STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105217	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH BEACH REHABILITATION CENTER	**2201 NE 170TH STREET NORTH MIAMI BEACH, FL 33160**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and interviews, the facility failed to prevent neglect of one (resident #1) out of four sampled residents with known wandering and exit seeking behaviors as evidenced by, resident #1 eloped on [DATE] at 1:48 p.m undetected, due to the facility's staff failure to implement the two (2) hour check system. This facility's deficient practice resulted in the death of resident's #1 whose body was found by law enforcement in an alley near the facility on [DATE] approximately 5:30 p.m. Cross reference F 689 & F 609 The findings include: Review of the facility policy and procedures Standards and Guidelines for Abuse Neglect and Exploitation (SG ANE) titled: Standard and Guidelines: SG ANE Investigations, revised [DATE] revealed, neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Item 3. PREVENTION : Staff , residents .The facility environment will be monitored to prevent any potential ANE through : Routine monitoring of the physical layout for unsafe or unsupervised areas to minimize occurrence. Review of the facility's policy titled, Standards and Guidelines: SG Resident Elopement revised [DATE] revealed: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., and order for discharge or leave of absence) and/or any necessary supervision to do so. Resident/ patient (s) who are not cognitively impaired and are legally able to make their own choices and have been informed of facility guidelines regarding leaving facility grounds, who choose not to follow these guidelines will not be considered in this definition as an elopement. Review of AHCA (Agency for Health care Administration) Immediate Report, dated [DATE] revealed that resident #1, with [DIAGNOSES REDACTED]. No apparent injury noted or reported. Review of clinical records face sheet revealed, resident #1 had an initial admission date of [DATE] and was readmitted to the facility on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of resident #1's Minimum Data Set ((MDS) dated [DATE], for the previous admission revealed in Section C- Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 7 out 15 indicating severe cognitive impairment. Section E - Behavior item for Wandering-Presence & Frequency : Has the resident wandered ? coded 1= Behavior of this type occurred 1 to 3 days. Review of the Admission/Readmission Nursing Notes for resident #1, dated [DATE] revealed that resident #1 was assessed as high risk for wandering and elopement. Review of the Nursing Progress Notes dated [DATE] for resident #1 revealed the last nursing notes entry was on [DATE] at 9:28 a.m. Review of Baseline Care Plan last revision on [DATE] revealed that resident #1 had a history of [REDACTED]. The interventions included keep resident safe by watching for tailgating at the exit doors. Reviewing the previously admission, initiated on [DATE] revealed that resident had a Care Plan for elopement risk/ wandering with history of attempts to leave facility unattended. Review of the Baseline Care Plan dated [DATE] revealed mobility care plan indicating Focus: resident needs help walking. Intervention : Walking: the resident can walk independently but will need someone to walk with .for safety due to either confusion or fall risk. Review of the weather in Miami on [DATE] revealed a variation between 82 F to 86 F in the afternoon with humidity between 81 to 84%. (Past weather in Miami .5 June .2020. www.timeanddate.com/weather/usa/miami/historic month=6&year=2020). Resident #1 being an elderly individual is especially vulnerable to the effects of heat, and are at risk of heat-related illnesses like heat stroke that could lead to death, according to the Center for Disease Control (CDC). On [DATE] at 9:08 a.m. during observations and interview with the Director of Nursing (DON), Administrator/Risk Manager, and Vice-President of Clinical Services the facility's exit door in the rehabilitation gym did not have a lock nor an alarm. They revealed during the observation that on [DATE], the day of the incident