STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105903	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANCO NURSING & REHABILITATION CENTER	**800 NW 95TH STREET MIAMI, FL 33150**

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, records and policies review, the facility failed to implement baseline care plan to ensure adequate supervision was provided for one resident (Resident #2) out of four sampled residents . Resident #2 was a vulnerable adult that eloped from the facility for approximately six hours, which placed his health and safety at risk. This facility's deficient practice has the potential to have an adverse effect on any newly admitted , cognitively impaired and vulnerable residents in the facility. There were 106 residents residing in the facility at the time of the survey. The Findings Included: Record review of the facility's Policies and Procedures document Titled .N125 Subject: Abuse, Neglect, Exploitation and Misappropriation. Effective Date: 11/30/2014 Revision Date 11/28/2017. Revealed: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or miss- appropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies and procedures . Neglect: is the failure of the center, 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; Examples include put are not limited to; Failure to adequately supervise a resident known to wander from the facility without the staff knowledge. Review of the clinical Face Sheet revealed Resident #2 was admitted in the Facility on 05/29/20. Hospital records for Resident #2 revealed a Final Discharge Note And Discharge Plan dated 5/29/20. It noted, the patient was seen and evaluated by medical team . Primary [DIAGNOSES REDACTED]. Secondary [DIAGNOSES REDACTED]. Clinical records also indicated Resident #2 was admitted to the facility since family was no longer able to take care of him . Review of the Admission data collection sheet, section P; Medication Review revealed the following Focus Medications (medications that may create an increased risk for the resident): Antipsychotic Name: Quetiapine 12.5 mg twice daily. Antidepressant Name: [MEDICATION NAME] 100 mg. Hypnotic Name:[MEDICATION NAME] mg at bedtime. diagnosis (DX) [MEDICAL CONDITION]/Inability to Sleep at night. A review of Resident #2's consent for use of psychoactive medication therapy revealed a signed consent for the use of [MEDICAL CONDITION] medications that included ordered: [MEDICATION NAME] .5 mg. every shift as needed. Dated 5/30/20. Specific condition to be treated; Pacing and Spontaneous rising. Review of the Baseline Care Plan for Resident #2 dated 5/29/20 revealed, care plan areas marked to be addressed included; falls /safety and elopement. The Goals included; Will remain free of injury, will not exit facility unassisted, will follow facility policy. Interventions; Evaluate cognitive status and gait steadiness, maintain safe environment, wander/risk assessment, apply exit alert device as needed; type: wander guard . Daily skilled nurse's notes for Resident #2 dated 6/3/20 showed Level of Consciousness very confused Behavior Problem; wandering during the evening shift. Nurse's note on 6/3/20 at 6:00 PM indicated: Resident Alert and in no apparent distress. Has great difficulty staying in room and engaged in wandering and questioning staff regarding discharge. All due meds given and well tolerated. Comfort safety measures maintained . 6/3/20 9:30 PM Resident eloped from the facility. Doctor {} notified. Friend/contact notified. Police notified. Additional notes detailed resident's behavior from 4:00 PM - 9:30 PM; At 5:00 PM Due meds given, questioning staff and wandering out of room, continuously redirected to room by all staff members. At 8:30 PM resident walked to back door of 300 wing hallway and pressed on door sounding alarm. Intercepted by nurse and escorted back to room directed to chair aside bed to watch television. 9:00 PM notified by staff that {Resident #2} was not in his room . code green initiated . notes ended at 9:30. Interview with Resident #2 on 6/9/20 at approximately 11:40 AM revealed, Resident #2 remembered that he left the facility at night, (could not remember the date). Resident # 2 stated that he left the facility because he needed to go see his friend {}, I went to look for {.}, he supposed to take care of me, but where is he now . During an interview with the Administrator / Risk Manager on 6/9/20 at 12:49 PM she reported I learned that {Resident #2} was not in the building on 6/3/20 at about 9:45 PM. I came to the building and we could not find him. The police found him the next morning unharmed at around 2:17 AM . The administrator explained that the resident returned to the facility with the police willingly. When he returned, he was assessed head to toe, for pain, skin injuries and documentation completed. The administrator stated that, Resident #2 had no injuries, no pain nor distress and had a functioning wander guard on his leg. The Administrator later reported, the risk to a resident when they elope is that anything can happen to them when they are not here. When a resident appears at risk for elopement, they should put the resident on supervision at least every 15 minutes and notify the unit manager and the Director of Nursing (DON), as well as re-direct the resident to the room. Interview on 6/20/20 at 12:20 PM with Staff A, Security Guard revealed, on the night of the incident, (6/3/2020) he was doing his routine rounds outside the property. He saw Resident #2 in the back of the building and asked him to leave the property. The Security Guard explained; I asked him if he lived here, and he said no, I'm just trying to go home. Staff A reported that Resident #2 did not have an ID bracelet that residents wear on their wrist, so he asked him to leave and walked Resident #2 to the gate. Staff A reported, It was almost 9:00 PM when I saw him. I think it was around 9:25 PM when the nurse asked me if I had seen him, I told them what happened The police got here and found him later that night Staff A, Guard explained that he received training on elopement and brand identification after the incident. But the Administrator was aware that the resident did not have an ID band at the time of the incident. Staff A added The resident was new in the facility; I've never seen him before. On 06/10/20 at 12:40 PM during a phone interview Staff B, Certified Nursing Assistant (CNA), reported she cared for Resident #2 during the night of the incident on 6/3/20. At approximately 7:45 PM the CNA noticed that Resident #2 attempted to exit the building . However, the resident was easily re-directed to his room. Staff B recalled that Resident #2 had a bracelet on his leg. None on his arm. The alarm did not go off at that time when she noticed Resident # 2 trying to elope through the emergency exit down the hallway at approximately 7:45 PM. Staff B reported that it was approximately 9:30 PM when she heard the alarm and looked for Resident #2 but could not find him . Staff B, explained that she proceeded to notify the nurse and they looked for Resident#2. Staff B reported that she later learned that the security guard saw the resident go out the gate. Interview with Staff C, Registered Nurse (RN) on 6/10/20 at 1:15 PM revealed, he noticed that Resident #2 attempted to exit the building on 6/3/2020 at approximately 8:30 PM. The resident was easily re-directed to his room. The resident had shown some behavior of confusion;. Staff C further stated, he was pleasant but with some confusion, preoccupied with events that had nothing to do with his current situation. Like mechanics . He also wanted to go to buy cigarettes . The alarm went off at approximately 8:30 PM, I could not turn it off because I did not have the correct code, the code I had did not work. I got busy re-directing him to his room and explained to him we could call his family; we called . his friend, He spoke to his friend . then he remained in his room and I alerted both CNAs on the unit about the current situation with the resident and his behavior, (they knew to monitor). The alarm stayed on, I could not turn it off, none of the CNAs had the code and I did not know how to page the security guard . I think by 9:30 we were already calling the police. The resident had the wander guard on Interview with

