STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106029	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE MARY HEALTH AND REHABILITATION CENTER	710 NORTH SUN DRIVE LAKE MARY, FL 32746

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 -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record and policy review and interviews with resident, resident family and staff, the facility failed to provide adequate supervision and a secure environment for 1 of 11 residents reviewed at risk for elopement of a total sample of 17 residents, (#2). These failures contributed to the elopement of resident #2 and placed him at risk for serious injury/impairment or death. While resident #2 was out of the facility unsupervised, there was a high likelihood he could have fallen, been hit by a car or become lost. On 7/3/20 at approximately 10:45 AM, resident #2 exited the facility through the main lobby when the lobby doors being monitored by staff and only opened manually using a key control on the wall. Resident #2 walked 0.19 miles down a sloping walkway and uneven sidewalks along a moderately trafficked 2-lane road to a convenience store located on a very busy corner of two major thoroughfares. The temperature on July 3rd was 90 degrees Fahrenheit which placed the resident at risk for dehydration and/or sun exposure. (www.weather.com) The resident was found by a Good Samaritan who noted that resident #2 appeared lost and became concerned for his safety. The Good Samaritan used resident #2's cell phone and located the resident's daughter's telephone number. The resident's whereabouts were unknown to the facility staff until the resident's daughter called the facility and informed them that her father was found at the convenience store parking lot. The facility's failure to provide adequate supervision and a secure environment resulted in Substandard Quality of Care at the Immediate Jeopardy level starting on 7/3/20. The Immediate Jeopardy was removed on 7/16/2020. Findings: Cross reference to F835 Resident #2 was an [AGE] year-old vulnerable adult, admitted to the facility from the hospital on [DATE]. The resident's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE], noted that the resident's Brief Interview for Mental Status (BIMS) score was 10 indicating he had moderately impaired cognition. On 7/14/20 at 3:18 PM, resident #2 confirmed he left the facility and went to the convenience store. The resident stated he left the facility in the morning but could not recall the date. He recalled that it was very hot that day. The resident explicitly expressed that he did not want to be at the facility. He stated that he had a house, a pension and social security in his country, the Dominican Republic, and wanted to return there. The resident stated he left the facility through the lobby front entrance and there were staff/people there but did not identify the staff at the entrance. He said someone at the door, and the door opened, but he could not say how exactly he exited the facility. The resident insisted that he did not go into the convenience store and produced a flip style cell phone, which was kept in his sock. He said he met a Spanish speaking family with a truck and they brought him back to the facility. On 7/14/20 at 3:49 PM, a meeting with the Unit Manager (UM) and Assistant Director of Nursing (ADON) verified that resident #2 exited the facility on 7/3/20 at about 10:45 AM. The UM stated she could not recall the last time she saw resident #2 on the morning of 7/3/20. The ADON stated there was a Clinical Meeting on 7/3/20 that took place in the conference room. At approximately 10:45 AM, she left the room to make copies and saw the resident sitting near the Human Resource Offices and the Receptionist and Maintenance Director were talking to the resident. The ADON stated at 11 AM, the Nursing Unit received a telephone call, from resident #2's daughter informing that her father was found at the convenience store. They were told the convenience store employees would bring her father back to the facility. At 3:59 PM the Administrator joined the meeting and shared the facility's investigation. He stated that on the morning of 7/3/20 there was a discharge occurring at the front lobby and that discharge may have added to the 'busyness' at the front entrance. The Administrator and his staff could not explain how resident #2 left the facility undetected while the front lobby doors were being monitored by the COVID-19 Screener. The Administrator stated the receptionist was the COVID-19 Screener at the time the resident left the facility. He provided a copy of the receptionist's written statement which noted that she saw the resident at approximately 10:45 AM, in the lobby and redirected him back to his room. At 4:21 PM the Maintenance Director joined the meeting and stated that he was the COVID-19 Screener and was monitoring the front doors on 7/3/20 from 10 AM to 11 AM. At this time, the Administrator admitted he was not aware that the Maintenance Director was the COVID-19 Screener when resident #2 exited the facility. The Administrator