the exit door of the rehabilitation gym did not have a lock and no alarm. They explained that the door gives access straight to Northeast 171 street. They explained that law enforcement found resident #1 deceased leaning over in the alley across the street at the front of rehabilitation gym. Resident # 1 left facility at 1:48 p.m. through the unlocked door in the gym. During the time of the elopement Staff B, Occupation Therapist (OT) was inside the rehabilitation gym. Resident #1 was not scheduled for therapy at the time of elopement. During review with the Administrator/Risk Manager on [DATE] at 11:15 a.m. of the video footage dated [DATE] showed, staff B entered the rehabilitation gym area on [DATE] at 1:41 pm. At 1:48 p.m. the video showed resident #1 walking directly without hesitation to the exit door of the rehabilitation gym that was unlocked and exited the facility unnoticed by Staff B. Further review revealed footage from the outside camera, showed resident #1 on the street waiting for cars to pass before crossing the street. On [DATE] at 11:28 a.m. during interview and observation the Director of Nursing (DON) revealed that the Rehab gym had a chatting area that was opened and had visibility of the entire room. The DON stated that the gym equipment shelves were obstructing the OT view on the day of the incident and they have moved the equipment shelves closer to the wall to enable visibility. Interview on [DATE] at 11:34 a.m. with Administrator revealed that at the time of resident #1's elopement, Staff B, OT was in the rehabilitation gym and did not hear the rehab gym exit door opening and closing at the time resident #1 eloped. The administrator explained that the facility never had an alarm for the exit door of the rehab gym. After resident #1 eloped, they were notified by the police at approximately 5:30 p.m. that a body was found in the street. The police wanted to verify if the body belonged to a resident that lived in the facility and that the body was still there. The Administrator stated that the staff are supposed to make rounds every two hours to check on the resident whereabouts and to make sure that everything was fine, and she would need to check if the nurse or Certified Nursing Assistant (CNA) completed rounds on the day of the incident. The Administrator reported that dinner time was at 5:00 p.m. and did not know if the nurse checked if resident #1 was there. Interview on [DATE] at 11:53 a.m. with Director of Nursing, Administrator, Vice-President of Clinical and Regional Director of Operations revealed that the Registered Nurse (RN) unit supervisor, staff H went with the police and recognized the body to be that of resident #1 and at that time staff H did not notice any injuries. They reported that the staff are required to do rounds every 2 hour and at the beginning of each shift, to check if residents were okay, and to provide care. The nurses provide information at change of shift to the oncoming nurse and the CNAs should provide information to the oncoming CNAs from one shift to the next. During the change of shift the nurses and the CNAs are supposed to make rounds to check on residents and make sure residents are in the facility. On the day resident #1 eloped, staff E, a CNA who started her shift at 3:00 p.m. noticed that resident #1 was not in the facility. At about 4:30 p.m. CNA, Staff E, told Staff H, RN that she had not seen resident #1 and RN stated that he was told that resident #1 was in the TV lounge, but he did not remember the name of the person that told him resident #1 was in the TV lounge. At 4:30 p.m. they started to search the entire facility. The DON stated that she was not working on the day the incident occurred and that the Health Information Manager called her by phone at around 5:00 p.m. and told her resident #1 was missing. The Administrator stated that she first heard that the resident was missing when the police officer came to the building and Staff H, RN never reported to her that resident #1 was missing and that they were searching for resident #1. The Administrator reported that resident #1 had no history of elopement. He was coded for

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.

