STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105250	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUNTINGTON PLACE	**1775 HUNTINGTON LANE ROCKLEDGE, FL 32955**

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, interview and record and record review, the facility failed to provide adequate supervision for a resident with severe cognitive impairment, known history of elopement and assessed at high risk for wandering/elopement for 1 of 3 residents reviewed at risk for elopement out of a total sample of 12 residents, (#10). These failures contributed to the elopement of resident #10 and placed him at risk for serious injury, impairment or death. While resident #10 was out of the facility unsupervised, there was high likelihood he could have fallen, become lost, or been hit by a car. On 08/03/20 at approximately 10 AM, while being monitored by staff every 30 minutes, resident #10 exited the facility through his room window. He opened one of the 2 side by side windows in his room, pushed out the screen, and exited through the window opening. Resident #10 walked 2 miles past multiple businesses, stores, gas stations and areas with deep culverts for water drainage until he was located by law enforcement standing at a bus stop in front of a local chain restaurant. The bus stop was close to an entrance and exit to Interstate 95 The temperature on August 3, 2020 was 94 degrees Fahrenheit with humidity of 51 percent which placed the resident at risk for dehydration and/or sun exposure (Timeanddate.com website at www.timeanddate.com accessed on 8/24, 2020). The resident was found by law enforcement who observed him standing at the bus stop with a white band on his ankle. The resident was out of the facility unsupervised for 3 hours when the facility received a call from law enforcement that the resident had been found at the bus stop near Interstate 95. The facility's failure to provide adequate supervision for a resident with severe cognitive impairment and history of wandering behavior resulted in Immediate Jeopardy starting on 08/03/20. The Immediate Jeopardy was removed on 08/04/20. Findings: Review of the facility Elopements and Wandering Resident Policy, not dated, read, Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . 2. 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 . 6. Monitoring and Managing Residents at Risk for Elopement . d. Adequate supervision will be provided to help prevent accidents and elopements . Review of the Facility Assessment Tool, dated 04/06/20, revealed that the facility was competent to provide care and services for residents with [DIAGNOSES REDACTED]. Resident #10 was a [AGE] year-old male with severe cognitive impairment and history of elopement. He was admitted to the facility on [DATE] from an acute care hospital. The resident's [DIAGNOSES REDACTED]. He was admitted to the acute care hospital on [DATE] for confusion and his neurological assessment revealed that his memory was poor with a [DIAGNOSES REDACTED]. He had previously been placed in an Assisted Living Facility (ALF) where he eloped and was found walking in a river. The Admission/Re-Admission Screening form dated 07/18/20 noted he was alert and oriented to person and time only and independent with mobility. The admission Minimum Data Set (MDS) assessment dated [DATE] noted that the resident's Brief Interview for Mental Status (BIMS) score was 3 indicating severely impaired cognition and behaviors included delusions. The admission Wandering assessment dated [DATE] documented he was ambulatory; had a history of [REDACTED]. A second Wandering Assessment was completed on 07/21/20 (72 hours after admission) and documented he continued to be at high risk to wander. The resident's plan of care initiated on 07/21/20 included elopement risk/exit seeking, history of exit seeking related to dementia, cognitive deficits and paranoia related to [MEDICAL CONDITION] and placement of Wander Guard device to his left ankle. The goal included the resident will not leave the facility unattended and remain safe in facility. Interventions were to monitor for tailgating,reassure resident when distressed over placement, divisional activities when exit-seeking behavior occurring (i.e: offer food, activities, and one-on-one company). A second plan of care included resident is at risk for complications related to [MEDICAL CONDITION] drug use: [DIAGNOSES REDACTED]. Physician orders [REDACTED]. The Social Service assessment dated [DATE] documented the assessment was completed with the resident who had short-term and long-term memory problems and since he is unable to make his own decisions, he has a Durable Power of Attorney. The sections for mood state, behavior problems and other history were left blank. The summary section documented the resident was very confused. The assessment did not include obtaining resident's past history from the resident's Power of Attorney. Review of a Behavior Note dated 07/27/20 revealed the resident was observed with superficial cuts on his