stated, That's what's boggling to me. The Administrator verified he did not get a witness statement from the Maintenance Director. The Maintenance Director confirmed that the COVID-19 Screener used a key switch to open and close the front lobby doors. The Maintenance Director added that he knew resident #2 and would not have let him out. He stated that when he was assigned as the screener, he usually conversed with the receptionist. On 7/15/20 at 1:15 PM, a meeting with the Administrator, Director of Nursing (DON), ADON and the Regional Director of Clinical Services (RDCS) was conducted. Witness statements and facility polices were reviewed. The staff stated the resident, upon admission was assessed for elopement and he was not an elopement risk. A second elopement assessment was done on 7/3/20 after the resident had exited the facility. Despite having left the facility, without staff's knowledge, the facility did not consider resident #2 as an elopement risk. The staff stated that in the morning of 7/2/20, the resident was transferred to the hospital for agitation and aggression toward another resident. The resident returned to the facility the same afternoon of 7/2/20. The staff stated that the hospital was to provide a private sitter, for the long weekend, starting on the morning on 7/3/20 through the morning on 7/6/20. However, the private sitter did not arrive until after the resident had eloped from the facility. On 7/6/20, after the private sitter had left, the facility placed the resident back on 15-minute observation checks. The staff stated that when the resident returned from the hospital on [DATE] another BIMS was conducted and the resident scored 14 out 15, indicating he was cognitively intact. The staff could not explain why another BIMS was required. There was no evidence that an unscheduled Minimum Data Set assessment had been completed. The resident's medical record revealed there was no indication that a Significant Correction MDS was submitted that included the resident's updated BIMS. The Resident Assessment Instrument Version 3.0 Manual (RAI), noted that the BIMS is a brief screener that aids in detecting cognitive impairment and that the final determination of level of impairment should be made by the resident's physician or mental health care specialist. The RDCS stated that the root cause of the elopement incident was that resident #2 did not follow the Leave of Absence (LOA) policy. The 7/2/20 Admission/Readmission Data Collection noted that the resident had returned to the facility (post hospital) and resident #2's mood was pleasant. The resident was deemed by staff not to be at risk for elopement. The staff noted that the resident was confused to place and time. On 7/14/20 at 2:49 PM, the surveyors retraced resident #2's elopement route from the facility's front door to the convenience store parking lot where the resident was found. The facility was located on a two-lane road which was used as a short cut linking two very busy thoroughfares. The convenience store was located at a busy intersection of a 7-lane divided highway. These two highways served as major arteries for the area. The resident's route revealed he walked on a downward sloping sidewalk towards the convenience store. The resident would have crossed a two lane road to get to the convenience store. The pavement on the route was cracked and uneven and there were several business driveways along the two-lane road. Adjacent to the convenience store was a retention pond that was dry at the time. The total distance of the route was 0.19 miles from

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106029	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE MARY HEALTH AND REHABILITATION CENTER	710 NORTH SUN DRIVE LAKE MARY, FL 32746

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) the facility. The weather was sunny and the temperature was approximately 90 degrees Fahrenheit at the time of the elopement. (www.weather.com) A review of the medical record did not reveal any indication that the facility had called resident #2's daughter for his history of wandering and/or elopement. On 7/15/20 at 10:11 AM, the resident's daughter was contacted by phone. She stated that a Good Samaritan, that spoke Spanish, found her father near the convenience store and used her father's cell phone to contact her. The Good Samaritan told her, that her father was very confused and could not say where he resided. The daughter stated she told the family to stay at the convenience store with her father, while she called the facility. The daughter stated she was very scared and kept calling the facility. She stated she called the facility at approximately 11 AM and the staff were not aware that her father was missing. She called the Good Samaritan back and asked him to bring her father back to the facility. The daughter stated she was concerned as her father could have been hit by a car and sustained major injuries. The daughter recalled the Social Service staff (SS) spoke to her about alternate placement. She said her father had history of confusion and had lived in a Senior