

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>686123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>06/16/2025</b>
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NAME OF PROVIDER OR SUPPLIER <b>KENDALL LAKES HEALTHCARE AND REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5280 SW 157 AVENUE , MIAMI, Florida, 33185</b>
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F0000	INITIAL COMMENTS  An unannounced complaint survey for complaint number 2025004883 was conducted on June 16, 2025 at Kendall Lakes Healthcare and Rehabilitation Center. The allegation was substantiated. The facility was not in compliance with CFR 42 Part 483 Requirements for Long-Term Care Facilities.  The following is a description of the non-compliance	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices  CFR(a): 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 observation, record review an interviews, the facility failed to provide adequate supervision for one (Resident #1) out of three residents sampled for elopement; as evidenced by on 04/05/2025 Resident #1 a vulnerable resident left the facility undetected through the facility's first floor exit/entrance door; Resident #1 was found on the sidewalk several blocks from the facility by the local law enforcement and returned to the facility within twenty (20) minutes after last seen in the facility by staff. There were 139 residents residing in the facility at the time of the survey.  The findings included:	F0689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.  F689 Free of Accident Hazards/Supervision/Devices  (a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  On 06/17/2025, the Director of Nursing re-educated Staff B, C, and D on the components of this regulation and the facility's Safety and Supervision of Residents & Accidents and Incidents – Investigating and Reporting policies with an emphasis on adequate supervision and safety.  (b) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;  On 04/05/2025, a Quality Review audit was completed on all residents, no new residents were identified as at risk for elopement. All residents already identified at risk for elopement were checked for wander guard placement and proper functioning.	07/16/2025

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 reverse for further 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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F0689 SS = D	<p>Continued from page 1 The facility's location is in a residential neighborhood with busy cross streets and close to a shopping plaza located 0.1 mile from the facility.</p> <p>The temperature on 04/05/2025 was 88 degrees Fahrenheit. according to <a href="https://www.accuweather.com">https://www.accuweather.com</a>.</p> <p>Review of the facility policy titled "Eloements" revision date 12/2002 states: Staff shall investigate and report on all cases of missing residents.</p> <p>Policy Interpretation and Implementation</p> <p>1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.</p> <p>a. If an employee observes a resident leaving the premises, he/she should:</p> <p>b. Attempt to prevent the departure in a courteous manner.</p> <p>c. Get help from other staff members in the immediate vicinity, if necessary, and instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.</p> <p>Review of the facility policy titled "Accidents and Incidents - Investigating and Reporting" revision date 07/2017 states: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>Record review of the Abuse/Neglect Log from January 2025 to June 2025 revealed the incident occurred on 04/05/25 at 11:39 AM.</p> <p>Record review of the Incident note dated 04/05/25 timestamped 12:20 PM documented: [Resident #1] is alert and oriented x (times) three (3), able to walk, has been admitted since 03/21/2025, today was observed by Police officers near a couple blocks away from</p>	F0689	<p>Continued from page 1</p> <p>By 06/25/2025, all current residents were re-evaluated for changes in conditions or risk factors that may pose a risk for a potential accident.</p> <p>Any issues or concerns were immediately addressed, interventions and care plans revised, as needed. No further discrepancies were observed.</p> <p>All new residents will be assessed for potential accidents upon admission.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>By 04/05/2025, Director of Nursing/designee reviewed and updated elopement binders; ensured binders were current and placed at each nursing station, therapy department, activity department, kitchen, &amp; front desk. Elopement binders updated when necessary.</p> <p>By 04/05/2025, Maintenance Director/designee checked all exit doors for proper functioning to include transponder for wander guard system. Daily audit of doors for proper functioning completed for three days, followed by weekly audits.</p> <p>On 04/05/2025, Clinical Educator/designee initiated education of all staff on the facility's Elopement standard and guidelines, ANEMMI with an emphasis on Neglect, Alarm Response, and Wander Guard placement and functioning. Newly hired staff will receive this education during orientation. Education continues monthly.</p> <p>On 04/05/2025, Clinical Educator/designee initiated elopement drills for all staff participation. Drills will be completed on each shift, will then move to monthly rotating each shift.</p> <p>On 04/05/2025, a single point of entry was set up at the front doors in the reception area. The front doors were set to remain locked at all times. To gain access, any non-employee will need to ring the doorbell for entry. Once inside, every non-employee must sign in</p>	

