STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105008	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCH PLAZA NURSING & REHABILITATION CENTER	**12505 NE 16TH AVE NORTH MIAMI, FL 33161**

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 observation, record reviews and interviews, the facility failed to prevent the neglect of one (Resident #1) out of three residents sampled during the time of this survey. The facility's staff failed to supervise and implement adequate measure to prevent the elopement of Resident #1 who was coded as an elopement risk. The facility neglected to adequately monitor and address Resident #1's displayed exit seeking behaviors and intent of elopement. The resident wore an alarm bracelet on his left arm that was not triggered when the resident eloped. The facility's system failure, lack of adequate supervision and a failure in ensuring an adequate alert monitoring system was in place allowed the resident to elope undetected by staff on 8/14/20 at 11:40 PM. The resident was not located until 2:00 PM on 8/15/20 at his home 5.9 miles from the facility by a family member who reported Resident #1's location to the facility. There were 83 residents residing in the facility at the time of the survey. Refer to F 607, F 689, F 835 and F 867. The findings included: Review of the facility's policy titled, Abuse, Neglect and Exploitation protocol written by the Administrator with a revision date of 11/2019, indicated: Our Facility will make all reasonable efforts to ensure that residents are free from verbal, sexual, physical and mental abuse, corporal punishment or involuntary seclusion, willful deprivation, of services to maintain the residents' physical and mental health and that their property will not be misappropriated, by the facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. A prompt thorough investigation will be conducted by the facility immediately. The facility's Policies and Procedures did not directly address neglect. Review of the Face Sheet for Resident #1 documented, the resident was admitted to the facility on [DATE] after being discharged from a local hospital following an incident where he was found unresponsive outside a local grocery store. Clinical [DIAGNOSES REDACTED]. Review of Resident #1's Behavioral Symptoms care plan dated 8/14/20 documented the resident exhibits the following behavior: elopement, observed trying to leave the facility with no apparent reason; Goal: Episodes of problem behavior will decrease to one a week/month thru next review date; Approaches: Keep resident safe with close supervision, Keep wander guard in place at all times, make staff aware of resident's high risk for elopement and monitor resident's whereabouts at frequent intervals. Review of the nursing progress notes documented the following: Dated 8/12/20 time stamped 2:19 PM- Resident observed in bed in lowest position, resident observed anxious getting out of the bed and room, voicing he has to go home; Dated 8/13/20 time stamped 2:51 PM-Resident observed in bed in lowest position, resident observed anxious getting out of the bed and room, voicing he has to go home; Dated 8/14/20 time stamped 7:15 AM (Recorded as Late Entry on 8/15/20 time stamped 1:40 AM)-Patient is able to ambulate with a walker. While giving patient medication at 6:00 AM, patient stated that he wanted to go out to pay some bills. Patient was redirected by the nurse and the nurse told him that he is not allowed to go out of the facility. Patient was able to understand and was placed inside of his room under close monitoring. Report was given to the next shift nurse about the patient statement. Patient is placed in his room and under close monitoring; Dated 8/14/20 time stamped 7:27 PM-Resident walks frequently in and out of bed, became anxious and is consistently asking to go home. Resident proceeds to open the door on several attempts. Resident was redirected, placed on close monitoring for elopement precaution; wander guard placed on resident's left arm. Sister was notified of the resident's behavior and elopement. Nursing progress note dated 8/14/20 time stamped 8:00 PM (Recorded as Late Entry on 8/15/20 time stamped 9:54 AM)-Resident received out of bed (OOB) at side door of facility ambulating with walker very agitated and trying to leave the facility; Awake Alert Oriented times two (AAOX2) with confusion. Resident was redirected on numerous occasions but insisted on leaving and wound not stay in room. One to one care implemented with Certified Nursing Assistants (CNAs) on duty. Wander guard in place and working; Dated 8/14/20 time stamped 11:00 PM-Resident noted in hallway in wheelchair (w/c). One to one monitoring continues with CNA on duty. Wander guard still in place for precaution. Nursing progress note dated 8/14/20 time stamped 11:40 PM-After the change on shift, the CNA on duty reported to assigned nurse that she brought the patient to his room and left him unattended. When she returned she noticed that the patient was missing. An extensive search of the facility and surrounding communities ensued. However, resident was unable to be located. Progress notes dated 08/15/2020 time stamped at 12:38 AM indicated, incident was reported to officer {name of police officer} via phone. Progress notes dated 08/15/2020 time stamped 1:10 AM indicated, officer on duty came to the facility and opened a report with {case #}. Search for resident continues. Review of the physician's orders [REDACTED]. Medications included: [MEDICATION NAME] 10 milligrams (mg) 1 tablet oral once a day at 9:00 AM for hypertension, Resident #1 missed the 9:00 AM dose on 8/15/20; [MEDICATION NAME] 25 mg(indicated for the treatment of [REDACTED].#1 missed the dose on 8/15/20; [MEDICATION NAME] HCL 25 mg (used chiefly to treat anxiety and alcoholism.)1 cap every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, Resident #1 missed all the doses on 8/15/20; [MEDICATION NAME] ER 24 hour. 25 mg (indicated for the treatment of [REDACTED].#1 missed the dose on 8/15/20 and Potassium Chloride 25 mg 2 tabs daily at 9:00 AM, missed dose on 8/15/20. Review of the Physical Therapy Evaluation and Plan of Treatment dated 8/13/20, documented resident #1 was certified to receive physical therapy on 8/12/20 and was referred due to new onset of decreased strength, decrease in functional mobility and decrease in transfers. Resident #1 was at risk for falls and was scheduled to receive physical therapy 6 times a week, daily. Review of the Physical Therapy Treatment Encounter Notes documented the following: Dated 8/13/20: Patient was observed ambulating in the hallway using a walker (not provided by rehab), he was standing at the nursing station, he was redirected back to his room and advised that he must remain in room as precaution; Dated 8/14/20: Resident observed standing at the nursing station. He was redirected and taken back to his room. Nursing made aware. Demonstrates impaired foot placements and walker management. He is not safe to ambulate alone, patient refused to release walker to therapist in an effort to prevent self-ambulation and falls. Review of the Physical Therapy Discharge Summary dated 8/17/20, documented the patient was advised on not ambulating alone. During observational review of the facility's video footage with the Administrator and Corporate staff on 8/18/20 at 12:23 PM. The video footage revealed that on 8/14/20 at 11:23 PM, resident #1, was wearing a baseball type hat, dressed in a black colored short, bright green shirt and sneakers was standing at the doorway to his room, during this time staff were observed in the hallway. On 8/14/20 at 11:37 PM, resident #1 ambulated from his room with no assistive device and proceeded through the double door that lead to the lobby area of the facility. Resident #1 attempted to open the front doors of the facility and was unsuccessful. Resident #1 then walked to the emergency fire exit door located at the side near the administration office, Resident #1 then pushed the door open without any difficulty at 11:40 PM on 8/14/20 and exited the facility undetected by staff. There was a nurse seated at the nurses' station and a Certified Nursing Assistant (CNA) had just walked past the resident's room down the hallway where the double doors leading to the lobby were located. Resident # 1 had a Wander Guard Bracelet on the wrist of his left arm and an identification band on his right wrist. The alarm on the exit door was not audible for staff to hear on any of floors in the facility within the care areas beyond the double doors.