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

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Staff C LPN on 6/11/20 at 4:03 PM revealed, the medications that Resident #2 received during the night of the incident on 6/3/20 at approximately 8:50 PM. [MEDICATION NAME] mg at bedtime. Staff C explained that Resident #2 should be monitored for Side effects [MEDICATION NAME] included Confusion and Sleepwalking.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, records and policy review, the facility failed to ensure adequate supervision for one resident (Resident #2) investigated for elopement out of four sampled residents. Resident #2, a vulnerable adult eloped from the facility for approximately six hours placing his health,safety and life at risk. This facility's deficient practice has the potential to have an adverse effect on any newly admitted , vulnerable and or cognitively impaired residents in the facility. There were 106 residents residing in the facility at the time of the survey. The Findings Included: Record review of the facility's Policies and Procedures revealed, document titled: . 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Friend/contact notified. Police notified. Additional notes detailed resident's behavior from 4:00 PM - 9:30 PM; At 5:00 PM Due meds given, questioning staff and wandering out of room, continuously redirected to room by all staff members. At 8:30 PM resident walked to back door of 300 wing hallway and pressed on door sounding alarm. Intercepted by nurse and escorted back to room directed to chair aside bed to watch television. 9:00 PM notified by staff that {Resident #2} was not in his room . code green initiated . notes ended at 9:30. Review of {Resident #2's} inventory of personal effects showed articles: 1 belt, 1 comb, 1, shoes, 2 slacks, 3 toothbrushes, $20 dollar bill . there was a note dated 6/4/20 that revealed the resident returned to facility with no belongings at 2:17 AM. Interview with Resident #2 on 6/9/20 at approximately 11:40 AM revealed, Resident #2 remembered that he left the facility at night, (could not remember the date). Resident # 2 stated that he left the facility because he needed to go see his friend {}, I went to look for {.}, he supposed to take care of me, but where is he now . During an interview with the Administrator / Risk Manager on 6/9/20 at 12:49 PM she reported I learned that {Resident #2} was not in the building on 6/3/20 at about 9:45 PM. I came to the building and we could not find him. The police found him the next morning unharmed at around 2:17 AM . The administrator explained that the resident returned to the facility with the police willingly. When he returned, he was assessed head to toe, for pain, skin injuries and documentation completed. The administrator stated that, Resident #2 had no injuries, no pain nor distress and had a functioning wander guard on his leg. The Administrator later reported, the risk to a resident when they elope is that anything can happen to them when they are not here. 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