Housing Apartment. He had left his apartment and was brought back by police as he could not find his way back. The daughter stated her father lived with her prior to hospitalization and facility admission. Further review of the Admission/Readmission Data Collection dated 7/2/20 (post hospital) revealed a section for Elopement Risk Evaluation. The questions and answers for elopement risk were noted as follows: 1. Is the resident cognitively impaired? - answer no 2. Is the resident independently mobile (ambulatory or wheelchair) -answer no 3. Does resident have poor decision making skills? -answer no 4. Has resident demonstrated exit-seeking behavior? -answer no 5. Does resident wander oblivious to safety needs? -answer no 6. Does resident have a history of elopement? -answer no 7. Dos resident have the ability to exit facility -answer no 8. Based on potential risk factors above, resident is determined to be AT RISK for elopement. - answer no On 7/16/20 at 11:26 PM, Registered Nurse B (RN B) confirmed she completed the Admission/Readmission Data Collection when the resident returned from the hospital on [DATE] She stated the resident spoke Spanish and that she used staff to translate. RN B stated that the resident's memory was okay but believed that he was cognitively impaired. She stated that she believed that resident #2 used to walk the hallways but she had not been assigned to him before. RN B added that the resident's routine was to walk to the front lobby saying that he wanted to leave. She stated he was supposed to have a private sitter per the hospital report, but the sitter arrived the next day. RN B indicated that she was assigned to resident #2 on the 3 PM-11 PM shift and that observation checks every 15 minutes were initiated. The medical record and the staff could not provide any assessment/reason as to why the resident required 15-minute checks. The elopement evaluation questions and answers were reviewed with RN B. RN B explained that although the responses might have been incorrect, resident #2 was monitored closely. A second Elopement Risk assessment was completed by RN C after the elopement incident dated 7/3/20. RN C noted that the resident was not an elopement risk. Question number 6 asked, 'Does the resident have a history of elopement? RN C answered this question with 'no.' On 7/15/20 at 2:45 PM, RN C described what occurred after resident #2 had eloped from the facility. She stated staff brought him back to his room and she performed a Skin Assessment and an Elopement Assessment. RN C stated she asked the ADON about the questions on Elopement Assessment Form and the ADON told her that the resident's exit from the facility earlier that morning did not count as an elopement. On 7/14/20 at 4:03 PM, Registered Nurse (RN A), who spoke Spanish, stated he was not working on 7/3/20 but was aware that the resident had eloped. RN A stated he had been assigned to the resident in the past. RN A stated that the resident told him, about his wanting to go back to the Dominican Republic. RN A stated as time progressed resident #2 became more confused and continued to say he wanted to go home. RN A stated he did not report resident #2's desire to go back home to his superiors. Since the facility staff did not deem the resident as an elopement risk, an elopement care plan was not developed with approaches to ensure the resident remained in the facility. The Elopement Risk Evaluation dated 7/3/20, post elopement noted the resident was not cognitively impaired, he did not display exit seeking behavior and he was not at risk for elopement. 1. Is the resident cognitively impaired? - answer was no 2. Is the resident independently mobile (ambulatory or wheelchair)? -answer was yes 3. Does the resident have poor decision-making skills? -answer was yes 4. Has the resident demonstrated exit seeking behaviors? -answer was no 5. Does the resident wander oblivious to safety needs? -answer was no 6. Does the resident have a history of elopement? - answer was no 7. Does the resident have the ability to exit the facility? -answer was yes 8. Based on potential risk factors above, resident is determined to be AT RISK for elopement. - answer no A review of the facility's investigation revealed that the facility failed to investigate and recognize how the resident eloped and make the necessary changes to prevent further elopements. On 7/15/20 at 2:47 PM the RDCS stated that they did not deem resident #2's incident on 7/3/20 as an elopement because his BIMS was 14. She stated that the resident did not follow the facility's Leave of Absence (LOA) policy. When asked if the resident had a physician's orders [REDACTED]. When asked if the resident #2 was educated on the facility's LOA Policy, in Spanish, the RDCS stated we will have to review the medical record. By the time of the exit meeting the facility failed to provide a physician's orders [REDACTED]. Due to the COVID-19 pandemic the Centers for Medicare and Medicaid had advised that only essential LOA such as physician/hospital/outpatient treatment should be allowed. The RDCS did not explain why a trip to a