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F0689 SS = D	<p>Continued from page 2 facility. The resident was able to provide information about being admitted for therapy and gave them his daughter's phone number. Police officer called facility and let the nurse know that they were going to bring the patient back, as patient knew where he resided. Resident stated that he walked to the therapy department and spoke to the therapist to get some information about therapy scheduled for today. Therapist denied patient having any therapy sessions scheduled for today and resident decided to leave the facility. Assessment was performed, patient able to answer every question asked, very pleasant, no signs of psychological/emotional distress, no injury or skin impairment, vital signs within normal limits. Denies any pain or discomfort. Resident's physician and patient's daughter were made aware.</p> <p>Record review of the nurses' progress note on 04/05/25 timestamped 13:51 (1:51 PM) Documented: Patient has been closely monitored, no signs of any changes on patient state of mind and functioning. Education was provided regarding sign out procedures, also new interventions discussed with patient and daughter. Resident able to make his own decisions, Patient states that he is forgetful at times, and he forget to let the nurse know that he wanted to go out. Resident requested a form that he can use to not occur this episode again. [wander alert device] discussed, patient asked and agreed to use it as a sign to let the nurse know when he is walking around exits doors. Daughter and son-in-law also agreed. [wander alert device] placed. Psychiatric evaluation also was done by Telehealth. Brief Interview for Mental status Score (BIMS) evaluation done. Resident was moved to a room near the nurses' station. Will continue with plan of care.</p> <p>Review of the medical records for Resident #1 revealed the resident was admitted to the facility on 03/21/25. Clinical diagnoses included but not limited to: Hypertensive Heart Disease without Heart Failure. Resident #1 was discharged from the facility on 04/18/25 to an Assistant Living Facility.</p> <p>Review of Resident #1's Physician's Orders Sheet for April 2025 orders included but not limited to: 04/05/25 to 04/18/25- [wander alert device] in place-every shift Monitor for placement and functioning. Per Resident and Resident Representative request, resident will transfer to an Assistant Living Facility. 04/18/25- Psychiatrist Evaluation.</p>	F0689	<p>Continued from page 2 into the visitor's log. Everyone leaving the building must do so from the front door and be let out by the receptionist or be escorted out by a staff member with a fob. Single point of entry and these entry and exit procedures continue to be in place.</p> <p>On 04/05/2025, Administrator/designee initiated QAPI Plan with Interdisciplinary Team, including Medical Director, participation on safety with a focus on elopement. Reviewed during QA Meeting on 04/08/2025.</p> <p>On 04/07/2025, Director of Nursing/designee began daily clinical review of new admissions/re-admissions and change in condition that may require increased supervision and/or risk for elopement evaluation. Admission and re-admission reviews continue during daily clinical meetings (Monday through Friday).</p> <p>On 04/07/2025, Maintenance Director/designee placed a Red Box/ Exit Door Alarm on every exit door to notify personnel of any unauthorized entry/exit attempts on emergency exit doors.</p> <p>By 07/16/2025, all employees will be re-educated by the Clinical educator/designee on the components of this regulation and the facility's Safety and Supervision of Residents &amp; Accidents and Incidents – Investigating and Reporting policies with an emphasis on adequate supervision and safety. Newly hired employees will receive education during orientation.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:</p> <p>The Administrator/designee will conduct a weekly Quality Review audit of residents x 4 weeks, and then every 2 weeks x 2 months to ensure compliance that supervision is adequate and interventions are appropriate, when necessary.</p> <p>Findings will be reported at the monthly QA/Risk Management meeting of these Quality Reviews will be reported until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Regional Director of Clinical Operations/designee when completing their</p>	

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F0689 SS = D	<p>Continued from page 3</p> <p>Record review of Resident #1 's Admission Minimum Data Set (MDS) dated 03/28/25 revealed the resident is cognitively intact. no exhibited no behaviors, for Functional Abilities the resident required partial assistance to walk 10 feet; the resident was receiving antipsychotic, antidepressant, and Antiplatelet medications and no physical restraints or alarms used.</p> <p>Record review of Resident #1's Care Plans Reference Date 04/05/25 revealed: Resident has determined a risk for elopement due to: had an episode of Elopement on 04/05/2025, wanders the unit and wanders near exit doors, ambulates with no devices, had expressed desire to leave. Resident will remain safe and will refrain from leaving facility unsupervised through the next review date. Date Initiated: 04/05/2025. Interventions include-Educate resident / responsible party regarding sign out procedures as needed. Encourage resident to participate in activities of choice, provide one-to-one supervision as needed. Include resident in Elopement Book. Nursing assessment to identify any changes in condition, physically/ mentally/Psychologically. Perform elopement assessments. Perform frequent observations of resident whereabouts every shift. Provide redirection, when observed going towards exit doors. A Psychiatrist evaluation to determine BIMS score, and Psychosocial/Mental distress. Room changed near to nurses' station. Update physician and responsible party if resident elopes. [wander alert device] in place as per resident request. Check placement and functioning every shift.</p> <p>Interview on 06/16/25 at 11:57 AM Certified Nursing Assistant (CNA), (Staff B) via telephone and Spanish Translator revealed on 04/05/2025 she was assigned to Resident #1 she remember giving the resident breakfast, he was given a shower with assistance, supervised the resident dressing himself and then he left his room to go to activities. "The last time I saw the resident before the elopement incident was around 11:15 AM in the common room in front of the nursing station on the 500 unit. I was told the resident was missing around 11:30 AM by the Registered Nurse (RN), nursing supervisor (Staff C) that stated the police department found the resident outside the facility. I was at work when the resident was returned to the facility, the resident appeared normal and was in very good condition."</p> <p>Interview on 06/16/25 at 12:06 PM Registered Nurse</p>	F0689	<p>Continued from page 3</p> <p>Quality Systems Review to maintain compliance.</p>	