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F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) elopement risk because he had dementia and he was walking around. Interview on [DATE] at 12:43 p.m. with Staff D, CNA revealed resident #1 was a little confused. She provided lunch to resident #1 on the day of the elopement at around 1:00 p.m. After lunch resident #1 he was walking around and that he usually walk around. Staff D,CNA reported that the last time she saw resident #1 was around 1:40 p.m. Staff D explained that she usually did rounds when she had the chance but did not because she was busy with other residents and did not notice that he was missing. Interview on [DATE] at 2:56 p.m. with Administrator, Director of Nursing, Vice President of Clinical, Regional Clinical Director and Regional Director of Operations revealed that on the day of the incident the Maintenance Director checked if all doors were working. The doors that the resident #1 used to leave the facility was the only door that did not have an alarm. On [DATE] at 4:07 p.m. the Maintenance director reported that on [DATE] the alarmed lock that was ordered for the rehabilitation gym's exit door was installed and working. The wander management systems for resident #1 was activated, but the exit door for the rehabilitation gym did not have the wander management systems on the day resident #1 eloped. Interview on [DATE] at 2:09 p.m. with Administrator /Risk Manager revealed that on the day of the elopement nobody came to tell her that resident #1 was missing. She was not in the facility because she had left for the day. She received a phone call around by 5:30 p.m. from Medical Records regarding the elopement. The elopement code green was triggered after the police officer came to the building. The administrator explained that she was driving back to the facility when Staff H went with the police to identify the body and recognized it was resident #1's body. The Administrator stated that the CNAs were supposed to report to the nurse as a first chain of command, but they could also report directly to her. The nurse could report to DON or to herself. The DON was off on the day of the incident, but the nurse had her phone number as well. Telephone Interview with Staff B Occupational Therapist on [DATE] at 3:37 p.m. revealed, around lunch time resident #1 came into the rehab gym, she noticed that he was there and told him he needed to exit the rehab gym because he couldn't be there. Staff B reported that she escorted resident #1 out of the gym. Staff B reported that time there were two maintenance staff in front of the rehab gym outside fixing something. Staff B reported, I don't know at what time he came back to the gym and didn't hear anything or anyone coming in or out of the gym. Staff B stated that after she got home around 6:30 p.m. the rehabilitation director called and told her that the resident had eloped. Telephone interview with Staff E, CNA on [DATE] at 2:14 p.m. revealed on the day of the incident she worked 3:00 pm to 11:00 p.m. Staff E,CNA reported being assigned to resident #1's room. Staff B stated that when she went to do rounds and did not see resident #1 she reported it to the nurse and the nurse told her to look for the resident at 4:30 pm. Staff E stated, by the time I went to look for him I saw the nurse already talking to the police. They gave me the room at 4:30 p.m. I checked the room and did not see the patient; I went immediately to tell the nurse. The nurse told me go look for him. By the time I finished I saw the nurse talking to the police outside. Staff E stated, my DON came and told me to come in and told me what happened. When I didn't see him, I reported it immediately. Staff E explained that resident # 1 usually walked around and go inside other patients' rooms, and staff would tell him not to go inside other rooms , he would go to therapy and then he would go back to his room. Staff E explained that resident #1 was a little confused. On [DATE] at 2:53 p.m. during a telephone interview, Licensed Practical Nurse (LPN), staff F revealed she worked the 7:00 a.m to 3:00 p.m. shift and resident #1 was on her assignment. Staff F reported that she saw resident walking around and eating. I was called by the Social Worker when I went home . I found out he was missing the following day because he was here on my shift. He was missing during my shift after one o'clock he was in his room eating and doing his thing. I was told that he was missing during my shift I didn't see him missing. When I was home the same evening, I got a call from the social worker asking me when the last time I had seen him and the next morning they mentioned that the patient had eloped. The patient was in the building when I left. I know I gave him his morning medications but I don't have the MARS in front of me, I'm not too sure if he was due for his evening medication but I know I gave him his morning medication. He was a pleasant man always a pleasant gentleman. He would walk around inside the building he used to watch TV in the activity room. The staff was there