convenience store was deemed as essential. As noted earlier, on 7/14/20 the Administrator stated that the facility had a discharge at the time the resident eloped and that may have added to the confusion at the front lobby that day. However, there was no evidence that the facility's discharge procedures were reviewed, and changes made to ensure that only the discharge resident and/or their belongings were leaving the facility. A review of the medical record revealed that resident #2 was sent to the hospital in the early morning of 7/2/20. On 7/16/20 at 3:25 PM, the Hospital Case Manager (HCM) confirmed by telephone that resident #2 was in the emergency room (ER) on 7/2/20. He stated the ER Physician had Baker Acted the resident in order to get a Psych Consult, but the Baker Act was later rescinded. He stated that the nursing home conveyed, to him, that the resident was ready for discharge from the nursing home. He attempted to discharge the resident to his daughter's house, but she refused. When asked why the resident needed a sitter, the HCM did not answer. He stated that he offered a private sitter to facilities in order for them to take the resident back. He stated the sitter was to start on 7/3/20 and end on the morning of 7/6/20. The resident returned to the nursing home on the afternoon of 7/2/20 without a sitter. There was no indication in the resident's medical record that the resident needed a private sitter for supervision. On 7/14/20 at 4:49 PM, RN C stated she was assigned to resident #2 on the 7 AM to 3 PM shift, on 7/3/20. The nurse indicated that resident #2 was readmitted the day before and did not know if the resident had a private sitter on the night shift. RN C stated, He was a wanderer, and that she and the assigned Certified Nursing Assistant were doing 15-minute checks on him. RN C stated the last time she saw the resident on 7/3/20 was at 10:30 AM. RN C stated she was involved with a discharge that morning at the front lobby and when she got back to her work area the assigned CNA was looking for the resident. On 7/6/20 the resident was placed back on 15-minute checks after the private sitter had departed. On 7/14/20 at 3:59 PM, the Administrator was asked why the facility did not provide a private sitter until the hospital sitter arrived. The Administrator did not provide an answer but stated that the hospital private sitter showed up eventually. The Administrator did not explain why the facility did not provide a sitter prior to the hospital contracted sitter's arrival. The facility staff did not explain how they determined the resident could be placed back on every 15-minute checks. At the time of elopement, the assigned level of supervision for resident #2 was 15-minute checks. An extended survey was completed on 7/16/2020. Review of the facility's corrective measures implemented on 7/15/16 by the facility revealed the following: o On 7/15/20, resident #2 was reassessed by the DON and found to be at risk for elopement. He had an electronic wander bracelet implemented and was placed on enhanced supervision to include 1:1, 15-minute checks or sitter services as indicated by his needs. Review of resident #2's medical record revealed nursing progress notes, physician's orders [REDACTED]. o The electronic monitoring system and exit doors were checked daily with daily review of documentation done by the ED or his designee. Review of maintenance logs indicated the required monitoring was completed. o Elopement drills were initiated on 7/15/20 on the 3:00 PM to 11:00 PM shift. Drills were scheduled every shift for 1 week or until all staff successfully passed the elopement competency test. Documentation of elopement drills was reviewed, and drills were on-going to incorporate staff on all shifts. Review of the Elopement Binder at the reception desk revealed photographs and demographic information of all residents who were at risk for elopement, including resident #2. o A dedicated staff member was assigned to monitor the front door from 8:00 AM to 8:00 PM, and a secondary entrance equipped with a camera and speaker will be used between 8:00 PM and 8:00 AM. Dedicated staff will be trained on elopement and use of the elopement book to verify identity. The ED or his designee will audit the process daily for 4 weeks. o Residents who required increased supervision will be reviewed in the daily clinical meeting to ensure compliance with safety check documentation o Staff education began on 7/15/20 and will be ongoing until 100% compliance is achieved. Topics included evaluation of elopement risk, updating plans of care, elopement procedure, assessment with change in condition, neglect, elopement policy and procedures, triggers indicating exit-seeking, and the leave of absence policy. Staff will not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106029	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE MARY HEALTH AND REHABILITATION CENTER	710 NORTH SUN DRIVE LAKE MARY, FL 32746