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) The wander guard alert system did not trigger to alert staff.(video footage evidence obtained) On 08/18/2020 at approximately 1:00 PM after review of the above mention video footage, the Senior Administrator and the Chief Nursing Officer conducted a demonstration with the state surveyor of the alarm door's audibility. During this demonstration it was revealed that the alarm for the emergency exit door was still not audible beyond the double doors in the lobby and could not be heard in the care areas, at the 1st floor front nurses' desk nor on the 2nd floor. The Senior Administrator and the Chief Nursing Officer at this time determined and acknowledged that the audible alarm for the fire emergency door was not loud enough and could not be heard at the 1st floor front nurses' desk nor on the 2nd floor and beyond the double doors in the lobby. During interview on 8/18/20 at 11:08 AM the Administrator/Risk Manager reported that, Resident #1 was put to bed by the 11:00 PM to 7:00 AM CNA (Staff B) and the CNA (Staff B) left the room and went to take care of another resident. When Staff B was done and went back to check on Resident #1 he was missing. Staff B notified the Licensed Practical Nurse (LPN) (Staff D) and Registered Nurse (RN) (Staff A), the Supervisor. They activated Code Pink (the facility's elopement code), they searched the whole facility and the outside grounds. They notified the Police Department and the sister. The police officer came and did a report. The police was given a description and a picture of Resident #1. The Administrator/Risk Manager reported that the police officer stated he was going to go look for the resident. The DON (Director of Nursing) came in to help with the facility search as soon as she was notified. The DON called the sister and started doing the reporting to all the local agency and the 1-day report. Immediate in-servicing was done to staff that were in the building. The Administrator/Risk Manager stated, We called the nearby hospitals the next day. A little bit before 2:00 PM the next day, the sister called and she said he was found at his house. She said that he preferred to stay at home with her and we notified the doctor and he was okay with it. We did an AMA (Against Medical Advice) form over the phone and we notified the police department that he was found. The resident had a Wander Guard. He took the Wander Guard off before leaving the facility. The sister said that he told her that he took the Wander Guard off. We believe he got out through the side door by my office. The sound on the alarm was not loud enough for the 1st floor nurses' station to hear it. Since then, maintenance made the alarm louder and placed a baby monitor at the 1st floor nurses' station. During interview on 8/18/20 at 11:20 AM, the DON reported that she was notified at approximately 12:00 AM by the supervisor. The DON state,I immediately got to the facility,we continued searching. I got in contact with the sister several times, back and forth. I immediately in-serviced the staff about elopement, one on one and reporting. We called for maintenance to come in and look at the door. We did the reporting. Stayed in contact with the sister throughout the morning. The DON stated that Resident #1's sister told her at around 12:00 PM on 8/15/2020 that she was on her way to his address to see if he was there .The DON stated, Once she got there she called me and said he was in good condition and did not want to return to the facility. The Against Medical Advice (AMA) form was signed verbally. The police department was notified and turned it over to another police department who were going to do a wellness check. The doctor was notified. During interview on 8/18/20 at 1:00 PM, the Director of Environmental Services stated, He tried to get out when I was with him on that day (8/14/20). I told them he was an elopement risk. They chose to put a Wander Guard on him and I checked it. The Wander Guard went off at all the doors (front, side door by nurses' station and back door used for delivery) and was able to be heard all over the building. During interview on 8/18/20 at 3:16 PM Registered Nurse Supervisor (Staff A) for the 7:00 PM to 7:00 AM shift stated, On that Friday night, my shift was 3:00 PM to 11:00 PM, he (resident #1) was having issues on getting out. It was told to me that he was having a problem getting out, he wanted to go home. I was told by the DON, that they had put a Wander Guard on him. At that point, I initiate one CNA in his room. I told the CNA; I was going to put her in that room. He was fine, walking around, going to the nurses' station. He was sitting in front of the nurses' station. He still wanted to go home. I contacted the sister, so he could talk to his sister. He wanted to go home before coming to the facility. I told the sister that her brother wanted to go home that he had a wander guard which was a device that alarms when he is close to the door. He was sitting down talking to his sister, he put down the phone. I told all the CNAs working on that shift to watch him. The CNA was following him, where ever he went. After dinner, I went upstairs. I was supervising the whole building. When I came back down, he was quiet and moving around. He was trying to get out of the double doors and the Wander Guard alarm went off and he was taken back to the nurses' station early in the evening. Around 11:20 PM to 11:40 PM, I heard the nurse say check the rooms. I asked what is going on, they say he is not in his room. They noticed during the changing of shift that the CNA on 3:00 PM to 11:00 PM shift told (Staff B) to watch him on the 11:00 PM to 7:00 PM shift. (Staff B) took the patient to the room and left him lying down to sleep. (Staff B) went to another room to change a patient but when Staff B returned the resident (resident #1) was no longer in the bed. She said she was gone for 5 to 7 minutes. I called the DON immediately. Most of the CNAs went outside on the streets, searching for the patient. Staff in the facility were searching room to room, bathroom to bathroom. The DON came here. I called the police to report the resident missing. He was wearing a lime green shirt with black pants. The Police Officer came and took the report and gave a case number. I called the doctor (Attending Physician) to tell him the resident is missing. He wore the Wander Guard on his left arm. When he got out, I did not hear the alarm because I was on the second floor. (Staff B) said she didn't hear the alarm go off. During interview on 8/18/20 at 4:30 PM via telephone Staff B, a Certified Nursing Assistant (CNA) 11:00 PM to 7:00 PM shift stated, I came to work at 11:00 PM. I put him (resident #1) in the room at 11:20 PM. I go take care of another patient and when I finished, I went back to his room. When I go to the room, I don't see him. They called the Administrator, the DON. Everyone was looking for him. They saw on the video he left at 11:40 PM. I had eleven patients that night. He was not on one to one. The CNA before told me to watch him. The nurse never told me to watch him. I don't remember no Wander Guard bracelet on him. I didn't hear an alarm. During interview on 8/18/20 at 6:28 PM via telephone, Resident's #1 sister stated, I have no idea what happened. They told me it was impossible for him to get out because he was wearing some type of bracelet. I spoke with the facility. I don't know about an AMA (Against Medical Advice). We didn't try to get him to go back to the facility. He didn't want to go back to the facility. He doesn't have a court order to be there, so we can't force him.They told me he must have taken off the bracelet but when I saw him it was still on. When I ask him, he won't tell me anything. His memory goes in and out. The police officer came by, they called me and I told them he was home. He is living on his own. I called them to let them know the police was here at his place. Since he has been out, he has not seen a doctor. During interview on 8/19/20 at 11:35 AM via telephone interview, Staff C, a Registered Nurse Supervisor for the 7:00 AM to 7:00 PM shift stated, I work on Friday, Saturday and Sunday. The resident (resident #1) left Friday night. I got the report on Saturday morning. I called the sister and she said that the brother was with her. The family agreed to keep him. They felt he would go right back home. She gave permission for the AMA and I explained to her what the AMA was. During interview on 8/19/20 at 2:33 PM with Staff D, a Licensed Practical Nurse that worked 7:00 PM to 7:00 AM shift stated, When I got in (resident #1) he seemed agitated and he was trying to leave the building. They had him on one to one monitoring. I spoke to him briefly to see where his mindset was. He seemed to be alert and oriented times two. He was confused. They continued him on one to one monitoring. I checked his vitals at 11:00 PM, I wrote it down. No meds were to be given at that time. The 3:00 PM to 11:00 PM shift still had him on monitoring and on the 11:00 PM to 7:00 AM shift. I was on the side where (resident #1) was from 11:00 PM to 11:15 PM and he was in his room. At 11:15 PM, I went to the south side, which was my side. Around 11:25 PM, the CNA(Staff B) came to me and said we can't find (resident #1). Staff D reported that the CNA stated that resident #1 was placed in his room, and when the CNA, Staff B returned to the room resident #1 was not there. Staff D, LPN stated, I started searching every room. I searched rooms, bathrooms, patios. I didn't find anything. I started searching around the facility and the community. A code pink was started and everyone was searching. The police was notified, his sister was notified. All of the notifications were done by the supervisor on duty at that time. He had a Wander Guard bracelet on. I can't remember which arm it was on. During interview on 8/19/20 at 3:16 PM Staff E, a Registered Physical Therapist stated, Resident #1 was scheduled to receive Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (SLP). He received an evaluation on 8/12/20 for PT, OT and SLP evaluation on 8/13/20. He was not safe to ambulate alone, determined on the evaluation dated 8/12/20. Nursing was made aware; he is not safe to ambulate alone. During interview the Administrator/Risk Manager on 8/20/20 at 12:20 PM stated, We don't have a policy on one to one supervision. We would need a doctor's order for one to one supervision. If they are at risk for elopement we will call the doctor to obtain the order. You need a doctor's order for a true one to one. Once the resident is exhibiting the behaviors, we call the doctor to obtain an order. If he doesn't order, we put them on close supervision, which is technically a one to one. We notified the doctor that he had eloped. We called the family member and were informed that the resident did not want to come back and did a verbal AMA on the phone with family member. We called the doctor a second time to notify him of an AMA. They had told me in the afternoon that he was exit seeking, the Wander Guard was put on him and working and on close supervision. When we came to figure out, how he got out, we became aware of him using the fire exit door. At night

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) when there is no noise, you should be able to hear the alarm. A baby monitor was added on Tuesday, 8/18/20 at the nurses' station to monitor if and when the fire exit door is opened. We felt we had fixed it by putting the key card at the doors. We could not put a key card at the fire exit door. On 8/20/20 to 8/21/20, the corrective actions related to the facility's failure to prevent the neglect verified by the survey team through observations, record review and interviews included: The staff were in-serviced/trained on 8/15/20 for 7:00 AM-7:00 PM shift, 7:00 PM-7:00 AM shift for nurses, 7:00 AM-3:00 PM shift, 3:00 PM-11:00 PM shift and 11:00 PM-7:00 AM shift for certified nursing assistants (CNA) regarding: Wandering precautions and wander guard device, Abuse and neglect and Monitoring patients with exit seeking behaviors and elopement risk. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on 8/15/2020 and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. An audit of all residents who reside in the facility was conducted to evaluate a risk for leaving the facility without informing staff and/or if they may desire to leave the facility. The nursing, therapy, social services, housekeeping and dietary departments were re-educated on the facility's policy and procedure of missing person protocol which include code pink, ensuring that the wandering observation tool is used effectively per facility's protocol. The facility-initiated Staff re-education on 8/15/20 for all shifts regarding Abuse and Neglect policy. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on 8/15/2020 and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. Prompt re-training was initiated on 8/15/20 for all shifts regarding Abuse Reporting, Need for 1 to 1, Elopement, Abuse and Neglect and Reporting Elopement, Fire Exit Doors and Audible Alarms, Abuse and Neglect/Elopement Identifying Patients with Exit Seeking Behaviors, Endorsing and Monitoring of Exit Seeking Residents-Implementing 1:1 and Code Pink.