watching. I'm not sure if he would walk to the rehab gym, I worked with him only on that Thursday after he came back from the hospital. Telephone Interview with Staff G Unit/Supervisor on [DATE] at 4:20 p.m., revealed she was in the building for about four hours the day resident #1 eloped. She was about to start her shift but at about 12:10 p.m. she left the facility. Staff G stated, I am aware that a patient eloped from the building, but I was not in the building when it happened. I am familiar with resident #1 he was noted for wandering around the unit, and he would wander to get his meals, but he would never elope. Staff G reported that when the incident occurred she was called back to help and she returned to the facility at around 6:30 p.m. Telephone Interview with Staff H Registered Nurse on [DATE] at 12:30 p.m. revealed he worked the 3:00 p.m. to 11:00 p.m. shift on the day of the incident and that resident # 1 was on his assignment for care. Staff H reported he was familiar with resident #1, he was short stature guy, he was confused, and he wasn't aware of situations around, was alert and oriented x 2. He used to wander into other residents' rooms, walk to the nurse's station, to the front lobby and never really wanted to stay inside his room. I am not aware of him trying to leave the facility before. I was in the facility ; I came in late that day. I became a part of it when they were doing code green when they were looking. I came in walked in with my headphones, I clocked in I put on my PPE, my mask on, I went to house stock medication room to put my personal things there. I am not too sure because it happened last Friday, I remember doing my rounds, we counted the medication and I went and started writing my documentation and went about doing my nursing routine until the code green was called. Staff H recalled the Certified Nursing Assistant mentioning something about resident #1 being missing but did not remember if it was before or after the code green, since he was doing his nursing routine. Staff H stated I don't know if it was before or after the code green. I recalled two staff members started searching and I had stopped what I was doing, I checked his room first, I went to the waiting area, I looked inside the rooms. Staff H stated that staff members found out the resident was missing at the same general time. I stepped outside and I saw an investigation was going on and he was already dead at that point. It was all during code green, all staff members were on board and looking . me being part of this, I went outside the facility and I saw they were doing an investigation. A police officer followed me to the facility, from there the secretary notified administration. The time I went outside was approximately between 5:00 p.m. and 5:30 pm. Staff H reported he recognized resident #1 laying down, his clothes were clean, his top and pants were clean, they were not dirty, there were no injuries from the back and since he was lying down facing down, he could not see. He stated the resident was found in the community. I did spot him across the street over where you had to make a right turn .leaning on a fence. At that point pretty much everyone was aware, everyone was looking during code green, I forgot who it was, but I spoke to someone in the front area, at that point we had more resources at hand. Staff H stated that he did not mention anything about seeing the body because he was so caught up in the moment and the resident actually being dead was a surprise Staff H stated, The police never came to the facility, I don't know if the police answered the facility, they were having a yellow fence, it looked to me that the resident was dead for a while, I saw one police officer looking at the back of the building two or three officers and a van surrounding. At that point they were trying to figure out what was going on to see how this guy ended up being dead, they came after I spotted it, they asked me if I recognized the man, I said yes that is one of my residents then I quickly walked back to the facility. That's how the police became involved. It's a small facility they may not know what happened the one small thing I heard was that Resident #1 left the facility at around 1:52 p.m. Staff H stated I did not mention that the resident was outside dead to administration because I was still caught up and we were focused on the nursing, I'm assuming they had already started the investigation. At that time the police was already there, the same officers I had met outside they walked me back to the facility. Someone within the building notified administration. When they came it was an open can, the police was already collecting statements, I'm assuming administration was making an investigation but I'm not sure what was going all around. I can't speak at what point administration found out the resident went missing, I can only tell you my point of view. While the code green was going on I went outside, I assumed he went outside the facility, when I walked outside that's when I found police officers already doing an investigation.