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** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) allowed to work until training has been received. Newly hired staff will receive the education in orientation. Interviews conducted indicated staff were knowledgeable about elopement procedures, supervision of residents at risk for elopement and elopement risk evaluations. Review of staff in-service attendance sheets revealed a current total of 70 of 145 staff (48%) had been educated. o The QAA committee will review audits of the interventions and re-educate and/or correct processes as needed. o On 7/15/20 and 7/16/20, the RDCS educated the ED and the DCS regarding auditing and correcting processes, ensuring safety with a focus on following elopement/LOA protocols, auditing safety processes including door function and the electronic wander system, ensuring staff understand processes and their roles, educating staff when processes are breached and about the role of QAPI. The ED and DON were also educated on ensuring accuracy of assessments to include family or representative input in obtaining pertinent history and developing the plan of care. Review of the in-service attendance sheet revealed signatures of the ED and DON to verify education topics addressed. o The sample was expanded to include all residents who wore monitoring devices due to the risk for elopement and 3 newly admitted residents who were evaluated for elopement risk. Observations and record reviews conducted revealed no concerns related to residents #5, 6, 7, 8, 9, 13, 14, 15, 16 & 17. The scope of severity of the deficiency was reduced to D-isolated, no actual harm with a potential for no more than minimal harm.
F 0835 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record and policy review and interviews with resident, resident family and staff, the facility failed to use its resources effectively to provide an adequate level of supervision and a secure environment to prevent elopement; and failed to conduct a comprehensive investigation to identify the root cause and develop appropriate interventions to ensure the safety of 1 of 11 residents reviewed for elopement risk, of a total sample of 17 residents, (#2). These failures contributed to the elopement of resident #2 and placed him at risk for serious injury/impairment/death. While resident #2 was out of the facility unsupervised, there was a high likelihood he could fallen, been hit by a car or become lost. On 7/03/20 at approximately 10:45 AM, resident #2, a vulnerable Spanish-speaking adult, exited the facility through the front lobby doors, less than 24 hours after re-admission from the hospital. Resident #2 walked across the facility's parking lot and turned left at the end of the driveway. He walked down a sloping and uneven sidewalk along a moderately trafficked 2-lane road towards a busy highway with a 7-lane intersection. Resident #2 crossed the 2-lane road and entered the parking lot of a gas station and convenience store approximately 0.19 miles from the facility. A Good Samaritan who spoke Spanish approached resident #2 and was able to determine he was from the nearby facility by looking through the contact list on the resident's cell phone and locating the daughter's telephone number. Resident #2's whereabouts were unknown to the facility until his daughter called the facility to inform staff her father was found at a convenience store in the area. The facility's failure to provide a secure environment, adequate supervision, additional safety interventions following the elopement and to conduct a thorough investigation of the incident to determine the root cause and thereby preventing reoccurrence, resulted in Immediate Jeopardy, starting on 7/03/20. The Immediate Jeopardy was removed on 7/16/20. Findings: Cross reference to F689 Resident #2 was an [AGE] year old male who was admitted to the facility on [DATE] for rehabilitation after hospitalization for a fall-related injury. His admission [DIAGNOSES REDACTED]. Resident #2 was transferred to the hospital on [DATE] for increased confusion, disorientation, delusions, agitation and physical aggression towards another resident. After evaluation in the hospital emergency department, resident #2 was readmitted to the facility later that same afternoon. The Minimum Data Set (MDS) 5-day Medicare assessment with assessment reference date (ARD) of 6/07/20 revealed resident #2 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. The assessment indicated resident #2 was able to walk with supervision, had unsteady balance but was able to stabilize himself without assistance. On 7/14/20 at 3:59 PM, the Executive Director (ED) confirmed resident #2 was sent to the hospital on Thursday 7/02/20 due to aggressive behaviors. He stated the facility readmitted resident #2 later the same day, on the condition the hospital would provide private sitters for the weekend, from Thursday evening until the following Monday morning, while the facility looked for appropriate placement for him. The ED stated the private sitter did not show up as arranged, and resident #2 was placed on 15-minute checks instead of 1:1 continuous supervision. The ED did not answer when asked why the facility did not provide a 1:1 sitter