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to implement their abuse and neglect policy as evidenced by the facility's staff failure to provide care and services including adequate supervision for one (resident #1) out of three residents sampled during the time of this survey. Due to the deficient practices, Resident #1 who displayed exit seeking behaviors, was documented as a high risk for elopement and on 8/14/20 at 11:40 PM eloped from the facility undetected through an emergency exit door in the lobby area of the facility. The resident was not located until 2:00 PM on 8/15/20 at his home 5.9 miles from the facility by a family member who reported resident #1's location to the facility. Refer to F 600, F 689, F 835 and F 867. The findings included: Review of the facility's policy titled, Abuse, Neglect and Exploitation protocol written by the Administrator and the revision date was on 11/2019, the policy documented: Our Facility will make all reasonable efforts to ensure that residents are free from verbal, sexual, physical and mental abuse, corporal punishment or involuntary seclusion, willful deprivation, of services to maintain the residents' physical and mental health and that their property will not be misappropriated, by the facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. A prompt thorough investigation will be conducted by the facility immediately. The facility's Policies and Procedures did not directly address neglect. Review of the Face Sheet for Resident #1 documented, the resident was admitted to the facility on [DATE] after being discharged from a local hospital following an incident where he was found unresponsive outside a local grocery store. Clinical [DIAGNOSES REDACTED]. Record review, observation of the facility's video footage and interviews revealed, the facility's staff had opportunities to prevent the elopement of resident #1 who was coded as an elopement risk. The facility neglected to adequately monitor and address resident #1's displayed exit seeking behaviors and intent of elopement. The resident wore an alarm bracelet on his left arm that was not triggered when the resident eloped. The facility's system failure, lack of adequate supervision and a failure in ensuring an adequate alert monitoring system was in place allowed the resident to elope undetected by staff on 8/14/20 at 11:40 PM. Review of Resident's #1 Behavioral Symptoms care plan dated 8/14/20 documented the resident exhibits the following behavior: elopement, observed trying to leave the facility with no apparent reason; Goal: Episodes of problem behavior will decrease to one a (week/month) thru next review date; Approaches: Keep resident safe with close supervision, Keep wander guard in place at all times; Make staff aware of resident's high risk for elopement; Monitor resident's whereabouts at frequent intervals. Review of the nursing progress notes documented the following: Dated 8/12/20 time stamped 2:19 PM- Resident observed in bed in lowest position, resident observed anxious getting out of the bed and room, voicing he has to go home; Dated 8/13/20 time stamped 2:51 PM-Resident observed in bed in lowest position, resident observed anxious getting out of the bed and room, voicing he has to go home; Dated 8/14/20 time stamped 7:15 AM (Recorded as Late Entry on 8/15/20 time stamped 1:40 AM)-Patient is able to ambulate with a walker. While giving patient medication at 6:00 AM, patient stated that he wanted to go out to pay some bills. Patient was redirected by the nurse and the nurse told him that he is not allowed to go out of the facility. Patient was able to understand and was placed inside of his room under close monitoring. Report were giving to the next shift nurse about the patient statement. Patient is placed in his room and under close monitoring; Dated 8/14/20 time stamped 7:27 PM-Resident walks frequently in and out bed, became anxious and is consistently asking to go home. Resident proceeds to open the door on several attempts. Resident was redirected, placed on close monitoring for elopement precaution; wander guard placed on resident's left arm. Sister was notified of the resident's behavior and elopement; Nursing progress note dated 8/14/20 time stamped 8:00 PM (Recorded as Late Entry on 8/15/20 time stamped 9:54 AM)-Resident received out of bed (OOB) at side door of facility ambulating with walker very agitated and trying to leave the facility. Awake Alert Oriented times two (AAOX2) with confusion. Resident was redirected on numerous occasions but insisted on leaving and wound not stay in room. One to one care implemented with Certified Nursing Assistants (CNAs) on duty. Wander guard in place and working; Dated 8/14/20 time stamped 11:00 PM-Resident noted in hallway in wheelchair (w/c). One to one monitoring continues with CNA on duty. Wander guard still in place for precaution. Nursing progress note dated 8/14/20 time stamped 11:40 PM-After the change on shift, the CNA on duty reported to assigned nurse that she brought the patient to his room and left him unattended. When she returned she noticed that the patient was missing. An extensive search of the facility and surrounding communities ensued. However, resident was unable to be located. Review of the physician's orders [REDACTED]. Medications were: [MEDICATION NAME] 10 milligrams (mg) 1 tablet oral once a day at 9:00 AM for hypertension, he missed the 9:00 AM dose on 8/15/20; [MEDICATION NAME] 25 mg(indicated for the treatment of [REDACTED].)1 cap every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, he missed the doses on 8/15/20; [MEDICATION NAME] ER 24 hour. 25 mg (indicated for the treatment of [REDACTED]. Review of the Physical Therapy Evaluation and Plan of Treatment dated 8/13/20, documented resident #1 was certified to receive physical therapy on 8/12/20 and was referred due to new onset of decrease in strength, decrease in functional mobility and decrease in transfers. The resident was at risk for falls. He was scheduled to receive physical therapy 6 times a week, daily. 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The video footage revealed that on 8/14/20 at 11:23 PM, resident #1, dressed in a black colored pants and green shirt was standing at the doorway to his room, during this time staff were observed in the hallway. On 8/14/20 at 11:37 PM, resident #1 ambulated from his room with no assistive device and proceeded through the double door that lead to the lobby area of the facility. Resident #1 attempted to open the front doors of the facility and was unsuccessful. Resident #1 then walked to the emergency fire exit door located at the side near the administration office, Resident #1 then pushed the door open without any difficulty at 11:40 PM on 8/14/20 and exited the facility undetected by staff. There was a nurse seated at the nurses' station and a Certified Nursing Assistant (CNA) had just walked past the resident's room down the hallway where the double doors leading to the lobby were located. Resident # 1 had a Wander Guard Bracelet on the wrist of his left arm and an identification band on his right wrist. The alarm on the exit door was not audible for staff to hear on any of floors in the facility within the care areas beyond the double doors. The wander guard alert system did not trigger to alert staff. (Video footage obtained) On 08/18/2020 at approximately 1:00 PM after review of the above mention video footage, the Senior Administrator and the Chief Nursing Officer conducted a demonstration with the state surveyor of the alarm door's audibility. During this demonstration it was revealed that the alarm for the emergency exit door was still not audible beyond the double doors in the lobby and

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) could not be heard in the care areas, at the 1st floor front nurses' desk nor on the 2nd floor. the Senior Administrator and the Chief Nursing Officer at this time determined and acknowledged that the audible alarm for the fire emergency door was not loud enough and could not be heard at the 1st floor front nurses' desk nor on the 2nd floor and beyond the double doors in the lobby. During interview on 8/18/20 at 11:08 AM the Administrator/Risk Manager reported that, Resident #1 was put to bed by the 11:00 PM to 7:00 AM CNA (Staff B) and the CNA (Staff B) left the room and went to take care of another resident. When Staff B was done and went back to check on Resident #1 he was missing. Staff B notified the Licensed Practical Nurse (LPN) (Staff D) and Registered Nurse (RN) (Staff A), the Supervisor. They activated Code Pink (the facility's elopement code), they searched the whole facility and the outside grounds. They notified the Police Department and the sister. The police officer came and did a report. The police was given a description and a picture of Resident #1. The Administrator/Risk Manager reported that the police officer stated he was going to go look for the resident. The DON (Director of Nursing) came in to help with the facility search as soon as she was notified. The DON called the sister and started doing the reporting to all the local agency and the 1-day report. Immediate in-servicing was done to staff that were in the building. The Administrator/Risk Manager stated, We called the nearby hospitals the next day. A little bit before 2:00 PM the next day, the sister called and she said he was found at his house. She said that he preferred to stay at home with her and we notified the doctor and he was okay with it. We did an AMA (Against Medical Advice) form over the phone and we notified the police department that he was found. The resident had a Wander Guard. He took the Wander Guard off before leaving the facility. The sister said that he told her that he took the Wander Guard off. We believe he got out through the side door by my office. The sound on the alarm was not loud enough for the 1st floor nurses' station to hear it. Since then, maintenance made the