F 0609 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to immediately report an incident of abuse and neglect that lead to a negative outcome for one (resident #1) out of 4 sampled residents. This deficient practice enabled resident #1 to

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F 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) elope from the facility undetected on [DATE] at 1:48 p.m The resident was not discovered as missing until 5:30p.m. on [DATE] .Subsequently, the resident was found deceased by law enforcement on [DATE], approximately 0.2 miles in an alley near the facility. The facility did not report the incident to the required agencies until 4 hours after the incident occurred on [DATE]. Refer to F 600 & F 689 The findings included: Record review of the facility Policy and Procedures titled: Standard and Guidelines: SG ANE investigations, revised [DATE] revealed that all allegations of abuse, neglect, mistreatment, exploitation of resident's funds or property are to be reported immediately to the Administrator and according to Federal and State Regulations. Any theft, resident to resident altercations where significant injury has occurred, or allegations/suspicions/ or witnesses abuse and neglect has occurred with significant injury or reasonable suspicion of a crime need reported to the local law enforcement. The facility will notify the Department of Children and Families as practically possible and the file the Federal Immediate Report to the State Agency (if applicable). Review of the Federal Immediate Reports for AHCA (Agency for Health Care Administration), provided by facility, revealed that the incident involving resident #1 was reported to AHCA on [DATE] at 11:31 p.m. The time of the incident was 5:30 p.m. The report indicated that resident #1 with [DIAGNOSES REDACTED]. No apparent injury noted or reported. Review of face sheet revealed that resident #1 initial admission was [DATE] and last admitted was [DATE]. The [DIAGNOSES REDACTED]. Record review of Admission/Readmission Nursing Notes for resident #1, dated [DATE] revealed that resident was assessed as high risk for wandering and elopement. Record review of the Minimum Data Set (MDS), for the previous admission for resident #1, dated [DATE] for Section C- Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 7 out 15 indicating severe cognitive impairment. Interview on [DATE] at 11:34 a.m. with Administrator/ Risk Manager at 11:40 a.m. revealed that the facility staff was notified by the police at 5:30 p.m. that they found the resident's #1 in the street and the body was still there. The police came to ask if the resident #1 was living in the facility. On [DATE] at 1:55 p.m. the Administrator revealed AHCA was notified on [DATE] at 11:31 p.m. and the Department of Children and Families (DCF) was prior to AHCA report. Interview on [DATE] at 2:56 p.m. with Administrator, Director of Nursing, Vice President of Clinical, Regional Clinical Director and Regional Director of Operations revealed that the Administrator was the Risk Manager and was responsible for the reporting of the incident to AHCA. The Administrator stated that she was aware that the incident should have been reported to within two (2) hours to the State Agencies.
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 observations, record reviews, and interviews the facility failed to provide adequate supervision and a secured environment for one (resident #1) out of four residents sampled for elopement. This facility's deficient practice enabled resident #1 to exit the facility undetected by staff on [DATE] at 1:48 p.m. Resident # 1 was found deceased by law enforcement in an alley near the facility. Refer F 600 & F 609 The findings included: Observation on ,[DATE]/ 2020 at 9:05 a.m. revealed there was an exit door inside the rehab gym. Upon entering the rehab gym there were two staff members, the rehab director and the corporate nurse. On ,[DATE]/ 2020 at 9:16 a.m. a tour of the rehab unit was conducted with the Administrator, Director of Nursing (DON), Vice President of Clinical Operations and Occupational Therapist (Staff A) revealed, the rehab gym's main entrance door had a keypad with a lock to enter. There was another exit door that lead to the street with a camera on both the inside and outside of the exit door that lead to the street. The door did not have an alarm and it was unlocked. The administrator stated once the staff leaves the rehab gym's area the door is locked. Before there was a lock, but during working hours the door remained unlocked and could be opened from the outside, but if there was no staff inside the rehab gym room or once staff left for the day, the door was locked. The Administrator explained that now the main door to enter the rehab gym has a keypad with a code is locked at all times. The Administrator reported that the other door inside the rehab gym that resident #1 exited through is an exit door that leads to the street (Northeast 171 street). The door had a camera inside and on the outside, it did not have an alarm, and it was unlocked. Further observation of the exit door revealed that upon exiting though this door to the outside there was a sidewalk that led to the street. On [DATE] at approximately 11:00 a.m. review of the surveillance video recorded on [DATE]th, 2020 with Administrator revealed : Staff B Occupational Therapist was observed walking inside the rehab gym towards the chart