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F0689 SS = D	<p>Continued from page 4</p> <p>(RN), Unit Supervisor (Staff C), via telephone with Spanish translator revealed: "On 04/05/25 I was the supervisor in charge of the facility, I received a call from the local police department around mid-morning stating they found one of the facility's residents on the sidewalk down the street and will be bringing the resident back to the facility. They were able to identify the resident from the bracelet he had on. The police department stated [Resident #1] was alert but slightly confused. After the phone call with the police department, I checked with the resident's assigned Licensed Practical Nurse (LPN), (Staff D) and CNA (Staff B), they both stated they saw the resident approximately 20-30 minutes ago. At approximately 11:40 AM, I received the resident at the entrance of the facility from the police officers, the resident appeared calm and was alert and oriented to person and place. [Resident#1] was assessed, there were no physical injuries or mental distress noted, [Resident #1] was returned to his room, the Director of Nursing (DON) and Administrator (NHA) were notified after the call from the police department and before the resident was returned to the facility."</p> <p>Interview on 06/16/25 at 12:16 PM via telephone, Licensed Practical Nurse (Staff D) stated: "I was the assigned nurse for [Resident #1] on 04/05/25 the day of the elopement incident. Around 11:00 AM was the last time I saw the resident in the facility." Staff D revealed the supervisor notified her 20 minutes later that the police department reported they found the resident and was returning him to the facility. "On the resident's return to the facility, I assessed the resident, he was alert and oriented, his vital signs were stable, and the resident stated he was trying to go home. I check on my residents at least every hour to an hour and a half to make sure all my residents are doing well during my shift."</p> <p>On 06/16/25 at 12:25 PM, the Administrator (NHA) revealed the Director of Nursing (DON) is the person who conducted the investigation and is currently on vacation. "I was informed of all the details of the investigation. I was notified by the DON around 12 noon on 04/05/25 that one of our residents was observed walking on the sidewalk outside of the facility and was returned by the police department. I was informed that the resident was alert and had a Brief Interview for mental status (BIMS) score of 14, he was calm, no injuries or areas of concern, and appeared to be in no physical or emotional distress. We notified the resident's physician, family, and psychiatrist who was</p>	F0689		

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F0689 SS = D	Continued from page 5 able to do a telehealth assessment of the resident on 04/05/25. A [wander alert system] was put in place on 04/05/25 with the resident and family consent. The resident and family were educated on how the [wander alert device] works. All residents with [wander alert devices] were checked for placement, function and active orders, all doors were checked to make sure the wander guard system was in place and working correctly, a head count was completed, all other residents were accounted for in the building. Elopement drills and education were completed immediately with all staff. New hires have been educated upon hire about elopement, elopement drills and code pink for elopement. There is an elopement binder at each nursing station, in the therapy Department, activity department and the reception desk. The elopement binder consists of a photograph of the residents at risk for elopement and their face sheets. We have implemented a lock down of the front entrance/exit door, which is now the only point of entry and put in place the visitor sign in sheet-every visitor that enters the building has to sign in, staff can use their identification badge to enter the building using the electronic door opening system and visitors have to ring the bell to be seen on the camera, in order to be granted access into the facility by the front desk staff. To leave the facility visitors must notify the reception staff to open the door to exit out of the facility or a staff member can escort the visitor to the front door and open the front door using their ID (identification) badge to access the electronic door opening system."	F0689		

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N0000	INITIAL COMMENTS  An unannounced survey for complaint number 2025004883 was conducted on June 16, 2025 at Kendall Lakes Healthcare and Rehabilitation Center. The facility had deficiencies at the time of the survey.  The following is a description of the non-compliance	N0000		
N0110 SS = D	Physical Environment - Safe, Clean, Homelike  CFR(a): 400.141(1)(h) FS: 59A-4.122(1) FAC  400.141(1)(h) FS  Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.  59A-4.122(1) FAC  The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible  This LICENSURE REQUIREMENT is NOT MET as evidenced by:  Based on observation, record review an interviews, the facility failed to provide adequate supervision for one (Resident #1) out of three residents sampled for elopement; as evidenced by on 04/05/2025 Resident #1 a vulnerable resident left the facility undetected through the facility's first floor exit/entrance door; Resident #1 was found on the sidewalk several blocks from the facility by the local law enforcement and returned to the facility within twenty (20) minutes after last seen in the facility by staff. There were 139 residents residing in the facility at the time of the survey.  The findings included:	N0110	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.  N110 FAC Physical Environment – Safe, Clean, Homelike  (a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  On 06/17/2025, the Director of Nursing re-educated Staff B, C, and D on the components of this regulation and the facility's Safety and Supervision of Residents & Accidents and Incidents – Investigating and Reporting policies with an emphasis on adequate supervision and safety.  (b) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;  On 04/05/2025, a Quality Review audit was completed on all residents, no new residents were identified as at risk for elopement.  By 06/25/2025, all current residents were re-evaluated	07/16/2025

