the documentation of the wander alert bracelets had been missing from the TARS.On 9/16/25 at 2:30 p.m., in an interview the Administrator said they were working on changing the codes to the doors, and no family