alarm louder and placed a baby monitor at the 1st floor nurses' station. During interview on 8/18/20 at 11:20 AM, the DON stated, The supervisor notified me. I immediately got to the facility, we continued searching the facility code pink. I got in contact with the sister several times, back and forth. I immediately in-serviced the staff about elopement, one on one and reporting. We called maintenance so they can come in and look at the door. We did the reporting. Stayed in contact with the sister throughout the morning. The DON stated that Resident #1's sister told her at around 12:00 PM on 8/15/2020 that she was on her way to his address to see if he was there. The DON stated, once she got there she called me and said he was in good condition and did not want to return to the facility. The AMA form was signed verbally. The police department was notified and turned it over to another police department who were going to do wellness check. The doctor was notified. During interview on 8/18/20 at 1:00 PM, the Director of Environmental Services stated, He tried to get out when I was with him on that day (8/14/20). I told them he was an elopement risk. They chose to put a Wander Guard on him and I checked it. The Wander Guard went off at all the doors (front, side door by nurses' station and back door used for delivery) and was able to be heard all over the building. During interview on 8/18/20 at 3:16 PM Staff A, a Registered Nurse Supervisor for the 7:00 PM to 7:00 AM shift stated, on that Friday night, my shift was 3:00 PM to 11:00 PM, he (resident #1) was having issues on getting out. It was told to me that he was having a problem getting out, he wanted to go home. I was told by the DON, that they had put a Wander Guard on him. At that point, I initiate one CNA in his room. I told the CNA; I was going to put her in that room. He was fine, walking around, going to the nurses' station. He was sitting in front of the nurses' station. He still wanted to go home. I contacted the sister, so he could talk to his sister. He wanted to go home before coming to the facility. I told the sister that her brother wanted to go home that he had a wander guard which was a device that alarms when he is close to the door. He was sitting down talking to his sister, he put down the phone. I told all the CNAs working on that shift to watch him. The CNA was following him, where ever he went. After dinner, I went upstairs. I was supervising the whole building. When I came back down, he was quiet and moving around. He was trying to get out of the double doors, and the Wander Guard alarm went off and he was taken back to the nurses' station early in the evening. Around 11:20 PM to 11:40 PM, I heard the nurse say check the rooms. I asked what is going on, they say he is not in his room. They noticed during the changing of shift that the CNA on 3:00 PM to 11:00 PM shift told (Staff B) to watch him on the 11:00 PM to 7:00 PM shift. (Staff B) took the patient to the room and left him lying down to sleep. (Staff B) went to another room to change a patient but when Staff B returned the resident (resident #1) was no longer in the bed. She said she was gone for 5 to 7 minutes. I called the DON immediately. Most of the CNAs went outside on the streets, searching for the patient. Staff in the facility were searching room to room, bathroom to bathroom. The DON came here. I called the police to report the resident missing. He was wearing a lime green shirt with black pants. The Police Officer came and took the report and gave a case number. I called doctor (Attending Physician) to tell him the resident is missing. He wore the Wander Guard on his left arm. When he got out, I did not hear the alarm because I was on the second floor. (Staff B) said she didn't hear the alarm go off. During interview on 8/18/20 at 4:30 PM via telephone interview Staff B, a Certified Nursing Assistant (CNA) 11:00 PM to 7:00 PM shift stated, I came to work at 11:00 PM. I put him (resident #1) in the room at 11:20 PM. I go take care of another patient and when I finished, I went back to his room. When I go to the room, I don't see him. They called the Administrator, the DON. Everyone was looking for him. They saw on the video he left at 11:40 PM. I had eleven patients that night. He was not on one to one. The CNA before told me to watch him. The nurse never told me to watch him. I don't remember no Wander Guard bracelet on him. I didn't hear an alarm. During interview on 8/18/20 at 6:28 PM via telephone, Resident's #1 sister stated, I don't know about an AMA (Against Medical Advice). We didn't try to get him to go back to the facility. He didn't want to go back to the facility. He doesn't have a court order to be there, so we can't force him. He is living on his own. I called them to let them know the police was here at his place. He doesn't use a walker or a cane. Since he has been out, he has not seen a doctor. During interview on 8/19/20 at 11:35 AM via telephone interview, Staff C, a Registered Nurse Supervisor for the 7:00 AM to 7:00 PM shift stated, the resident (resident #1) left Friday night. I got the report on Saturday morning. I called the sister and she said that the brother was with her. The family agreed to keep him. They felt he would go right back home. She gave permission for the AMA and I explained to her what the AMA was. During interview on 8/19/20 at 2:33 PM with Staff D, a Licensed Practical Nurse that worked 7:00 PM to 7:00 AM shift stated, When I got in (resident #1) he seemed agitated and he was trying to leave the building. They had him on one to one monitoring. I spoke to him briefly to see where his mindset was. He seemed to be alert and oriented times two. He was confused. They continued him on one to one monitoring. I checked his vitals at 11:00 PM, I wrote it down. No meds were to be given at that time. The 3:00 PM to 11:00 PM shift still had him on monitoring and on the 11:00 PM to 7:00 AM shift. I was on the side where (resident #1) was from 11:00 PM to 11:15 PM and he was in his room. At 11:15 PM, I went to the south side, which was my side. Around 11:25 PM, the CNA(Staff B) came to me and said we can't find (resident #1). Staff D reported that the CNA stated that resident #1 was placed in his room, and when the CNA, Staff B returned to the room resident #1 was not there. Staff D, LPN stated, I started searching every room. I searched rooms, bathrooms, patios. I didn't find anything. I started searching around the facility and the community. A code pink was started and everyone was searching. The police was notified, his sister was notified. All of the notifications were done by the supervisor on duty at that time. He had a Wander Guard bracelet on. I can't remember which arm it was on. During interview on 8/19/20 at 3:16 PM Staff E, a Registered Physical Therapist reported, Resident #1 was not safe to ambulate alone, determined on 8/12/20 evaluation date. Nursing was made aware; he is not safe to ambulate alone. During interview on 8/20/20 at 12:20 PM the Administrator/Risk Manager stated, We don't have a policy on one to one supervision. We would need a doctor's order for one to one supervision. If they are at risk for elopement we will call the doctor to obtain the order. You need a doctor's order for a true one to one. Once the resident is exhibiting the behaviors, we call the doctor to obtain an order. If he doesn't order, we put them on close supervision, which is technically a one to one. We notified the doctor that he had eloped. We called the family member and were informed that the resident did not want to come back and did a verbal AMA on the phone with family member. We called the doctor a second time to notify him of an AMA. They had told me in the afternoon that he was exit seeking, the Wander Guard was put on him and working and on close supervision. When we came to figure out, how he got out, we became aware of him using the fire exit door. At night when there is no noise, you should be able to hear the alarm. A baby monitor was added on Tuesday, 8/18/20 at the nurses' station to monitor if and when the fire exit door is opened. We felt we had fixed it by putting the key card at the doors. We could not put a key card at the fire exit door. On 8/20/20 to 8/21/20, the corrective actions verified by the survey team related to the facility's failure to implement their abuse and neglect policy included: The staff were in-serviced/trained on 8/15/20 for 7:00 AM-7:00 PM shift, 7:00 PM-7:00 AM shift for nurses, 7:00 AM-3:00 PM shift, 3:00 PM-11:00 PM shift and 11:00 PM-7:00 AM shift for certified nursing assistants (CNA) regarding: Wandering precautions and wander guard device, Abuse and neglect and Monitoring patients with exit seeking behaviors and elopement risk. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on 8/15/2020 and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. An audit of all residents

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) who reside in the facility was conducted to evaluate a risk for leaving the facility without informing staff and/or if they may desire to leave the facility. The nursing, therapy, social services, housekeeping and dietary departments were re-educated on the facility's policy and procedure of missing person protocol which include code pink, ensuring that the wandering observation tool is used effectively per facility's protocol. The facility-initiated Staff re-education on 8/15/20 for all shifts regarding Abuse and Neglect policy. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on 8/15/2020 and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. Prompt re-training was initiated on 8/15/20 for all shifts regarding Abuse Reporting, Need for 1 to 1, Elopement, Abuse and Neglect and Reporting Elopement, Fire Exit Doors and Audible Alarms, Abuse and Neglect/Elopement Identifying Patients with Exit Seeking Behaviors, Endorsing and Monitoring of Exit Seeking Residents-Implementing 1:1 and Code Pink.