Office of Primary Care and Health Systems Management

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N0110 SS = D	<p>Continued from page 4</p> <p>Interview on 06/16/25 at 12:06 PM Registered Nurse (RN), Unit Supervisor (Staff C), via telephone with Spanish translator revealed: "On 04/05/25 I was the supervisor in charge of the facility, I received a call from the local police department around mid-morning stating they found one of the facility's residents on the sidewalk down the street and will be bringing the resident back to the facility. They were able to identify the resident from the bracelet he had on. The police department stated [Resident #1] was alert but slightly confused. After the phone call with the police department, I checked with the resident's assigned Licensed Practical Nurse (LPN), (Staff D) and CNA (Staff B), they both stated they saw the resident approximately 20-30 minutes ago. At approximately 11:40 AM, I received the resident at the entrance of the facility from the police officers, the resident appeared calm and was alert and oriented to person and place. [Resident#1] was assessed, there were no physical injuries or mental distress noted. [Resident #1] was returned to his room, the Director of Nursing (DON) and Administrator (NHA) were notified after the call from the police department and before the resident was returned to the facility."</p> <p>Interview on 06/16/25 at 12:16 PM via telephone, Licensed Practical Nurse (Staff D) stated: "I was the assigned nurse for [Resident #1] on 04/05/25 the day of the elopement incident. Around 11:00 AM was the last time I saw the resident in the facility." Staff D revealed the supervisor notified her 20 minutes later that the police department reported they found the resident and was returning him to the facility. "On the resident's return to the facility, I assessed the resident, he was alert and oriented, his vital signs were stable, and the resident stated he was trying to go home. I check on my residents at least every hour to an hour and a half to make sure all my residents are doing well during my shift."</p> <p>On 06/16/25 at 12:25 PM, the Administrator (NHA) revealed the Director of Nursing (DON) is the person who conducted the investigation and is currently on vacation. "I was informed of all the details of the investigation. I was notified by the DON around 12 noon on 04/05/25 that one of our residents was observed walking on the sidewalk outside of the facility and was returned by the police department. I was informed that the resident was alert and had a Brief Interview for mental status (BIMS) score of 14, he was calm, no injuries or areas of concern, and appeared to be in no physical or emotional distress. We notified the</p>	N0110		

Florida State Department of Health

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N0110 SS = D	<p>Continued from page 5 resident's physician, family, and psychiatrist who was able to do a telehealth assessment of the resident on 04/05/25. A [wander alert system] was put in place on 04/05/25 with the resident and family consent. The resident and family were educated on how the [wander alert device] works. All residents with [wander alert devices] were checked for placement, function and active orders, all doors were checked to make sure the wander guard system was in place and working correctly, a head count was completed, all other residents were accounted for in the building. Elopement drills and education were completed immediately with all staff. New hires have been educated upon hire about elopement, elopement drills and code pink for elopement. There is an elopement binder at each nursing station, in the therapy Department, activity department and the reception desk. The elopement binder consists of a photograph of the residents at risk for elopement and their face sheets. We have implemented a lock down of the front entrance/exit door, which is now the only point of entry and put in place the visitor sign in sheet-every visitor that enters the building has to sign in, staff can use their identification badge to enter the building using the electronic door opening system and visitors have to ring the bell to be seen on the camera, in order to be granted access into the facility by the front desk staff. To leave the facility visitors must notify the reception staff to open the door to exit out of the facility or a staff member can escort the visitor to the front door and open the front door using their ID (identification) badge to access the electronic door opening system."</p> <p>Class III</p>	N0110		