area. On [DATE] at 1:41 p.m. resident #1 was observed walking inside the rehab gym towards the exit door. On [DATE] at 1:48pm. Resident #1 was observed opening the exit door of the rehab gym, the door did not have an alarm, resident #1 was observed exiting the facility and walking towards the street closest to the exit door of the rehab gym. The administrator stated resident #1 was found deceased by law enforcement at approximately 5:00 p.m. Review of clinical records face sheet revealed, resident #1 had an initial admission date of [DATE] and was readmitted to the facility on [DATE]. Clinical [DIAGNOSES REDACTED]. Review of resident #1's quarterly Minimum Data Set ((MDS) dated [DATE], revealed in Section C- Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 7 out 15 indicating severe cognitive impairment. Section E - Behavior item for Wandering-Presence & Frequency: Has the resident wandered ? coded 1= Behavior of this type occurred 1 to 3 days. Review of care plan for resident #1 dated [DATE] with revision date of [DATE] revealed the resident was an elopement risk/wanderer history of attempts to leave facility unattended, impaired safety awareness, wanders aimlessly. Goals: resident will not leave facility unattended through the next review date . Interventions: Check for proper functioning of the audible alarm system regularly . On [DATE] at 11:41 a.m. the Administrator revealed that, at the time resident#1 went inside the rehab gym area, there was only one staff member in the rehab gym. The staff that was inside the rehab gym stated that she did not hear the door, or if someone entered the room and that she was documenting in the chart. The Administrator reported that at approximately 5:30 p.m. the police came to the facility to ask if someone was missing and to let the facility know that the resident had been found and the body was still in the alley in front of the facility. The administrator revealed that rounds were supposed to be done every two hours to check on the residents and make sure everything was fine before this incident happened. The administrator was unable to provide information that confirmed staff completed rounds. The administrator stated that she needed to check if staff did the rounds, because the rounds were supposed to be done by the nurse or the Certified Nursing Assistant. Interview with Staff E Certified Nursing Assistant (CNA) on [DATE] at 2:14 p.m. revealed Staff E worked from 3:00 p.m. to 11:00 p.m. on day of the incident. Staff E reported that at 4:30 p.m. she was assigned and extra room the assigned room was resident #1's room. Staff E stated they gave me the room at 4:30 p.m. I checked the room and did not see the patient, I went immediately to tell the nurse, the nurse told me go look for him, I went to the north wing to get him by the time I finished I saw the nurse talking to the police outside. Staff E explained that when the DON came she reported what happened. Staff E explained that resident #1 was a little confused and usually walked around the facility getting snacks and going into other residents' rooms and staff would redirect the resident by telling him to go back to his room. Staff E stated conducted rounds every 30 minutes and sometimes the residents called. Interview with staff F Licensed Practical Nurse (LPN) on [DATE] at 2:53 p.m. revealed she was familiar with resident #1. On the day resident #1 eloped she worked 7:00 a.m. to 3:00 p.m. and resident #1 was assigned to her for care. Staff F reported that she saw resident #1 in the facility walking around and eating during her shift. Staff E stated that resident # 1 was in the building when she left and that she gave the resident his morning medications. Staff E stated that she was not sure if resident #1 was due afternoon medications because she did not have the Medication Administration Record [REDACTED]. Staff F reported that resident #1 walked around inside the building and used to watch TV in the activity room and she was not sure if resident #1 he would walk to the rehab gym. Staff F reported, that she was called by the Social Worker after she went home asking when the last time was she saw resident #1 . She found out that resident #1 was missing the next morning when it was mentioned that the patient had eloped and that resident #1 went missing during her shift after one o'clock. Staff E explained that resident was in his room eating. Telephone Interview with Staff B, Occupational Therapist on [DATE] at 3:37 p.m. revealed, she remembered at around lunch time resident #1 came into the rehab gym, she noticed that resident #1 was there and told him he needed to exit the rehab gym because he couldn't be there. Staff E stated she went with resident #1 and he exited the gym. Staff E stated that there were two maintenance staff at the front of the rehab gym outside fixing something. Staff B reported that she did not hear resident #1 come back inside the rehab gym or go towards the door. She stated, I don't know at what time he came back to the gym and didn't hear anything of anyone coming in or out of the gym. She reported that she found out that resident # 1 had eloped after she got home around 6:30 p.m. and received a call from the Director of Rehabilitation informed her that resident#1 had eloped. During an Interview with Administrator, Regional Clinical Director, Vice President of Clinical, Regional Vice President for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Operations