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, interviews and record review, the facility failed to provide adequate supervision and a secured environment for one (resident #1) out of three sampled residents with exit seeking behaviors. This deficient practice enabled resident #1 to exit the facility at 11:40 PM on 8/14/20, undetected. The facility's system failure, lack of adequate supervision and a failure in ensuring an adequate and effective alert monitoring system was in place allowed the resident to elope undetected by staff on 8/14/20 at 11:40 PM. The resident was not located until 2:00 PM on 8/15/20 at his home 5.9 miles from the facility by a family member who reported resident #1's location to the facility. There were 83 residents residing in the facility at the time of the survey. Refer to F 600, F 607, F 835 and F 867. The findings included: Review of the facility's policy titled, Elopement revised February 2019 indicated: Policy Statement: Staff shall investigate and report all cases of missing residents. Elopement is defined as a resident leaving an area of supervision to an area of non-supervision. Review of the Face Sheet for Resident #1 documented, the resident was admitted to the facility on [DATE] after being discharged from a local hospital following an incident where he was found unresponsive outside a local grocery store. Clinical [DIAGNOSES REDACTED]. Review of the Wandering Observation Guide dated 8/14/20 documented resident #1 was ambulatory and had a history of [REDACTED].#1 had a BIMS Summary Score of 9 out of 15 indicating moderate impairment and noted that the resident was confused but is able to make needs known and can follow simple commands. Review of Resident's #1 Behavioral Symptoms care plan dated 8/14/20 documented the resident exhibits the following behavior: elopement, observed trying to leave the facility with no apparent reason; Goal: Episodes of problem behavior will decrease to one a (week/month) thru next review date. Approaches: Keep resident safe with close supervision, keep wander guard in place at all times, make staff aware of resident's high risk for elopement and monitor resident's whereabouts at frequent intervals. Review of the physician's orders [REDACTED]. Medications were: [MEDICATION NAME] 10 milligrams (mg) 1 tablet oral once a day at 9:00 AM for hypertension, he missed the 9:00 AM dose on 8/15/20; [MEDICATION NAME] 25 mg (indicated for the treatment of [REDACTED].)1 cap every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, he missed the doses on 8/15/20; [MEDICATION NAME] ER 24 hour. 25 mg (indicated for the treatment of [REDACTED]. Review of the nursing progress notes documented the following: Dated 8/12/20 time stamped 2:19 PM- Resident observed in bed in lowest position, resident observed anxious getting out of the bed and room, voicing he has to go home; Dated 8/13/20 time stamped 2:51 PM-Resident observed in bed in lowest position, resident observed anxious getting out of the bed and room, voicing he has to go home; Dated 8/14/20 time stamped 7:15 AM (Recorded as Late Entry on 8/15/20 time stamped 1:40 AM)-Patient is able to ambulate with a walker. While giving patient medication at 6:00 AM, patient stated that he wanted to go out to pay some bills. Patient was redirected by the nurse and the nurse told him that he is not allowed to go out of the facility. Patient was able to understand and was placed inside of his room under close monitoring. Report were giving to the next shift nurse about the patient statement. Patient is placed in his room and under close monitoring; Dated 8/14/20 time stamped 7:27 PM-Resident walks frequently in and out bed, became anxious and is consistently asking to go home. Resident proceeds to open the door on several attempts. Resident was redirected, placed on close monitoring for elopement precaution; wander guard placed on resident's left arm. Sister was notified of the resident's behavior and elopement. Nursing progress note dated 8/14/20 time stamped 8:00 PM (recorded as late entry on 8/15/20 time stamped 9:54 AM)-Resident received out of bed (OOB) at side door of facility ambulating with walker very agitated and trying to leave the facility, Awake Alert Oriented times two (AAOX2) with confusion. Resident was redirected on numerous occasions but insisted on leaving and wound not stay in room. One to one care implemented with Certified Nursing Assistants (CNAs) on duty. Wander guard in place and working; Dated 8/14/20 time stamped 11:00 PM -Resident noted in hallway in wheelchair (w/c). One to one monitoring continues with CNA on duty. Wander guard still in place for precaution. Nursing progress note dated 8/14/20 time stamped 11:40 PM- After the change on shift, the CNA on duty reported to assigned nurse that she brought the patient to his room and left him unattended. Upon return she noticed that the patient was missing. An extensive search of the facility and surrounding communities ensued. However, resident was unable to be located. Review of the Physical Therapy Evaluation and Plan of Treatment dated 8/13/20, documented resident #1 was certified to received physical therapy on 8/12/20 and was referred due to new onset of decrease in strength, decrease in functional mobility and decrease in transfers. The resident was at risk for falls. He was scheduled to receive physical therapy 6 times a week, daily. Review of the Physical Therapy Treatment Encounter Notes documented the following: Dated 8/13/20: Patient was observed ambulating in the hallway using a walker (not provided by rehab), he was standing at the nursing station, he was redirected back to his room and advised that he must remain in room as precaution; Dated 8/14/20: Resident observed standing at the nursing station. He was redirected and taken back to his room. Nursing made aware. Demonstrates impaired foot placements and walker management. He is not safe to ambulate alone, patient refused to release walker to therapist in an effort to prevent self-ambulation and falls. Review of the Physical Therapy Discharge Summary dated 8/17/20, documented the patient was advised on not ambulating alone. During observational review of the facility's video footage with the Administrator and Corporate staff on 8/18/20 at 12:23 PM. The video footage revealed that on 8/14/20 at 11:23 PM, resident #1 dressed in a black colored pants and green shirt was standing at the doorway to his room, during this time staff were observed on the hallway. On 8/14/20 at 11:37 PM resident #1 ambulated from his room with no assistive device and proceeded through the double door that lead to the lobby area of the facility. Resident #1 attempted to open the front doors of the facility and was unsuccessful. The resident then walked to the emergency fire exit door located at the side near the administration office, the resident pushed the door without any difficulty at 11:40 PM on 8/14/20 and exited the facility undetected by staff. There was a nurse seated at the nurses' station and a Certified Nursing Assistant (CNA) had just walked past the resident's room down the hall where the double doors leading to the lobby were located. The resident had a Wander guard Bracelet on the wrist of his left arm and an identification band on the right wrist. The alarm on the exit door was not audible for staff to hear on any of the floors in the facility within the care areas beyond the double doors. The wander guard alert system did not trigger to alert staff. Based on the reviewed facility's video footage, the facility's staff had opportunities to prevent the elopement of resident #1 who was coded as an elopement risk. The facility neglected to adequately monitor and address resident #1's displayed exit seeking behaviors and intent of elopement. Resident #1 had an alarm bracelet on his left arm that was not triggered when he eloped. The facility's system failure, lack of adequate supervision and a failure in ensuring an adequate and effective alert monitoring system was in place allowed the resident to elope undetected by staff on 8/14/20 at 11:40 PM. Based on observational tour of the facility's parameter increased risk factors included the fact that, the facility is located in an area that has high traffic volume, busy intersections and is located near a major highway and train tracks. Both locations where the facility is located and the location where the resident was found the next day, are high traffic areas with busy two lane roads and four lane cross streets. A review of the National Weather Service climate Data for the Miami area on August 14, 2020 to August 15, 2020 ranged at record breaking temperatures of 82 degrees Fahrenheit (F) to 92 degrees F. During interview on 8/18/20 at 11:08 AM the Administrator/Risk Manager reported that, Resident #1 was put to bed by the 11:00 PM to 7:00 AM CNA (Staff B) and the CNA (Staff B) went to take care of her next resident. When Staff B was done and went back to check on him and he was missing. Staff B notified the Licensed Practical Nurse (LPN) (Staff D) and Registered Nurse (RN) (Staff A), the Supervisor. They activated Code Pink which is our elopement code, they searched the whole facility and the outside grounds. They notified the Police Department and the sister. The police officer came and did a report. The police was given a description and a picture of Resident #1 and the police officer stated that he was going

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) to go look for the resident. The DON (Director of Nursing) came in to help with the facility search as soon as she was notified. The DON called the sister and started doing the reporting to all the local agency and our 1-day report. Immediate in-servicing was done to staff that were in the building. The administrator stated , We called the nearby hospitals the next day. A little bit before 2:00 PM the next day, the sister called and she said he was found at his house. She said that he preferred to stay at home with her and we notified the doctor and he was okay with it. We did an AMA (Against Medical Advice) form over the phone and we notified the police department that he was found. The resident had a Wander Guard. He took the Wander Guard off before leaving the facility. The sister said that he told her that he took the Wander Guard off. We believe he got out through the side door by my office. The sound on the alarm was not loud enough for the 1st floor nurses' station to hear it. Since then, maintenance made the alarm louder and placed a baby monitor at the 1st floor nurses' station. On 8/18/20 at 11:20 AM, the DON stated, The supervisor notified me. I immediately got to the facility, we continued searching the facility code pink. I got in contact with the sister several times, back and forth. I immediately in-serviced the staff about elopement, one on one and reporting. We called maintenance so they can come in and look at the door. We did the reporting. Stayed in contact with the sister throughout the morning. The DON stated that Resident #1's sister told her at around 12:00 PM on 8/15/2020 that she was on her way to his address to see if he was there. The DON stated, once she got there she called me and said he was in good condition and did not want to return to the facility. The AMA form was signed verbally. The police department was notified and turned it over to another police department who were going to do wellness check. The doctor was notified. During interview on 8/18/20 at 1:00 PM, the Director of Environmental Services stated, He tried to get out when I was with him on that day(8/14/20). I told them he was an elopement risk. They chose to put a Wander Guard on him and I checked it. The Wander Guard went off at all the doors (front, side door by nurses' station and back door used for delivery) and was able to be heard all over the building. During interview on 8/18/20 at 3:16 PM Staff A, a Registered Nurse Supervisor for the 7:00 PM to 7:00 AM shift stated, on that Friday night, my shift was 3:00 PM to 11:00 PM, he (resident #1) was having issues on getting out. It was