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N0000	INITIAL COMMENTS  An unannounced survey for complaint number 2025004883 was conducted on June 16, 2025 at Kendall Lakes Healthcare and Rehabilitation Center. The facility had deficiencies at the time of the survey.  The following is a description of the non-compliance	N0000		
N0110 SS = D	Physical Environment - Safe, Clean, Homelike  CFR(a): 400.141(1)(h) FS: 59A-4.122(1) FAC  400.141(1)(h) FS  Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.  59A-4.122(1) FAC  The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible  This LICENSURE REQUIREMENT is NOT MET as evidenced by:  Based on observation, record review an interviews, the facility failed to provide adequate supervision for one (Resident #1) out of three residents sampled for elopement; as evidenced by on 04/05/2025 Resident #1 a vulnerable resident left the facility undetected through the facility's first floor exit/entrance door; Resident #1 was found on the sidewalk several blocks from the facility by the local law enforcement and returned to the facility within twenty (20) minutes after last seen in the facility by staff. There were 139 residents residing in the facility at the time of the survey.  The findings included:	N0110	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.  N110 FAC Physical Environment – Safe, Clean, Homelike  (a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  On 06/17/2025, the Director of Nursing re-educated Staff B, C, and D on the components of this regulation and the facility's Safety and Supervision of Residents & Accidents and Incidents – Investigating and Reporting policies with an emphasis on adequate supervision and safety.  (b) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;  On 04/05/2025, a Quality Review audit was completed on all residents, no new residents were identified as at risk for elopement.  By 06/25/2025, all current residents were re-evaluated	07/17/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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N0110 SS = D	<p>Continued from page 1</p> <p>The facility's location is in a residential neighborhood with busy cross streets and close to a shopping plaza located 0.1 mile from the facility.</p> <p>The temperature on 04/05/2025 was 88 degrees Fahrenheit, according to <a href="https://www.accuweather.com">https://www.accuweather.com</a>.</p> <p>Review of the facility policy titled "Elopements" revision date 12/2002 states: Staff shall investigate and report on all cases of missing residents.</p> <p>Policy Interpretation and Implementation</p> <p>1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.</p> <p>a. If an employee observes a resident leaving the premises, he/she should:</p> <p>b. Attempt to prevent the departure in a courteous manner.</p> <p>c. Get help from other staff members in the immediate vicinity, if necessary, and instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.</p> <p>Review of the facility policy titled "Accidents and Incidents - Investigating and Reporting" revision date 07/2017 states: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>Record review of the Abuse/Neglect Log from January 2025 to June 2025 revealed the incident occurred on 04/05/25 at 11:39 AM.</p> <p>Record review of the Incident note dated 04/05/25 timestamped 12:20 PM documented: [Resident #1] is alert and oriented x (times) three (3), able to walk, has been admitted since 03/21/2025, today was observed by</p>	N0110	<p>Continued from page 1 for changes in conditions or risk factors that may pose a risk for a potential accident.</p> <p>Any issues or concerns were immediately addressed, interventions and care plans revised, as needed. No further discrepancies were observed.</p> <p>All new residents will be assessed for potential accidents upon admission.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>By 04/05/2025, Director of Nursing/designee reviewed and updated elopement binders; ensured binders were current and placed at each nursing station, therapy department, activity department, kitchen, &amp; front desk. Elopement binders updated when necessary.</p> <p>By 04/05/2025, Maintenance Director/designee checked all exit doors for proper functioning to include transponder for wander guard system. Daily audit of doors for proper functioning completed for three days, followed by weekly audits.</p> <p>On 04/05/2025, Clinical Educator/designee initiated education of all staff on the facility's Elopement standard and guidelines, ANEMMI with an emphasis on Neglect, Alarm Response, and Wander Guard placement and functioning. Newly hired staff will receive this education during orientation. Education continues monthly.</p> <p>On 04/05/2025, Clinical Educator/designee initiated elopement drills for all staff participation. Drills will be completed on each shift, will then move to monthly rotating each shift.</p> <p>On 04/05/2025, a single point of entry was set up at the front doors in the reception area. The front doors were set to remain locked at all times. To gain access, any non-employee will need to ring the doorbell for entry. Once inside, every non-employee must sign in into the visitor's log. Everyone leaving the building must do so from the front door and be let out by the</p>	

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N0110 SS = D	<p>Continued from page 4</p> <p>Interview on 06/16/25 at 12:06 PM Registered Nurse (RN), Unit Supervisor (Staff C), via telephone with Spanish translator revealed: "On 04/05/25 I was the supervisor in charge of the facility, I received a call from the local police department around mid-morning stating they found one of the facility's residents on the sidewalk down the street and will be bringing the resident back to the facility. They were able to identify the resident from the bracelet he had on. The police department stated [Resident #1] was alert but slightly confused. After the phone call with the police department, I checked with the resident's assigned Licensed Practical Nurse (LPN), (Staff D) and CNA (Staff B), they both stated they saw the resident approximately 20-30 minutes ago. At approximately 11:40 AM, I received the resident at the entrance of the facility from the police officers, the resident appeared calm and was alert and oriented to person and place. [Resident#1] was assessed, there were no physical injuries or mental distress noted. [Resident #1] was returned to his room, the Director of Nursing (DON) and Administrator (NHA) were notified after the call from the police department and before the resident was returned to the facility."</p> <p>Interview on 06/16/25 at 12:16 PM via telephone, Licensed Practical Nurse (Staff D) stated: "I was the assigned nurse for [Resident #1] on 04/05/25 the day of the elopement incident. Around 11:00 AM was the last time I saw the resident in the facility." Staff D revealed the supervisor notified her 20 minutes later that the police department reported they found the resident and was returning him to the facility. "On the resident's return to the facility, I assessed the resident, he was alert and oriented, his vital signs were stable, and the resident stated he was trying to go home. I check on my residents at least every hour to an hour and a half to make sure all my residents are doing well during my shift."</p> <p>On 06/16/25 at 12:25 PM, the Administrator (NHA) revealed the Director of Nursing (DON) is the person who conducted the investigation and is currently on vacation. "I was informed of all the details of the investigation. I was notified by the DON around 12 noon on 04/05/25 that one of our residents was observed walking on the sidewalk outside of the facility and was returned by the police department. I was informed that the resident was alert and had a Brief Interview for mental status (BIMS) score of 14, he was calm, no injuries or areas of concern, and appeared to be in no physical or emotional distress. We notified the</p>	N0110		