right thumb and index finger caused by a disposable razor. The resident had stated, those were to protect, there are people out to get me. After this incident interventions put in place included every 30-minute safety checks, room door to be left open, room to be checked for unsafe items every shift, kitchen to supply paper plates and plastic utensils and psychological services pending. On 08/20/20 at 9:32 AM, the Administrator stated that resident #10 was admitted to the facility for short-term rehabilitation. He had previously lived in an Assisted Living Facility (ALF) and he left the facility and was found in a river. She said that on 8/03/20 at 10 AM, resident #10 opened the window in his room, pushed out the window screen and exited through the open window. At 10:10 AM the Occupational Therapist (OT) entered resident #10's room to provide therapy services and the resident was not there. The OT notified the Certified Nursing Assistant (CNA) assigned to resident #10. When they both could not locate the resident, an Elopement announcement was called over the intercom system. An immediate search was conducted in the interior, and exterior of the facility. The search was expanded to include the surrounding property and surrounding streets without success in locating resident #10. A CNA went into the resident's room and pulled up the window blinds. The window had been opened and the screen had been pushed out. At this time resident #10's physician, responsible party and Law Enforcement were notified. According to the Administrator 14 Law Enforcement officers responded to the facility. A bloodhound with handler were called to search for the resident and a drone was used. The bloodhound picked up resident #10's scent which lead out of the facility parking lot to the gas station/convenience store across the street. It was not until 3 hours later at 1 PM that resident #10 was found by Law Enforcement in front of a major home improvement store on the heavily trafficked highway close to Interstate 95. The resident was then transferred to the hospital for evaluation and he returned to the facility the same day at 5 PM (7 hours after the elopement). The administrator stated that she completed an investigation, but she never attempted to interview the resident or conduct and interview with the resident's responsible party to help establish why he left the facility. The administrator said the root cause for the elopement was the facility could not have predicted that the resident would elope through his window. She said upon return to the facility, resident #10's room was changed for closer supervision and he was placed on 1:1 supervision. On 08/04/20 at 11:45 AM (18 hours later) while on 1:1 supervision, resident #10 jumped off his bed and used both his arms to smash the glass out of his room window. He attempted to climb out but retreated. He then ran out of his room, through the lobby, past the receptionist desk and ran directly into the double glass fire/exit door causing him to fall backwards. He sustained lacerations to both arms that were bleeding. The Administrator stated that in February 2019 the facility had a similar incident where a resident eloped through his room window. As a result, 2 screws

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) were placed in all room windows and audits of all room windows were being conducted monthly by the Maintenance Director. On 08/03/20 immediately after resident #10's elopement, the Maintenance Director identified 6 room windows that did not have 2 screws in place. On 08/20/20 at 11:12 AM, the Maintenance Director stated that he was responsible for checking all the facility windows every month. All resident room windows should have 1 hex head screw in each window frame which allows the window to open only 6 inches. Every month I was checking that the screws were in place and that the window would open and close properly. On 08/03/20 the Administrator asked me to check all resident room windows to make sure that the screws were in place. He stated that his audit conducted on 08/03/20 revealed that out of a total of 120 resident room windows, 6 windows were found to be missing 1 screw in the window frame. The missing screws were replaced. Review of the monthly window audits conducted by the Maintenance Director on 07/03/20 and 08/03/20 documented all room window nails (screws) were in place. The audit conducted on 08/03/20, after the elopement revealed that rooms 105, 108, 121, 134, 136, 158 and 160 did not have the required screws in place. This placed 8 other residents at potential risk for elopement since the windows were not secured and were able to be fully opened. The monthly audits only identified that the screws were in place. The security of the screws into the window frame was not part of the auditing process. On 08/20/20 at 12:53 PM, the Director of Nursing (DON) stated that that all residents were checked at least every 2 hours. She said that residents with Wander Guard devices had been assessed at risk for