told to me that he was having a problem getting out, he wanted to go home. I was told by the DON, that they had put a Wander Guard on him. At that point, I initiate one CNA in his room. I told the CNA; I was going to put her in that room. He was fine, walking around, going to the nurses' station. He was sitting in front of the nurses' station. He still wanted to go home. I contacted the sister, so he could talk to his sister. He wanted to go home before coming to the facility. I told the sister that her brother wanted to go home that he had a wander guard which was a device that alarms when he is close to the door. He was sitting down talking to his sister, he put down the phone. I told all the CNAs working on that shift to watch him. The CNA was following him, where ever he went. After dinner, I went upstairs. I was supervising the whole building. When I came back down, he was quiet and moving around. He was trying to get out of the double doors and the Wander Guard alarm went off and he was taken back to the nurses' station early in the evening. Around 11:20 PM to 11:40 PM, I heard the nurse say check the rooms. I asked what is going on, they say he is not in his room. They noticed during the changing of shift that the CNA on 3:00 PM to 11:00 PM shift told (Staff B) to watch him on the 11:00 PM to 7:00 PM shift. (Staff B) took the patient to the room and left him lying down to sleep. (Staff B) went to another room to change a patient but when Staff B returned the resident (resident #1) was no longer in the bed. She said she was gone for 5 to 7 minutes. I called the DON immediately. Most of the CNAs went outside on the streets, searching for the patient. Staff in the facility were searching room to room, bathroom to bathroom. The DON came here. I called the police to report the resident missing. He was wearing a lime green shirt with black pants. The Police Officer came and took the report and gave a case number. I called doctor (Attending Physician) to tell him the resident is missing. He wore the Wander Guard on his left arm. When he got out, I did not hear the alarm because I was on the second floor. (Staff B) said she didn't hear the alarm go off. During interview with Staff B, a Certified Nursing Assistant (CNA) (11:00 PM to 7:00 PM shift) on 8/18/20 at 4:30 PM via telephone stated, I came to work at 11:00 PM. I put him (resident #1) in the room at 11:20 PM. I go take care of another patient and when I finished, I went back to his room. When I go to the room, I don't see him. They called the Administrator, the DON. Everyone was looking for him. They saw on the video he left at 11:40 PM. I had eleven patients that night. He was not on one to one. The CNA before told me to watch him. The nurse never told me to watch him. I don't remember no Wander Guard bracelet on him. I didn't hear an alarm. During a telephone interview with Resident's #1 sister on 8/18/20 at 6:28 PM via telephone. She stated, I have no idea what happened. They told me it was impossible for him to get out because he was wearing some type of bracelet. They were in touch with me constantly. They continued reaching out to me to see if I heard from him. I would have hoped he would stay there for a while. I spoke with the facility. I don't know about an AMA (Against Medical Advice). We didn't try to get him to go back to the facility. He didn't want to go back to the facility. He doesn't have a court order to be there, so we can't force him They told me he must have taken off the bracelet but when I saw him it was still on. He has not told me what happened and how he got out of the facility. Some family members have told me, they saw him get out of a car. When I ask him, he won't tell me anything. His memory goes in and out. The police officer came by, they called me and I told them he was home. He is living on his own. I called them to let them know the police was here at his place. He doesn't use a walker or a cane. They were trying to help him walk there. The sister revealed that since he has been out, he has not seen a doctor. During an interview with Staff C, a Registered Nurse Supervisor (7:00 AM to 7:00 PM shift) on 8/19/20 at 11:35 AM via telephone. She stated, I work on Friday, Saturday and Sunday. The resident (resident #1) left Friday night. I got the report on Saturday morning. I called the sister and she said that the brother was with her. The family agreed to keep him. They felt he would go right back home. She gave permission for the AMA and I explained to her what the AMA was. During an interview with Staff D, a Licensed Practical Nurse (7:00 PM to 7:00 AM shift) on 8/19/20 at 2:33 PM stated, When I got in (resident #1) he seemed agitated and he was trying to leave the building. They had him on one to one monitoring. I spoke to him briefly to see where his mindset was. He seemed to be alert and oriented times two. He started saying things that he was confused. They continued him on one to one monitoring. I checked his vitals at 11:00 PM, I wrote it down. No meds were to be given at that time. The 3:00 PM to 11:00 PM shift still had him on monitoring and on the 11:00 PM to 7:00 AM shift. I was on the side where (resident #1) was from 11:00 PM to 11:15 PM and he was in his room. At 11:15 PM, I went to the south side, which was my side. Around 11:25 PM, the CNA(Staff B) came to me and said we can't find (resident #1). Staff D reported that the CNA stated that resident #1 was placed in his room, and when the CNA, Staff B returned to the room resident #1 was not there. Staff D, LPN stated, I started searching every room. I searched rooms, bathrooms, patios. I didn't find anything. I started searching around the facility and the community. A code pink was started and everyone was searching. The police was notified, his sister was notified. All of the notifications were done by the supervisor on duty at that time. He had a Wander Guard bracelet on. I can't remember which arm it was on. During interview on 8/19/20 at 3:16 PM Staff E, a Registered Physical Therapist stated, He (resident #1) was scheduled to receive Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (SLP). He received an evaluation on 8/12/20 for PT, OT and SLP evaluation on 8/13/20. He was not safe to ambulate alone, determined on the date of evaluation 8/12/20 .Nursing was made aware; he is not safe to ambulate alone. During an interview with the Administrator/Risk Management on 8/20/20 at 12:20 PM stated, We don't have a policy on one to one supervision. We would need a doctor's order for one to one supervision. If they are at risk for elopement we will call the doctor to obtain the order. You need a doctor's order for a true one to one. Once the resident is exhibiting the behaviors, we call the doctor to obtain an order. If he doesn't order, we put them on close supervision, which is technically a one to one. We notified the doctor that he had eloped. We called the family member and were informed that the resident did not want to come back and did a verbal AMA on the phone with family member. We called the doctor a second time to notify him of an AMA. They had told me in the afternoon that he was exit seeking, the Wander Guard was put on him and working and on close supervision. When we came to figure out, how he got out, we became aware of him using the fire exit door. At night when there is no noise, you should be able to hear the alarm. A baby monitor was added on Tuesday, 8/18/20 at the nurses' station to monitor if and when the fire exit door is opened. We felt we had fixed it by putting the key card at the doors. We could not put a key card at the fire exit door. On 8/20/20 to 8/21/20, the corrective actions verified by the survey team related to the facility's failure provide adequate supervision and a secured environment included: The staff were In-serviced/trained on 8/15/20 for 7:00 AM-7:00 PM shift, 7:00 PM-7:00 AM shift for nurses, 7:00 AM-3:00 PM shift, 3:00 PM-11:00 PM shift and 11:00 PM-7:00 AM shift for certified nursing assistants (CNA) regarding: Wandering precautions and wander guard device, Abuse and neglect and Monitoring patients with exit seeking behaviors and elopement risk. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on 8/15/2020 and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. An audit of all residents who reside in the facility was conducted to evaluate a risk for leaving the facility without informing staff and/or if they may desire to leave the facility. The nursing staff, therapy, social services, housekeeping

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	105008	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCH PLAZA NURSING & REHABILITATION CENTER	**12505 NE 16TH AVE NORTH MIAMI, FL 33161**

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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 6) and dietary departments were re-educated on the facility's policy and procedure of missing person protocol which include code pink, ensuring that the wandering observation tool is used effectively per facility's protocol. Prompt re-training was initiated on 8/15/20 for all shifts regarding Abuse Reporting, Need for 1 to 1, Elopement, Abuse and Neglect and Reporting Elopement, Fire Exit Doors and Audible Alarms, Abuse and Neglect/Elopement Identifying Patients with Exit Seeking Behaviors, Endorsing and Monitoring of Exit Seeking Residents-Implementing 1:1 and Code Pink.
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 observations, record reviews and interviews, the facility's administration failed to implement, provide and ensure that effective and efficient preventative measures were in place to prevent the, neglect and elopement of one resident (Resident #1) out of three sampled residents who displayed exit seeking behaviors. As evidenced by inadequate safety measures that included an ineffective wander alert system, failure to ensure exit door alarm was audible in all areas of the facility in the event of an emergency and failure by staff to provide and implement specific instructions to care staff for assigned level of supervision for resident #1 who was a high risk for elopement. These deficient practices enabled resident #1 to exit the facility undetected at 11:40 PM through an emergency exit door on 8/14/20 placing the resident at risk for harm and or injury. There were 83 residents residing in the facility at the time of the survey. Refer to F 600, F 607, F 689 and F 867. The findings included: Record review of the facility's policy titled, Abuse, Neglect and Exploitation protocol written by the Administrator and the revision date was on 11/2019, the policy documented: Our Facility will make all reasonable efforts to ensure that residents are free from verbal, sexual, physical and mental abuse, corporal punishment or involuntary seclusion, willful deprivation, of services to maintain the residents' physical and mental health and that their property will not be misappropriated, by the facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. A prompt thorough investigation will be conducted by the facility immediately. The facility's Policies and Procedures did not directly address neglect. Review of the facility's policy titled, Elopement revised February 2019 indicated: Policy Statement: Staff shall investigate and report all cases of missing residents. Elopement is defined as a resident leaving an area of supervision to an area of non-supervision. Review of the Job Description for the Nursing Home Administrator documented: The Administrator is responsible for developing, managing and supervising the overall functions of the facility in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is also responsible for providing a positive, caring and homelike environment for the residents. Review of the Job Description for the Director of Nursing documented: The Director of Nursing is responsible for planning, organizing, developing and directing the day to day functions of the nursing department in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is also responsible for providing a positive, caring and