and Director Of Nursing on [DATE] at 12:12 p.m. it was revealed that the Registered Nurse (RN), staff H was the person that went and identified the body. Staff H did not notice any apparent injuries. They explained that prior to the incident the staff were doing rounds to monitor the resident's wandering. The rounds were to be made every two hours, beginning of shift, when given medication and throughout the day. The DON stated, we do rounds to know the whereabouts of the residents and give care. The administrator confirmed the Certified Nursing Assistants (CNAs) and nurses from report the information given from nurse to the other nurse and the CNA to the other CNA at the start of every shift. The DON confirmed and stated that related to the incident that occurred Both the nurse and the CNA were supposed to conduct the rounds to check. The administrator revealed that according to the statements that they reviewed related to the incident; the CNA did not see the resident when she got to the facility at 3:00 p.m She stated that the CNA did tell the nurse (staff H) that she did not see the resident at about 4:30 p.m. When they started the search at 4:30 p.m. Staff H, was told by one of the employees that resident #1 was in the TV lounge but doesn't remember the name of the staff who told staff H that resident #1 was in the TV lounge. The administrator stated that she would have to look at the statement from the nurse to check at what time was the resident at the TV. The administrator stated that at 4:30 p.m. they started to search for the resident in the facility. The DON- stated she wasn't in the facility that day but they called her to let her know the resident was not in the facility and she did not remember the time they called to let her know. The administrator stated that the resident never eloped from the facility before, he was coded for elopement because he has history of dementia and used to always walk around. The rehab gym would be open and the residents could go inside if there was someone inside the gym. If no staff was there the gym was always locked. He knew the rehab gym, but he was not receiving therapy. In general, he used to walk around the facility. The Administrator stated that staff H did not come to let her know that the resident was missing. The first time she found out the resident was missing was at 5:30 p.m. The administrator stated that the nurse did not tell anyone. The DON -stated the Nurse Manager was the one that called her after the police came to identify the resident and let them know. Vice President of Clinical Operations stated that rounds should be done every two hours and is a standard measure procedure to provide care for the residents and the information is not specified in the facility's policy. She reported that the nurses, the Occupational Therapist and the CNA were removed from the schedule. Telephone Interview with Staff H a Registered Nurse (RN) on [DATE] at 12:30 p.m. revealed he worked the 3:00 p.m. to 11:00 p.m. shift on the day of the incident and that resident # 1 was on his assignment for care. Staff H reported he was familiar with resident #1, he was short stature guy, he was confused, and he wasn't aware of situations around, he was alert and oriented x 2 and he used to wander into other residents' rooms, walk to the nurse's station, to the front lobby and never really wanted to stay inside his room. I am not aware of him trying to leave the facility before. I was in the facility; I came in late that day. I became a part of it when they were doing code green when they were looking. I came in walked in with my headphones, I clocked in I put on my PPE, my mask on, I went to house stock medication room to put my personal things there. I am not too sure because it happened last Friday, I remember doing my rounds, we counted the medication and I went and started writing my documentation and went about doing my nursing routine until the code green was called. Staff H recalled the Certified Nursing Assistant mentioning something about resident #1 being missing but did not remember if it was before or after the code green, since he was doing his nursing routine. Staff H stated I don't know if it was before or after the code green. I recalled two staff members started searching and I had stopped what I was doing, I checked his room first, I went to the waiting area, I looked inside the rooms. Staff H stated that staff members found out the resident was missing at the same general time. I stepped outside and I saw an investigation was going on and he was already dead at that point. It was all during code green, all staff members were on board and looking . me being part of this, I went outside the facility and I saw they were doing an investigation. A police officer followed me to the facility, from there the secretary notified administration. The time I went outside was approximately between 5:00 p.m. and 5:30 p.m. Staff H reported he recognized resident #1 laying down, his clothes were clean, his top and pants were clean, they were not dirty, there were no injuries from the back and since he was lying down facing down, he could not see. He stated the resident was found in the community. I did spot him across the street over where you had to make a right turn .leaning on a fence. At that point pretty much everyone was aware, everyone was looking during code green, I forgot who it was, but I spoke to someone in the front area, at