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N0110 SS = D	<p>Continued from page 5</p> <p>resident's physician, family, and psychiatrist who was able to do a telehealth assessment of the resident on 04/05/25. A [wander alert system] was put in place on 04/05/25 with the resident and family consent. The resident and family were educated on how the [wander alert device] works. All residents with [wander alert devices] were checked for placement, function and active orders, all doors were checked to make sure the wander guard system was in place and working correctly, a head count was completed, all other residents were accounted for in the building. Elopement drills and education were completed immediately with all staff. New hires have been educated upon hire about elopement, elopement drills and code pink for elopement. There is an elopement binder at each nursing station, in the therapy Department, activity department and the reception desk. The elopement binder consists of a photograph of the residents at risk for elopement and their face sheets. We have implemented a lock down of the front entrance/exit door, which is now the only point of entry and put in place the visitor sign in sheet-every visitor that enters the building has to sign in, staff can use their identification badge to enter the building using the electronic door opening system and visitors have to ring the bell to be seen on the camera, in order to be granted access into the facility by the front desk staff. To leave the facility visitors must notify the reception staff to open the door to exit out of the facility or a staff member can escort the visitor to the front door and open the front door using their ID (identification) badge to access the electronic door opening system."</p> <p>Class III</p>	N0110		

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F0000	INITIAL COMMENTS  An unannounced complaint survey for complaint number 2025004883 was conducted on June 16, 2025 at Kendall Lakes Healthcare and Rehabilitation Center. The allegation was substantiated. The facility was not in compliance with CFR 42 Part 483 Requirements for Long-Term Care Facilities.  The following is a description of the non-compliance	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices  CFR(a): 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 observation, record review an interviews, the facility failed to provide adequate supervision for one (Resident #1) out of three residents sampled for elopement; as evidenced by on 04/05/2025 Resident #1 a vulnerable resident left the facility undetected through the facility's first floor exit/entrance door; Resident #1 was found on the sidewalk several blocks from the facility by the local law enforcement and returned to the facility within twenty (20) minutes after last seen in the facility by staff. There were 139 residents residing in the facility at the time of the survey.  The findings included:	F0689	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.  F689 Free of Accident Hazards/Supervision/Devices  (a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  On 06/17/2025, the Director of Nursing re-educated Staff B, C, and D on the components of this regulation and the facility's Safety and Supervision of Residents & Accidents and Incidents – Investigating and Reporting policies with an emphasis on adequate supervision and safety.  (b) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;  On 04/05/2025, a Quality Review audit was completed on all residents, no new residents were identified as at risk for elopement. All residents already identified at risk for elopement were checked for wander guard placement and proper functioning.	07/17/2025