homelike environment for the residents. Review of the Job Description for the Nursing Supervisor documented: The Nursing Supervisor is responsible for supervising the day to day nursing activities in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is also responsible for providing a positive, caring and homelike environment for the residents. Review of the Job Description for the Registered Nurse documented: The primary purpose of your job description is to provide direct nursing care the residents and to supervise the day to day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state and local standards, guidelines and regulations that govern our facility and as may be required by the Director of Nursing services to ensure that the highest degree of quality care is maintained at all times. Review of the Job Description for the Licensed Practical Nurse documented: The Licensed Practical Nurse is responsible for providing professional care in accordance with established nursing policies and procedures. He/she is also responsible for providing a positive, caring and homelike environment for the residents. During observational review of the facility's video footage with the Administrator and Corporate staff on 8/18/20 at 12:23 PM. The video footage revealed that on 8/14/20 at 11:23 PM, resident #1 dressed in a black colored pants and green shirt was standing at the doorway to his room, during this time staff were observed on the hallway. On 8/14/20 at 11:37 PM resident #1 ambulated from his room with no assistive device and proceeded through the double door that lead to the lobby area of the facility. Resident #1 attempted to open the front doors of the facility and was unsuccessful. The resident then walked to the emergency fire exit door located at the side near the administration office, the resident pushed the door without any difficulty at 11:40 PM on 8/14/20 and exited the facility undetected by staff. There was a nurse seated at the nurses' station and a Certified Nursing Assistant (CNA) had just walked past the resident's room down the hall where the double doors leading to the lobby were located. The resident was observed wearing a Wander Guard Bracelet on the wrist of his left arm and an identification band on the right wrist. The alarm on the exit door was not audible for staff to hear on any of floors in the facility within the care areas beyond the double doors. The wander guard alert system did not trigger to alert staff.(Video footage evidence obtained) On 08/18/2020 at approximately 1:00 PM after review of the above mention video footage, the Senior Administrator and the Chief Nursing Officer conducted a demonstration with the state surveyor of the alarm door's audibility. During this demonstration it was revealed that the alarm for the emergency exit door was still not audible in the care areas, at the 1st floor front nurses' desk nor on the 2nd floor and could not be heard at the beyond the double doors in the lobby. the Senior Administrator and the Chief Nursing Officer at this time determined and acknowledged that the audible alarm for the fire emergency door was not loud enough and could not be heard beyond the double front doors from the lobby. Based on observational tour of the facility's parameter increased risk factors included the fact that, the Facility is in an area that has high traffic volume, busy intersections and is located near a major highway and train tracks. Review of the Face Sheet for Resident #1 documented, the resident was admitted to the facility on [DATE] after being discharged from a local hospital following an incident where he was found unresponsive outside a local grocery store. Clinical [DIAGNOSES REDACTED]. Review of Resident's #1 Behavioral Symptoms care plan dated 8/14/20 documented the resident exhibits the following behavior: elopement, observed trying to leave the facility with no apparent reason; Goal: Episodes of problem behavior will decrease to one a (week/month) thru next review date; Approaches: Keep resident safe with close supervision, Keep wander guard in place at all times; Make staff aware of resident's high risk for elopement; Monitor resident's whereabouts at frequent intervals. Review of the physician's orders [REDACTED]. Medications were: [MEDICATION NAME] 10 milligrams (mg) 1 tablet oral once a day at 9:00 AM for hypertension, he missed the 9:00 AM dose on 8/15/20; [MEDICATION NAME] 25 mg(indicated for the treatment of [REDACTED].)1 cap every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, he missed the doses on 8/15/20; [MEDICATION NAME] ER 24 hour. 25 mg (indicated for the treatment of [REDACTED]. During interview on 8/18/20 at 11:08 AM the Administrator/Risk Manager reported that, Resident #1 was put to bed by the 11-7 CNA (Staff B) and the CNA (Staff B) went to take care of her next resident. When Staff B was done and went back to check on him and he was missing. Staff B notified the Licensed Practical Nurse (LPN) (Staff D) and Registered Nurse (RN) (Staff A), the Supervisor. They activated Code Pink which is our elopement code, they searched the whole facility and the outside grounds. They notified the Police Department and the sister. The police officer came and did a report. The police was given a description and a picture of Resident #1 and the police officer stated that he was going to go look for the resident. The DON (Director of Nursing) came in to help with the facility search as soon as she was notified. The DON called the sister and started doing the reporting to all the local agency and our 1-day report. Immediate in-servicing was done to staff that were in the building. The administrator stated , We called the nearby hospitals the next day. A little bit before 2:00 PM the next day, the sister called and she said he was found at his house. She said that he preferred to stay at home with her and we notified the doctor and he was okay with it. We did an AMA (Against Medical Advice) form over the phone and we notified the police department that he was found. The resident had a Wander Guard. He took the Wander Guard off before leaving the facility. The sister said that he told her that he took the Wander Guard off. We believe he got out through the side door by my office. The sound on the alarm was not loud enough for the 1st floor nurses' station to hear it. Since then, maintenance made the alarm louder and placed a baby monitor at the 1st floor nurses' station. During interview on 8/18/20 at 11:20 AM, the DON stated, The supervisor notified me. I immediately got to the facility, we continued searching the facility code pink. I got in contact with the sister several times, back and forth. I immediately in-serviced the staff about elopement, one on one and reporting. We called maintenance so they can come in and look at the door. We did the reporting. Stayed in contact with the sister throughout the morning. The DON stated that Resident #1's sister told her at around 12:00 PM on

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) 8/15/2020 that she was on her way to his address to see if he was there. The DON stated, once she got there she called me and said he was in good condition and did not want to return to the facility. The AMA form was signed verbally. The police department was notified and turned it over to another police department who were going to do wellness check. The doctor was notified. The DON reported that the CNA (Staff B) was given verbal instructions by LPN (Staff D) to closely monitor Resident #1. During interview on 8/18/20 at 3:16 PM Staff A, a Registered Nurse Supervisor for the 7:00 PM to 7:00 AM shift stated, On that Friday night, my shift was 3:00 PM to 11:00 PM, he (resident #1) was having issues on getting out. It was told to me that he was having a problem getting out, he wanted to go home. I was told by the DON, that they had put a Wander Guard on him. At that point, I initiate one CNA in his room. I told the CNA; I was going to put her in that room. He was fine, walking around, going to the nurses' station. He was sitting in front of the nurses' station. He still wanted to go home. I contacted the sister, so he could talk to his sister. He wanted to go home before coming to the facility. I told the sister that her brother wanted to go home that he had a wander guard which was a device that alarms when he is close to the door. He was sitting down talking to his sister, he put down the phone. I told all the CNAs working on that shift to watch him. The CNA was following him, where ever he went. After dinner, I went upstairs. I was supervising the whole building. When I came back down, he was quiet and moving around. He was trying to get out of the double doors and the Wander Guard alarm went off and he was taken back to the nurses' station early in the evening. Around 11:20 PM to 11:40 PM, I heard the nurse say check the rooms. I asked what is going on, they say he is not in his room. They noticed during the changing of shift that the CNA on 3:00 PM to 11:00 PM shift told (Staff B) to watch him on the 11:00 PM to 7:00 PM shift. (Staff B) took the patient to the room and left him lying down to sleep. (Staff B) went to another room to change a patient but when Staff B returned the resident (resident #1) was no longer in the bed. She said she was gone for 5 to 7 minutes. I called the DON immediately. Most of the CNAs went outside on the streets, searching for the patient. Staff in the facility were searching room to room, bathroom to bathroom. The DON came here. I called the police to report the resident missing. He was wearing a lime green shirt with black pants. The Police Officer came and took the report and gave a case number. I called doctor (Attending Physician) to tell him the resident is missing. He wore the Wander Guard on his left arm. When he got out, I did not hear the alarm because I was on the second floor. (Staff B) said she didn't hear the alarm go off. During interview on 8/18/20 at 4:30 PM, via telephone Staff B, a Certified Nursing Assistant (CNA) for the 11:00 PM to 7:00 PM shift revealed, she was assigned Resident #1 on 8/14/20. Staff B reported that she left Resident #1 in his room and went to care for another resident, upon return, Resident #1 was not in his room. Staff B stated , they saw on the video he left at 11:40 PM. I had eleven patients that night. He was not on one to one. The CNA before told me to watch him. The nurse never told me to watch him. I don't remember no Wander Guard bracelet on him. I didn't hear an alarm. During interview on 8/18/20 at 6:28 PM via telephone, Resident's #1 sister stated, I spoke with the facility. I don't know about an AMA (Against Medical Advice). We didn't try to get him to go back to the facility. He didn't want to go back to the facility. They told me he must have taken off the bracelet but when I saw him it was still on. Some family members have told me, they saw him get out of a car. When I ask him, he won't tell me anything. His memory goes in and out. The police officer came by, they called me and I told them he was home. He is living on his own. I called them to let them know the police was here at his place .They were trying to help him walk there. Since he has been out, he has not seen a doctor. During interview on 8/19/20 at 11:35 AM via telephone interview, Staff C, a Registered Nurse Supervisor for the 7:00 AM to 7:00 PM shift stated, I called the sister and she said that the brother was with her. The family agreed to keep him. They felt he would go right back home. She gave permission for the AMA and I explained to her what the AMA was. During interview on 8/19/20 at 2:33 PM with Staff D, a Licensed Practical Nurse that worked 7:00 PM to 7:00 AM shift stated, When I got in (resident #1) he seemed agitated and he was trying to leave the building. They had him on one to one monitoring. I spoke to him briefly to see where his mindset was. He seemed to be alert and oriented times two. He was confused. They continued him on one to one monitoring. I checked his vitals at 11:00 PM, I wrote it down. No meds were to be given at that time. The 