wandering/elopement and supervision was the same unless the resident was talking about leaving or showing behaviors of wandering. She said that resident #10 was placed on every 30 minute checks following his incident with the razor. The facility has no policy for supervision for a resident who is at high risk for wandering/elopement. His intention was to leave regardless of interventions that were in place. On 08/20/20 at 12:15 PM, CNA A revealed she was assigned to resident #10 on 08/03/20. She stated that the resident was on every 30-minute and she last observed the resident at 10 AM resting in bed. On 08/20/20 at 12:57 PM, the Administrator revealed that resident #10 was placed on every 30-minute checks on 07/26/20 because of behaviors. He was found dismantling a disposable razor which was in his personal belongings and was not found during his admission process. He had only small cuts on his fingers. She explained that the Interdisciplinary Team had made the decision for every 30-minute checks because it was a standard to start with every 30-minute checks. We felt the 30-minute checks were appropriate for his behavior issues. On 08/21/20 at 11:35 AM, Licensed Practical Nurse (LPN) B stated that she was the nurse assigned to resident #10 on 08/03/20 when he eloped from the facility. She said she checked his room and then notified the receptionist. I then went outside and discovered that the resident's window was opened. I did not notice if anything was on the ground. I ran to my car to check the roads near the facility but was not able to find him, so I returned to the facility to take care of my residents. She stated that she was present when resident #10 returned to the facility at 5 PM but she never asked the resident why he left the facility. On 08/20/20 at 1:05 PM, an observation of resident #10's room was conducted with the Administrator. The room was located on the South Wing at the very end of the hallway and was adjacent to an exit door. The room had 2 side by side windows that faced the back-parking lot. Observations out of the room window revealed several parked cars, 2 trash dumpster's and thick woods at the back and side of the property. On 08/20/20 at 3:30 PM, a phone interview was conducted with resident #10's responsible party. She revealed that she was the Power of Attorney and had been involved in his care for a long time. She said that resident #10 had [MEDICAL CONDITION] that had radiated to his brain which required [MEDICAL CONDITION] treatments, [MEDICAL CONDITION], placement of a gastrostomy tube (GT) with frequent feedings and placement of a port for his [MEDICAL CONDITION]. He then developed memory problems and also had a family history dementia. He was previously at an Assisted Living Facility (ALF) and he was doing well until he eloped and was found walking in a river behind the facility. He was a professional fisherman and then worked in maintenance. This is probably why he navigates to water. She said she received a phone call on 08/03/20 from the facility informing that he had eloped from the facility through his room window and that Law Enforcement was looking for him. She stated that when she placed him at the facility, I expected that he would not get out by himself because I was told it was a secure facility. I thought it was a locked facility. My concern was getting him back and I was very worried about him being near any water because that is where he ended up when he left the ALF. He is still in the hospital and I am having problems with finding a place that will take him due to his elopement behaviors. On 08/20/20 at 3:35 PM, a phone interview was conducted with the Brevard Law Enforcement Officer who located resident #10 on 08/03/20. He stated that he responded to the facility at 10:05 AM and there were 13 officers that were dispatched to the facility. A bloodhound with handler and a drone was set up to assist with locating the resident. The bloodhound was able to pick up resident #10's scent from the facility to the gas station/convenience store across the street. Then his scent was lost. The officer said he drove around for 3 hours looking for the resident. While driving north bound on a highly trafficked 5-lane highway, I observed a male staggering around at the bus stop in front a local chain restaurant which was near Interstate 95. I noticed a white bracelet on his ankle, and he was wearing flip flops, a navy colored shirt and shorts and his feet were dirty. The officer said the resident was in the sun and he was not sweating. Since the temperature was in the 90's I knew he might be dehydrated so I provided him with some water. He was stumbling around and confused. The resident stated he had left the facility through the bedroom window, I just opened it up and crawled out. When he was asked why he left the facility he responded that he needed to get out of the building before the nurse with the medications got to his room. According to the resident, The meds were killing people and he did not feel safe at the