Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80804	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE BAY REHAB AND CARE CENTER	4033 BEAVER LANE PORT CHARLOTTE, FL 33952

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N 000	INITIAL COMMENTS An unannounced complaint survey for #2025002274 was conducted on at Charlotte Bay Rehab and Care Center, a skilled nursing facility in Port Charlotte, Florida. Complaint #2025002274 was unsubstantiated. No deficiencies were found at the time of the visit.	N 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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F 000	INITIAL COMMENTS An unannounced complaint survey for #2025002274 was conducted on at Charlotte Bay Rehab and Care Center, a skilled nursing facility in Port Charlotte, Florida. Complaint #2025002274 was substantiated with a citation at F689. Charlotte Bay Rehab and Care Center is not in compliance with the Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement procedures to identify risk for elopement and adequately monitor 1 (Resident #1) of 1 resident reviewed who left the facility without staff knowledge. The findings included: Review of the facility's policy titled, "Nursing - missing resident/elopement" with a revision date of indicated: 1. Residents of the facility shall be maintained in	F 689	1) Resident #1 elopement evaluation completed. 2) Current residents had elopement evaluations completed 3) Systematic Change: Residents will be evaluated for elopement on admission, readmission, quarterly and with a change in conditions. Residents identified by	

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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.

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F 689	Continued From page 1 a safe and secure environment. Residents may be considered missing and or to have eloped if they: d. leave the facility without authorization. 3. Locating the resident. D. Documentation regarding the elopement should be done in the interdisciplinary progress notes. E. An accident/incident form should be completed by a nurse including statements from all involved staff. F. At the next scheduled morning report, safety committee meeting, and QAPI (Quality Assurance and Performance Improvement) meeting the incident should be discussed and root cause analysis of elopement should be identified. 4. An event report should be completed and available for review by the facility Risk Manager. 5. The facility Risk Manager should determine if the event qualifies (according to state guidelines) as an adverse incident then appropriate reporting should be carried out. On at 9:12 a.m., an entrance conference was held with the Administrator and Director of Nursing (DON). The Administrator said there had been no elopements as far as they knew. Review of the clinical record for Resident #1 revealed an admission date of . Diagnoses included Major , , Adjustment with Mixed , and Depressed . The Admission Minimum Data Set (MDS) assessment with a target date of revealed the resident's cognition was severely , with a Score of "07". Resident #1 used a manual wheelchair and was dependent on staff to wheel 50 .	F 689	, , as a for an electric scooter will have an elopement evaluation completed prior to receiving the scooter. Regional Director of Clinical Services reeducated DON regarding completion of a thorough investigation. DON educated , , staff regarding , , to nursing communication for residents receiving , , that are to receive an electric scooter. ADON reeducated current staff regarding identifying residents for risk of elopement. New staff will be educated during orientation. 4) Facility DOR / Designee will conduct a quality review of residents receiving , , for assessment of use of an electric scooter to ensure , , to nursing communication is completed so completion of elopement evaluation can be initiated weekly for 4 weeks then every 2 weeks for 2 months then monthly. Results of these audits will presented to the QAPI committee until the committee determines substantial compliance has been achieved. Facility ADON / Designee will conduct a quality review of 10 residents for completion of elopement evaluation on admission, readmission, quarterly, significant change and prior to approval of electric scooter weekly for 4 weeks then	

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F 689	Continued From page 2 Review of the elopement risk evaluation dated revealed Resident #1 had no and was not at risk for elopement. The care plan initiated on and revised on specified Resident #1 could go on leave of absence with responsible party. Review of the Rehab Speech Screen dated revealed documentation Resident #1 presented with, "baseline speech, language and . Poor participation during eval . . (patient) also stated, "I want out of here." On the Social Worker initiated a care plan indicating Resident #1 had function/ or thought processes related to short term memory loss. Interventions included to cue, reorient and supervise the resident as needed. The elopement evaluation dated noted Resident #1 was and had poor decision-making skills. Resident #1 did not have the ability to leave the facility. The evaluation noted the resident had no exit seeking behaviors and was not at risk of elopement. Review of the progress notes revealed an entry dated that read, "Elopement Risk- guard in place". (Alerts staff when a resident leaves a designated safe area). The progress note did not explain the reason for the alert bracelet. On Resident #1's care plan was updated and noted the resident was an elopement risk/ related to safety awareness. The goal was to maintain the resident's safety. The interventions included	F 689	every 2 weeks for 2 months then monthly. Results of these audits will presented to the QAPI committee until the committee determines substantial compliance has been achieved.	