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 reverse for further 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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F0689 SS = D	<p>Continued from page 1 The facility's location is in a residential neighborhood with busy cross streets and close to a shopping plaza located 0.1 mile from the facility.</p> <p>The temperature on 04/05/2025 was 88 degrees Fahrenheit. according to <a href="https://www.accuweather.com">https://www.accuweather.com</a>.</p> <p>Review of the facility policy titled "Eloplacements" revision date 12/2002 states: Staff shall investigate and report on all cases of missing residents.</p> <p>Policy Interpretation and Implementation</p> <p>1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.</p> <p>a. If an employee observes a resident leaving the premises, he/she should:</p> <p>b. Attempt to prevent the departure in a courteous manner.</p> <p>c. Get help from other staff members in the immediate vicinity, if necessary, and instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.</p> <p>Review of the facility policy titled "Accidents and Incidents - Investigating and Reporting" revision date 07/2017 states: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>Record review of the Abuse/Neglect Log from January 2025 to June 2025 revealed the incident occurred on 04/05/25 at 11:39 AM.</p> <p>Record review of the Incident note dated 04/05/25 timestamped 12:20 PM documented: [Resident #1] is alert and oriented x (times) three (3), able to walk, has been admitted since 03/21/2025, today was observed by Police officers near a couple blocks away from</p>	F0689	<p>Continued from page 1</p> <p>By 06/25/2025, all current residents were re-evaluated for changes in conditions or risk factors that may pose a risk for a potential accident.</p> <p>Any issues or concerns were immediately addressed, interventions and care plans revised, as needed. No further discrepancies were observed.</p> <p>All new residents will be assessed for potential accidents upon admission.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>By 04/05/2025, Director of Nursing/designee reviewed and updated elopement binders; ensured binders were current and placed at each nursing station, therapy department, activity department, kitchen, &amp; front desk. Elopement binders updated when necessary.</p> <p>By 04/05/2025, Maintenance Director/designee checked all exit doors for proper functioning to include transponder for wander guard system. Daily audit of doors for proper functioning completed for three days, followed by weekly audits.</p> <p>On 04/05/2025, Clinical Educator/designee initiated education of all staff on the facility's Elopement standard and guidelines, ANEMMI with an emphasis on Neglect, Alarm Response, and Wander Guard placement and functioning. Newly hired staff will receive this education during orientation. Education continues monthly.</p> <p>On 04/05/2025, Clinical Educator/designee initiated elopement drills for all staff participation. Drills will be completed on each shift, will then move to monthly rotating each shift.</p> <p>On 04/05/2025, a single point of entry was set up at the front doors in the reception area. The front doors were set to remain locked at all times. To gain access, any non-employee will need to ring the doorbell for entry. Once inside, every non-employee must sign in</p>	

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F0689 SS = D	<p>Continued from page 2 facility. The resident was able to provide information about being admitted for therapy and gave them his daughter's phone number. Police officer called facility and let the nurse know that they were going to bring the patient back, as patient knew where he resided. Resident stated that he walked to the therapy department and spoke to the therapist to get some information about therapy scheduled for today. Therapist denied patient having any therapy sessions scheduled for today and resident decided to leave the facility. Assessment was performed, patient able to answer every question asked, very pleasant, no signs of psychological/emotional distress, no injury or skin impairment, vital signs within normal limits. Denies any pain or discomfort. Resident's physician and patient's daughter were made aware.</p> <p>Record review of the nurses' progress note on 04/05/25 timestamped 13:51 (1:51 PM) Documented: Patient has been closely monitored, no signs of any changes on patient state of mind and functioning. Education was provided regarding sign out procedures, also new interventions discussed with patient and daughter. Resident able to make his own decisions, Patient states that he is forgetful at times, and he forget to let the nurse know that he wanted to go out. Resident requested a form that he can use to not occur this episode again. [wander alert device] discussed, patient asked and agreed to use it as a sign to let the nurse know when he is walking around exits doors. Daughter and son-in-law also agreed. [wander alert device] placed. Psychiatric evaluation also was done by Telehealth. Brief Interview for Mental status Score (BIMS) evaluation done. Resident was moved to a room near the nurses' station. Will continue with plan of care.</p> <p>Review of the medical records for Resident #1 revealed the resident was admitted to the facility on 03/21/25. Clinical diagnoses included but not limited to: Hypertensive Heart Disease without Heart Failure. Resident #1 was discharged from the facility on 04/18/25 to an Assistant Living Facility.</p> <p>Review of Resident #1's Physician's Orders Sheet for April 2025 orders included but not limited to: 04/05/25 to 04/18/25- [wander alert device] in place-every shift Monitor for placement and functioning. Per Resident and Resident Representative request, resident will transfer to an Assistant Living Facility. 04/18/25- Psychiatrist Evaluation.</p>	F0689	<p>Continued from page 2 into the visitor's log. Everyone leaving the building must do so from the front door and be let out by the receptionist or be escorted out by a staff member with a fob. Single point of entry and these entry and exit procedures continue to be in place.</p> <p>On 04/05/2025, Administrator/designee initiated QAPI Plan with Interdisciplinary Team, including Medical Director, participation on safety with a focus on elopement. Reviewed during QA Meeting on 04/08/2025.</p> <p>On 04/07/2025, Director of Nursing/designee began daily clinical review of new admissions/re-admissions and change in condition that may require increased supervision and/or risk for elopement evaluation. Admission and re-admission reviews continue during daily clinical meetings (Monday through Friday).</p> <p>On 04/07/2025, Maintenance Director/designee placed a Red Box/ Exit Door Alarm on every exit door to notify personnel of any unauthorized entry/exit attempts on emergency exit doors.</p> <p>By 07/16/2025, all employees will be re-educated by the Clinical educator/designee on the components of this regulation and the facility's Safety and Supervision of Residents &amp; Accidents and Incidents – Investigating and Reporting policies with an emphasis on adequate supervision and safety. Newly hired employees will receive education during orientation.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place:</p> <p>The Administrator/designee will conduct a weekly Quality Review audit of residents x 4 weeks, and then every 2 weeks x 2 months to ensure compliance that supervision is adequate and interventions are appropriate, when necessary.</p> <p>Findings will be reported at the monthly QA/Risk Management meeting of these Quality Reviews will be reported until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Regional Director of Clinical Operations/designee when completing their</p>	