if it was deemed necessary by admissions staff and administration. The ED confirmed resident #2 left the facility without knowledge of staff less than 24 hours after re-admission, on 7/03/20, the first morning of the holiday weekend. He explained resident #2 ended up at a nearby convenience store and his daughter spoke with someone at the store by telephone. The daughter notified the facility and asked the person to take her father back. The ED stated the facility investigated the incident and determined the root cause to be resident #2 left the facility because he wanted to go home to his daughter. The ED and Assistant Director of Nursing (ADON) stated at the time resident #2 went missing there were residents being discharged at the front door. Despite completion of an incident investigation, both the ED and ADON acknowledged they were still unsure how resident #2 was able to exit the facility since the front door was monitored by a staff member and had to be manually opened and closed. The ED stated he interviewed the receptionist who was monitoring the door at the time resident #2 left the facility. He provided the receptionist's written statement that indicated she spoke to resident #2 in the lobby on 7/03/20 at approximately 10:45 AM and instructed him to return to the nursing unit. On 7/14/20 at 4:12 PM, the receptionist confirmed resident #2 was in the lobby near the front door and she re-directed him away from the area. The receptionist stated the facility's Maintenance Director was seated at the screening table in the lobby and was responsible for opening, closing and monitoring the front door at that time. She recalled she was not seated at her desk behind the reception window, rather she stood in front of the Maintenance Director at the screening table. On 7/14/20 at 4:21 PM, the ED expressed surprise at the information provided by the receptionist. He said, That's what's boggling to me. Nobody told me (the Maintenance Director) was up there. That piece of information did not come across to me until now. To my knowledge (the receptionist) was watching the door. On 7/14/20 at 4:30 PM, the Maintenance Director confirmed he was assigned to monitor the door from 10:00 AM to 11:00 AM on the day resident #2 left the building. The Maintenance Director explained he had to manually open the door for every person who entered or exited the facility. He explained he knew resident #2 on sight and would never have opened the front door for him. When asked if he could have been distracted, the Maintenance Director said, Most times when I'm up there I talk to (the receptionist). On 7/15/20 at 1:15 PM, the ED and ADON continued to explain their investigation findings and actions taken after resident #2 was returned to the facility. The ED stated his investigation included a statement from the Spanish-speaking Assistant Business Development Coordinator (ABDC) who retrieved resident #2 from the Good Samaritan who returned him to the facility. The ED stated the statement indicated resident #2 was brought back by a construction worker who was working at the convenience store. Review of the ABDC's statement revealed a reference to the family that brought resident #2 back to the facility, but no mention of a construction worker. When asked how he arrived at that conclusion, the ED stated he assumed it was a construction worker. The ADON stated she assessed and interviewed resident #2 with translation assistance from the ABDC after he was returned to the facility. She stated she also spoke to resident #2's daughter and notified the Medical Director. However, review of resident #2's medical record revealed no documentation of the elopement incident, notifications made or revisions to the plan of care. The ADON stated she did not interview the Good Samaritan who returned resident #2 to the facility. She acknowledged she did not document many of her post-incident actions. She said, We were all busy doing the timeline and we slipped up. I did not go back to verify there was a nurse's note or a change in condition note. The ADON stated the facility's interdisciplinary team (IDT) including the ED and Regional Director of Clinical Director (RDCS) reviewed the incident in the daily clinical meeting on Monday, 7/05/20. She stated they reviewed the timeline of the event and actions taken. The ADON stated the IDT looked at resident #2's BIMS score and decided the incident did not meet the criteria of an elopement. She said, We decided the resident did not follow the Leave of Absence policy. The ADON explained resident #2 was re-assessed on 7/03/20 after he was returned to the facility, and he was still not deemed at risk for elopement although he left the building unsupervised that morning. She stated resident #2 did not need an elopement care plan or an electronic wander bracelet based on the nursing assessment findings and IDT review of the incident. The ED reiterated resident #2 was alert and oriented, knew what he wanted to do, and acted on a previously expressed desire to leave the facility. When asked about the definition of an elopement, the ED said, It's whatever is on the policy. Review of the facility's policy and procedure (P&P) for Missing Patient / Resident revised on 8/23/17, revealed an elopement was .when a patient/resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106029	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE MARY HEALTH AND REHABILITATION CENTER	710 NORTH SUN DRIVE LAKE MARY, FL 32746