facility. Review of the Brevard Law Enforcement Incident Report narrative dated 08/03/20 revealed at 10:05 AM, Law Enforcement responded to a report of a missing and endangered adult. The resident is a disabled elderly adult who suffers from several medical conditions, Dementia and other psychological conditions as well as physical conditions. A search was conducted in the immediate areas surrounding the facility and a bloodhound was used to track the resident. The track led south from the facility to the wood line on the south side of the parking lot. The track then led east and then south and ended. The resident was found by Law Enforcement walking south bound on a highly trafficked 5-lane highway. The resident stated that he did not feel safe at the facility because a staff member was going to beat him and kill him. The resident was then transferred to the hospital to be evaluated for possible injuries. While at the hospital the resident did not speak much and what he would say did not make any sense. On 08/21/20 at 6:15 PM, a phone interview with resident #10's physician who was also the facility's Medical Director. He stated that the resident had significant advanced Dementia and he was rapidly declining. He said the resident was unpredictable and needed close supervision. The physician added that since the resident had attempted to elope from the facility on 2 occasions, he will require a secure room with alarms on the windows. I have had 2 conversations by phone with the facility about purchasing window alarms. The first discussion was on 08/03/20 and the second was today (08/21/20). Review of the corrective measures implemented on 08/04/20 by the facility to remove Immediate Jeopardy revealed the following: The Maintenance Director checked and secured all 60 resident room windows and validated the function of the facility exit doors and ensured that all resident windows were locked and secured. The maintenance management system was updated to reflect ongoing monthly checks of window safety. All 92 residents were re-evaluated for elopement risk. 8 residents were identified with wander guard placement: the placement and function were validated, the presence of resident information in the elopement books and care plan review was completed. Education on elopement policy and procedures was completed with 87 of 87 active employees by the Director of Nursing and/or designee. The validation was completed with elopement drills on 8/03/20, 8/05/20. 8/06/20, 8/07/20 on all shifts. An Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting was held on 08/03/20 with the Administrator, Director of Nursing, Medical Director and 6 other management staff. All members reviewed the elopement policy and procedure, educational plan and auditing plan. Audits of resident room windows were conducted on 08/03/20, 08/04/20, 08/05/20, 08/06/20/ 08/10/20, 08/10/20, 08/13/20, 08/14/20, 08/17/20, and 08/21/20 twice a day and all resident room windows were locked and secure. An educational plan was developed and 87/88 employees were educated on 08/03/20. One staff member who is on leave of absence will be educated prior to returning to work. Contracted staff were to be educated upon their initial assignment to the facility and the facility orientation will include in depth education on the elopement policy and procedure. Anyone unable to demonstrate understanding will receive additional education with immediate competency testing. The failure to demonstrate continued competency will result in further disciplinary action up to and including termination. An additional Ad Hoc QAPI meeting was held on 08/21/20 with the Administrator, Director of Nursing, Medical Director and 7 of 18 managerial staff members including members of the facility's Governing Body in which this plan was accepted. The effectiveness of this plan will be evaluated on a weekly basis via QAPI meeting for 4 weeks and then monthly for 5 months. Education and elopement drill sign in sheets were reviewed and revealed that staff attended in person or were called at home and education was completed. 70% of the staff had participated in the elopement drills. Window audit forms were reviewed and completed by the Administrator, Administrator in Training (AIT) and/or designated person. No issues were identified. A purchase order date 08/21/20 for window alarms had been completed and reviewed. The Administrator stated that

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) window alarms will be placed on room windows of the resident with wander guard devices. The resident sample was expanded to include 2 additional residents (#11, #12) who were assessed as being wander/elopement risk, having a wander guard device in place and independent with ambulation. Record reviews, observations and interviews with staff revealed no issues. Interviews with 11 staff members on 7/21/20 revealed they were knowledgeable regarding the facility's elopement policy and procedure, wander guard placement, supervision and missing resident process.