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F0689 SS = D	<p>Continued from page 3</p> <p>Record review of Resident #1 's Admission Minimum Data Set (MDS) dated 03/28/25 revealed the resident is cognitively intact. no exhibited no behaviors, for Functional Abilities the resident required partial assistance to walk 10 feet; the resident was receiving antipsychotic, antidepressant, and Antiplatelet medications and no physical restraints or alarms used.</p> <p>Record review of Resident #1's Care Plans Reference Date 04/05/25 revealed: Resident has determined a risk for elopement due to: had an episode of Elopement on 04/05/2025, wanders the unit and wanders near exit doors, ambulates with no devices, had expressed desire to leave. Resident will remain safe and will refrain from leaving facility unsupervised through the next review date. Date Initiated: 04/05/2025. Interventions include-Educate resident / responsible party regarding sign out procedures as needed. Encourage resident to participate in activities of choice, provide one-to-one supervision as needed. Include resident in Elopement Book. Nursing assessment to identify any changes in condition, physically/ mentally/Psychologically. Perform elopement assessments. Perform frequent observations of resident whereabouts every shift. Provide redirection, when observed going towards exit doors. A Psychiatrist evaluation to determine BIMS score, and Psychosocial/Mental distress. Room changed near to nurses' station. Update physician and responsible party if resident elopes. [wander alert device] in place as per resident request. Check placement and functioning every shift.</p> <p>Interview on 06/16/25 at 11:57 AM Certified Nursing Assistant (CNA), (Staff B) via telephone and Spanish Translator revealed on 04/05/2025 she was assigned to Resident #1 she remember giving the resident breakfast, he was given a shower with assistance, supervised the resident dressing himself and then he left his room to go to activities. "The last time I saw the resident before the elopement incident was around 11:15 AM in the common room in front of the nursing station on the 500 unit. I was told the resident was missing around 11:30 AM by the Registered Nurse (RN), nursing supervisor (Staff C) that stated the police department found the resident outside the facility. I was at work when the resident was returned to the facility, the resident appeared normal and was in very good condition."</p> <p>Interview on 06/16/25 at 12:06 PM Registered Nurse</p>	F0689	<p>Continued from page 3</p> <p>Quality Systems Review to maintain compliance.</p>	

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F0689 SS = D	<p>Continued from page 4</p> <p>(RN), Unit Supervisor (Staff C), via telephone with Spanish translator revealed: "On 04/05/25 I was the supervisor in charge of the facility, I received a call from the local police department around mid-morning stating they found one of the facility's residents on the sidewalk down the street and will be bringing the resident back to the facility. They were able to identify the resident from the bracelet he had on. The police department stated [Resident #1] was alert but slightly confused. After the phone call with the police department, I checked with the resident's assigned Licensed Practical Nurse (LPN), (Staff D) and CNA (Staff B), they both stated they saw the resident approximately 20-30 minutes ago. At approximately 11:40 AM, I received the resident at the entrance of the facility from the police officers, the resident appeared calm and was alert and oriented to person and place. [Resident#1] was assessed, there were no physical injuries or mental distress noted, [Resident #1] was returned to his room, the Director of Nursing (DON) and Administrator (NHA) were notified after the call from the police department and before the resident was returned to the facility."</p> <p>Interview on 06/16/25 at 12:16 PM via telephone, Licensed Practical Nurse (Staff D) stated: "I was the assigned nurse for [Resident #1] on 04/05/25 the day of the elopement incident. Around 11:00 AM was the last time I saw the resident in the facility." Staff D revealed the supervisor notified her 20 minutes later that the police department reported they found the resident and was returning him to the facility. "On the resident's return to the facility, I assessed the resident, he was alert and oriented, his vital signs were stable, and the resident stated he was trying to go home. I check on my residents at least every hour to an hour and a half to make sure all my residents are doing well during my shift."</p> <p>On 06/16/25 at 12:25 PM, the Administrator (NHA) revealed the Director of Nursing (DON) is the person who conducted the investigation and is currently on vacation. "I was informed of all the details of the investigation. I was notified by the DON around 12 noon on 04/05/25 that one of our residents was observed walking on the sidewalk outside of the facility and was returned by the police department. I was informed that the resident was alert and had a Brief Interview for mental status (BIMS) score of 14, he was calm, no injuries or areas of concern, and appeared to be in no physical or emotional distress. We notified the resident's physician, family, and psychiatrist who was</p>	F0689		

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