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury. The P&P directed staff to first determine if a missing resident was out on authorized leave, then conduct a search. The document indicated after a missing resident was found and returned to the facility, documentation would be made in the medical record regarding the incident, assessment findings and notifications. Staff were to Review and revise the interventions as indicated related to elopement and wandering risk and update the Care Plan and Kardex. The ADON acknowledged according to the facility's P&P, resident #2 had eloped. The ED and ADON confirmed the IDT reviewed the incident investigation and post-elopement risk evaluation but did not implement any additional interventions to ensure resident #2's safety. They explained resident #2 had a private sitter until the morning of 7/05/20 and then returned to 15-minute checks. The ED and ADON did not respond when asked why the facility would continue an intervention that was proven to be ineffective since resident #2 was able to elope between 15-minute checks. On 7/15/20 at 2:47 PM, the RDCS stated she met with the IDT and concurred with the team that resident #2 was not an elopement risk. She explained the event was not an elopement because resident #2's BIMS score was 14 which indicated he was cognitively intact. The RDCS said, He did not follow the leave of absence policy and process. However, she acknowledged resident #2 did not have a physician's orders [REDACTED]. She was informed resident #2 had a history of [REDACTED]. The RDCS confirmed it was necessary to interview family or representative of a cognitively impaired resident to accurately complete the evaluation form regarding elopement risk. The RDCS stated the IDT should have developed appropriate care plan interventions to address the root cause of the incident but she was not able to provide any supportive documentation. Review of resident #2's medical record revealed no new or revised care plans related to behaviors that caused resident #2 to leave the facility or his risk for elopement. On 7/16/20 at 11:55 AM, the Director of Nursing (DON) stated she was on vacation at the time resident #2 left the facility unsupervised. She stated she returned to work on 7/13/20 but was not aware a resident left the facility unsupervised until the survey team arrived on 7/14/20, 11 days after the incident occurred. She expressed astonishment and frustration that she was not notified of the incident by the ED and ADON as soon as possible. The DON confirmed the facility had procedures to prevent resident elopement that included accurate elopement risk evaluation and re-evaluation when indicated, comprehensive incident investigation, immediate interventions and care plan revisions. The DON stated she reviewed resident #2's medical record after she became aware of the incident. She confirmed resident #2 eloped from the facility as defined in the policy. The DON stated she noted inaccuracies and omissions in the investigation and nursing documentation. She confirmed the IDT did not identify resident #2 as an elopement risk even after he left the building unsupervised. The DON explained an elopement care plan was not triggered because of the inaccurate assessment. The DON stated she re-assessed resident #2 earlier that morning and determined he met elopement risk criteria that required an electronic wander bracelet for safety. The policy and procedure for Accident and Incident Investigation effective 11/30/14 read, Certain Accidents and Incidents . will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event. The document indicated an incident report should be completed for any event that was inconsistent with routine resident care and facility operations. The procedure revealed the ED, the DON or her designee would document the investigation of the incident to include . interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers, which may have had contact with the resident and may help with the investigation. On 7/16/20 at 12:37 PM, the ED stated he concluded resident #2 took advantage of activities related to other residents being discharged at the front door to exit the facility unnoticed. When asked if the facility implemented any new measures during the discharge process to prevent the same incident from happening again, the ED paused for a moment, shook his head and said, We'll have to look at that because discharges go on throughout the day. On 7/16/20 at 12:58 PM, the Medical Director was informed of concerns identified regarding incompleteness of the facility's investigation, and conflicting information on where resident #2 was found and who brought him back to the facility. He was apprised of ineffective safety