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F 689	Continued From page 3 checking the placement and function of the alert bracelet. On at 9:53 a.m., in an interview the Maintenance Director said on Assistant Director of Nursing (ADON) Staff B found Resident #1 outside, on the sidewalk near C wing. ADON Staff B notified the Director of Nursing (DON) and followed the resident in her car. He drove the DON in his car and dropped her off a few streets away from where Resident #1 was. The Maintenance Director said the front door opens at 8:00 a.m., and Resident #1 probably went out that door and then around the building. On at 9:55 a.m., in an interview ADON Staff B said on she arrived in the parking lot of the facility at approximately 8:30 a.m. She saw Resident #1 coming out the door located on the side of building by the C wing. The door was open, but she did not hear an alarm going off. When she pulled into the parking space, she realized Resident #1 was leaving the parking lot in his electric scooter. He did not stop and began crossing the road. ADON Staff B said physically she was not able to get to the resident on . She got in her car, called the DON and followed Resident #1 in her car. Resident #1 had crossed the road and was on the sidewalk. He went down the street to the curve by a restaurant, turned right on a street, then left on another street. She said she followed Resident #1 to keep him safe while talking on the phone to the DON. ADON Staff B said she finally got him to stop. She asked him where he was going, and if he had signed out. Resident #1 responded he just wanted to get out for a little while. The DON arrived by car with the Maintenance Director. The	F 689		

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F 689	Continued From page 4	F 689		

DON walked with Resident #1 to the facility. ADON Staff B said she has had training in elopement. To her understanding, an elopement was when a resident is outside the building without staff knowledge. ADON Staff B said Resident #1 exited the facility through a door equipped with a alert alarm. Resident #1 did not have a alarm bracelet; therefore, the door would not have alarmed.

On at 10:53 a.m., in an interview the Maintenance Director said he didn't know if Resident #1 exited the building through the side door. He said the side door has an alarm which he checks the function every day. He said once the alarm is activated, a pass key is needed to turn off the alarm. He said no one told him there was a problem with the alarm of the side door.

On at 10:11 a.m., the C wing door was observed with the Administrator. The Administrator explained the first door can be opened by pushing a green button. The second door can only be opened by punching a code or pressing on the egress bar for 15 seconds. However, when the egress bar releases, it will activate an alarm.

On at 10:40 a.m., in an interview the DON said on at around 8:20 a.m., ADON Staff B called her and said she was watching Resident #1 going down the road. The ADON told her where Resident #1 was. She stayed on the phone with the ADON until she got to where the resident was. The ADON got the resident to stop. She walked him to the facility. The DON said she was not familiar with Resident #1. He said he was getting air. The DON said she verified Resident #1 did not sign out before

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F 689	Continued From page 5	F 689		

leaving the facility. She said Resident #1's scored a "07" on the (a score of 07 or below indicated severe ,). She said Resident #1 had no prior attempt to leave the facility. After the incident, they updated the resident's care plan and initiated a alarm. She said they really did not know through which door the resident exited the building. She spoke to a few staff members at the time of the incident but did not do a formal investigation. She reported the incident to the Regional Nurse since the Administrator was on vacation. She said she did not consider the incident an elopement since ADON Staff B followed the resident in her car the entire time.

On at approximately 10:45 a.m., the side door by the C wing was observed with the DON. The DON pushed the green button and opened the first door. She pushed the egress bar on the second door for approximately 15 seconds. The door opened and the alarm went off. The Minimum Data Set (MDS) nurse responded to the alarm and said the door will continue to alarm until it is turned off with a key.

On at 10:58 a.m., in an interview the Regional Nurse verified the DON notified her when Resident #1 left the facility on . She said no investigation had been done. She did not consider the incident to be an elopement. She said ADON Staff B followed Resident #1 in the car and would have been able to stop him from getting hit by a car or involved in any type of accident.

On at 12:00 p.m., observation of the route taken by Resident #1 on showed the resident crossed two streets and traveled

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F 689	Continued From page 6 approximately 0.3 miles from the facility when ADON Staff B was able to get him to stop. On at 2:25 p.m., in an interview the Speech , said during the first assessment on Resident #1 scored "07" on the . She said it indicated severe , but the resident was not participatory, and it was not a true picture of his cognition. She said he got the electric scooter on , , evaluated him and determined he was safe to use the scooter. Review of the Occupational , progress note dated revealed documentation the resident needed distant supervision with use of personal power wheelchair in facility and outside of facility on sidewalk and sitting areas. The resident has been instructed each session on safety rules and facility protocols with resident knowing he is not allowed in parking lot or off facility grounds. Overall it is recommended resident be distant supervision with use of personal power chair in order to provide the resident with as much independence during the day as possible. On at 3:50 p.m., in a telephone interview the , Advanced Practice Registered Nurse (APRN) said she had seen and assessed Resident #1. She said Resident #1's cognition was not that great, and he was "child-like". He was not able to be on his own and leave the facility on his own. On at 4:40 p.m., a meeting was held with the Administrator, the DON and the Regional Nurse. The DON verified Resident #1's cognition was severely , and verified an elopement	F 689		

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F 689	Continued From page 7 evaluation was not done when the resident started using the electric scooter. The Administrator said Resident #1 could have left through the front door and proceeded around the building, but they did not know and did not investigate. He said they would look into the incident and develop a plan to prevent further occurrences.	F 689		