that point we had more resources at hand. Staff H stated that he did not mention anything about seeing the body because he was so caught up in the moment and the resident actually being dead was a surprise Staff H stated, The police never came to the facility, I don't know if the police answered the facility, they were having a yellow fence, it looked to me that the resident was dead for a while, I saw one police officer looking at the back of the building two or three officers and a van surrounding. At that point they were trying to figure out what was going on to see how this guy ended up being dead, they came after I spotted it, they asked me if I recognized the man, I said yes that is one of my residents then I quickly walked back to the facility. That's how the police became involved. It's a small facility they may not know what happened the one small thing I heard was that Resident #1 left the facility at around 1:52 p.m. Staff H stated I did not mention that the resident was outside dead to administration because I was still caught up and we were focused on the nursing, I'm assuming they had already started the investigation. At that time the police was already there, the same officers I had met outside they walked me back to the facility. Someone within the building notified administration. When they came it was an open can, the police was already collecting statements, I'm assuming administration was making an investigation but I'm not sure what was going all around. I can't speak at what point administration found out the resident went missing, I can only tell you my point of view. While the code green was going on I went outside, I assumed he went outside the facility, when I walked outside that's when I found police officers already doing an investigation. Interview with Assistant Director of Nursing (ADON) and Regional Clinical Director on [DATE] at 1:24 p.m. revealed that, during a code green for elopement a staff is chosen at random to run the elopement drill and mostly the nurses and nursing assistants would do it. The Regional Clinical Director stated they call code green and the staff would come to the designated area which is the main dining room. At that designated point the assignments are given to check rooms and the outside area. Everybody responds but the person who is most senior in the building would be given the directions. The Regional Clinical Director stated I wasn't here that day, but yes, they called the code green and did the room search on that day. The code green was called after the police came. In conclusion the police came to the facility and asked if there was a missing a person and code green for elopement was called after. Review of the facility policy revealed : Standards and Guidelines (SG) Resident Elopement policy revised [DATE] revealed in the guidelines : it is the responsibility of all associates, upon identification to immediately report their supervisor any member suspected to be missing/elopement. Procedure: A coordinated search of the unit will be conducted and other units will also be notified and properly searched. Search teams will cover entire units (bathrooms, closets, etc.), as well as all other areas of the facility (lobby, dining rooms, offices). Time and location where the member was last seen will be established, to include whom they were with, as well as appearance. (i.e. clothing) Record review of facility's policy titled SG Abuse Neglect and Exploitation (ANE) and Investigations Section: Risk Management revision date [DATE] revealed: It will be the standard of this facility honor resident's rights and to address with employees the seven components regarding mistreatment, abuse, neglect, sexual misconduct, injuries of unknown source, involuntary seclusion, corporal punishment, misappropriation of resident property or funds or use of physical or chemical restraint not required to treat the resident's symptoms in accordance with Federal Law. It will be the standard of this facility to ensure that all alleged violations of Federal or State laws, which involve mistreatment, neglect, abuse (verbal, mental physical or sexual), injuries of undetermined source, involuntary seclusion, corporal punishment, misappropriation of resident property or funds or use or physical or chemical restraint not in accordance with regulation to treat resident's symptoms be reported immediately to the administrator/DNS/designee. Neglect .is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identification .When any allegation or confirmed abuse, neglect, mistreatment or exploitation of a resident occurs including suspicion, the appropriate state agencies will be notified immediately including Adult Protective Services ,[DATE]-ABUSE, federal reporting using the Immediate and 5 day Federal Reports and the local police or Ombudsman if indicated. Protection .The facility will protect residents from harm during an investigation up to and including removing the suspected employee(s) from the work . Reporting .All allegations of abuse, neglect, mistreatment, exploitation of residents' funds or property are to be reported immediately to the Administrator and according to Federal and State Regulations. Any theft, resident to resident altercations where significant injury has occurred, or allegations/suspicions/ or witnessed abuse or neglect has occurred with significant injury or reasonable suspicion of a crime need reported to the local law enforcement.