interventions put in place before and after the elopement incident due to inaccurate elopement risk evaluations. On review of the facility's policy and procedure, the Medical Director said, By definition, this was an elopement. He acknowledged it was necessary to determine the accurate root cause of resident #2's elopement in order to correct the situation for him and to prevent any further resident elopements. Review of the Facility Assessment Tool dated 1/06/20 revealed the facility accepted residents with psychiatric and mood disorders and neurological system diseases including dementia. The document indicated staff was able to provide care and services to Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment . The assessment tool revealed residents would receive person-centered care including conversations to get to know resident and identify risks and hazards for residents. Review of the ED's job description revealed duties and responsibilities including Maintain and guide the implementation of facility policies and procedures . ensure a safe, clean and comfortable environment for residents . Maintain a file for and monitor incident reports. The ADON's job description revealed she would Assist in the implementation of and monitor compliance with policies, procedures, and standards of practice . assist in the development, implementation, and monitoring of an accurate and effective documentation system . An extended survey was conducted on 7/16/2020. Review of corrective measures implemented on 7/15/16 by the facility revealed the following: * On 7/15/20, resident #2 was reassessed by the DON and found to be at risk for elopement. He had an electronic wander bracelet implemented and was placed on enhanced supervision to include 1:1, 15-minute checks or sitter services as indicated by his needs. Review of resident #2's medical record revealed nursing progress notes, physician's orders [REDACTED]. * The electronic monitoring system and exit doors were checked daily with daily review of documentation done by the ED or his designee. Review of maintenance logs indicated the required monitoring was completed. * Elopement drills were initiated on 7/15/20 on the 3:00 PM to 11:00 PM shift. Drills were scheduled every shift for 1 week or until all staff successfully passed the elopement competency test. Documentation of elopement drills was reviewed, and drills were on-going to incorporate staff on all shifts. Review of the Elopement Binder at the reception desk revealed photographs and demographic information for all residents who were at risk for elopement, including resident #2. * A dedicated staff member will be assigned to monitor the front door from 8:00 AM to 8:00 PM, and a secondary entrance equipped with a camera and speaker will be used between 8:00 PM and 8:00 AM. Dedicated staff will be trained on elopement and use of the elopement book to verify identity. The ED or his designee will audit the process daily for 4 weeks. * Residents who required increased supervision will be reviewed in the daily clinical meeting to ensure compliance with safety check documentation * Staff education began on 7/15/20 and will be ongoing until 100% compliance is achieved. Topics included evaluation of elopement risk, updating plans of care, elopement procedure, assessment with change in condition, neglect, elopement policy and procedures, triggers indicating exit-seeking, and the leave of absence policy. Staff will not be allowed to work until training had been received. Newly hired staff will receive the education in orientation. Interviews conducted indicated staff were knowledgeable about elopement procedures, supervision of residents at risk for elopement and elopement risk evaluations. Review of staff in-service attendance sheets revealed a current total of 70 of 145 staff (48%) had been educated. * The Quality Assurance and Performance Improvement (QAPI) committee will review audits of the interventions and re-educate and/or correct processes as needed. * On 7/15/20 and 7/16/20, the RDCS educated the ED and the DCS regarding auditing and correcting processes, ensuring safety with a focus on following elopement and leave of absence protocols, auditing safety processes including door function and the electronic wander system, ensuring staff understood processes and their roles, educating staff when processes were breached and the role of QAPI. The ED and DON were also educated on ensuring accuracy of assessments to include family or representative input in obtaining pertinent history and developing the plan of care. Review of the in-service attendance sheet revealed signatures of the ED and DON to verify education topics addressed. * The sample was expanded to include all residents who wore monitoring devices due to the risk for elopement and 3 newly admitted residents who were evaluated for elopement risk. Observations and record reviews conducted revealed no concerns related to residents #5, 6, 7, 8, 9, 13, 14, 15, 16 & 17. The scope of severity of the deficiency was reduced to D-isolated, no actual harm with a potential for no more than minimal harm.