3:00 PM to 11:00 PM shift still had him on monitoring and on the 11:00 PM to 7:00 AM shift. I was on the side where (resident #1) was from 11:00 PM to 11:15 PM and he was in his room. At 11:15 PM, I went to the south side, which was my side. Around 11:25 PM, the CNA (Staff B) came to me and said we can't find (resident #1). Staff D reported that the CNA stated that resident #1 was placed in his room, and when the CNA, Staff B returned to the room resident #1 was not there. Staff D, LPN stated, I started searching every room. I searched rooms, bathrooms, patios. I didn't find anything. I started searching around the facility and the community. A code pink was started and everyone was searching. The police was notified, his sister was notified. All of the notifications were done by the supervisor on duty at that time. He had a Wander Guard bracelet on. I can't remember which arm it was on. During interview on 8/19/20 at 3:16 PM Staff E, a Registered Physical Therapist stated, He (resident #1) received an evaluation on 8/12/20 for PT, OT and SLP evaluation on 8/13/20. Long term goal for PT was safely able to ambulate level surface 100 feet using the roller walker and stand by assist. Short term goal safely ambulate on level surfaces 20 feet using rolling walker with with continuous steps, with use of ankle strategy and with use of stepping strategy 60% of the time with decreased assist from caregivers to increase independence and safety in room. He was only supposed to use the rolling walker when he was receiving PT therapy in his room. He was not safe to ambulate alone, determined on the date of evaluation 8/12/20. Nursing was made aware; he is not safe to ambulate alone. During an interview with the Administrator/Risk Management on 8/20/20 at 12:20 PM stated, We don't have a policy on one to one supervision. We would need a doctor's order for one to one supervision. If they are at risk for elopement we will call the doctor to obtain the order. You need a doctor's order for a true one to one. Once the resident is exhibiting the behaviors, we call the doctor to obtain an order. If he doesn't order, we put them on close supervision, which is technically a one to one. We notified the doctor that he had eloped. We called the family member and were informed that the resident did not want to come back and did a verbal AMA on the phone with family member. We called the doctor a second time to notify him of an AMA. They had told me in the afternoon that he was exit seeking, the Wander Guard was put on him and working and on close supervision. When we came to figure out, how he got out, we became aware of him using the fire exit door. At night when there is no noise, you should be able to hear the alarm. A baby monitor was added on Tuesday, 8/18/20 at the nurses' station to monitor if and when the fire exit door is opened. We felt we had fixed it by putting the key card at the doors. We could not put a key card at the fire exit door. On 8/20/20 to 08/21/20 the survey team verified the facility's immediate jeopardy removal plan that included: All residents were screened and determined we had no further residents that have exit seeking behaviors. Maintenance Director and or designee has completed a facility screen of all fire exit doors. Wander Guard representative did a facility visit and inspection of Wander Guard sensor device. As a result replacing exiting sensors. Facility conducted a facility wide elopement screening to identify any residents displaying exit seeking behavior. The facility added a non-recording live monitor that will sound with any door openings. The facility will systematically incorporate a monthly mock elopement drill to ensure that staff remain vigilant of residents that have exit seeking behaviors and/or wandering. When an actual resident is identified as an elopement risk, the following will occur: Facility will initiate a nurse to nurse verification upon shift change of all/any resident displaying exit seeking behaviors and/or on elopement precautions. This will be tracked on a communication log. Wander guard log of visible placement on resident to be initiated and checked by nurse every shift .This will be an immediate implemented system and permanent: The facility added an Elopement book to front desk and both nurse's station and it will be there to place those residents at risk as an identifier and quick reference. All Fire alarm doors will be checked every shift by Maintenance Supervisor and/or designee and documented on a log. During morning meeting, new admissions will be reviewed for exit seeking behaviors to identify and discuss by interdisciplinary team and place prompt interventions. Any residents that require a 1:1 monitoring will be initialized by nurse supervisor until physician's orders [REDACTED]. Education will be completed by DON and/or designee. Any residents displaying exit seeking behaviors, will be immediately placed on 1:1 monitoring which will be done by assigning a C.N.A. to care solely for that resident and keep him/her on his/her visual field at all times. C.N.A. would not be leaving resident without 1:1 monitoring without relief of another staff member. MD will be notified to obtain 1:1 monitoring orders and any other new orders resident might require. Education will be completed by DON and/or designee. 100% of staff will be in-serviced on: 1) New audible and visual alarm on Exit doors by administration area with visual and audible sound in nursing station on first floor: education will be continued to be provided by Maintenance Director and/or designee. 2) Awareness of all residents with wander guard and the audible sound it makes: education will be provided by DON and/or designee. Nursing Staff will receive education on endorsing and monitoring of any resident displaying exit seeking behaviors and or on Elopement Precautions/ One to One monitoring.
F 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**

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F 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's quality assurance and assessment committee failed to identify quality concerns to implement effective plans of action related to adequate supervision resulting in repeated deficient practice. The facility's history includes deficient practice for failing to supervise residents resulting in elopement within the past 12 months. The previous incident resulted in the identification of immediate jeopardy that occurred when another resident eloped from the facility undetected on [DATE] and was found deceased on [DATE] eleven miles from the facility. The facility was cited for Freedom from Abuse and Neglect, Develop/Implement, Abuse/Neglect Policies, Free of Accident Hazards, Supervision, Devices and Administration. On [DATE], the facility was negligent and failed to provide adequate supervision and effective services to prevent the elopement of one (Resident #1) out of three sampled residents with exit seeking behaviors, resulting in Resident #1 eloping from the facility at 11:40 PM, through an emergency exit door located in the facility's lobby area undetected. These repeated deficient practices has the potential to affect any of the 83 residents residing in the facility. Refer to F 600, F 607, F 689 and F 835. The findings included: Record review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated [DATE], [DATE] and [DATE] documented the facility had a QAPI Committee meeting monthly. Attendees included: the Administrator, Director of Nursing (DON), Medical Director, Social Services, Activities, Nutrition, MDS, Therapy, Environmental/Maintenance, Business Office, Business Development, Licensed Nurse, Human Resources, Medical Records. The documentation provided did not indicate previous elopement issue and concerns related to the immediate jeopardy/substandard quality of care that occurred on [DATE]. During interview with the Administrator/Risk Manager on [DATE] at 12:20 PM revealed, the QAPI meetings are conducted monthly. The QAPI committee consists of all department heads and the Medical Director. The Administrator/Risk Manager stated, We review the policies in QAPI (Quality Assurance Performance Improvement). Usually in December and as needed during the year. We don't have a policy on one to one supervision. We would need a doctors' order for one to one supervision. If they are at risk for elopement will call the doctor to obtain the order. You need a doctors' order for a true one to one. Once the resident is exhibiting the behaviors, call the doctor to obtain an order. If he doesn't order, we put them on close supervision, which is technically a one to one. We notified the doctor had eloped. We called the family member and were informed that the resident did not want to come back. Verbal AMA on the phone with family member. We called the doctor a second time to notify him of an AMA. They had told me in the afternoon that he was exit seeking, the Wander Guard was put on him and working and on close supervision. When we came to figure out, how he got out, we became aware of him using the fire exit door. At night when there is no noise, you should be able to hear the alarm. Baby monitor was added on Tuesday, [DATE] at the nurses' station to monitor if and when the fire exit door is opened. We felt we had fixed it by putting the key card at the doors. We could not put a key card at the fire exit door. During interview on [DATE] at 2:33 PM the Senior Administrator revealed, an evaluation of the Elopement Drills will be incorporated into our QAPI. We will be conducting these drills monthly on alternating shift. The first drill conducted [DATE] was conducted at the change of shift with 7:00 AM to 3:00 PM shift and 11:00 PM to 7:00 AM staff that were present. On [DATE] to [DATE], the corrective actions that were verified by the survey team related the facility's Quality Assurance and Performance Improvement (QAPI) Committee failure to identify quality concerns to implement effective plans of action related to adequate supervision resulting in repeated deficient practice included: The staff were in-serviced/trained on [DATE] for 7:00 AM to 7:00 PM shift, 7:00 PM to 7:00 AM shift for nurses, 7:00 AM to 3:00 PM shift, 3:00 PM to 11:00 PM shift and 11:00 PM to 7:00 AM shift for certified nursing assistants (CNA) regarding: Wandering precautions and wander guard device, Abuse and neglect and Monitoring patients with exit seeking behaviors and elopement risk. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on [DATE] and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. An audit of all residents who reside in the facility was conducted to evaluate a risk for leaving the facility without informing staff and/or if they may desire to leave the facility. The nursing, therapy, social services, housekeeping and dietary departments were re-educated on the facility's policy and procedure of missing person protocol which include code pink, ensuring that the wandering observation tool is used effectively per facility's protocol. The facility-initiated Staff re-education on [DATE] for all shifts regarding Abuse and Neglect policy. A 24-hour security guard was brought in to monitor exits. The facility contracted an electrical company on [DATE] and they will be adding a flashing light and audible notification to the main nurse's station on the 1st floor. Prompt re-training was initiated on [DATE] for all shifts regarding Abuse Reporting, Need for 1 to 1, Elopement, Abuse and Neglect and Reporting Elopement, Fire Exit Doors and Audible Alarms, Abuse and Neglect/Elopement Identifying Patients with Exit Seeking Behaviors, Endorsing and Monitoring of Exit Seeking Residents-Implementing 1:1 and Code Pink. The Quality Assurance team will monitor compliance and will provide feedback to the management company as to results of monthly meeting regarding Abuse and Neglect and Resident safety. Administrator and/or designee will gather information from the interdisciplinary team and report to Quality Assurance committee monthly and adjust better ensure the safety of our residents as needed.