STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105471	A. BUILDING _____ B. WING _____	**07/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKS HEALTHCARE AND REHABILITATION CENTER	**9311 S ORANGE BLOSSOM TRL ORLANDO, FL 32837**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to maintain privacy and confidentiality of medical records for 2 of 5 residents of a total sample of 23 residents reviewed to ensure privacy of health information, (residents #2 and #3). Findings: Resident #1 was admitted to the facility on [DATE] and discharged home on[DATE]. Resident #1 provided evidence of private health information for residents' #2 and #3. In an interview on 7/17/20 at 1:19 PM, she stated, that private health information pertaining to residents #2 and #3 were included with her discharge medications when she went home on 7/1/20. Resident #2 was admitted to the facility on [DATE] from an acute care facility with [DIAGNOSES REDACTED]. Resident #1 provided a medication blister pack label including the name of the medication and dosing information for resident #2 which was included with her medications at discharge. Resident #3 was admitted to the facility on [DATE] from an acute care facility with [DIAGNOSES REDACTED]. Review of the provided evidence from Resident #1 showed resident #3's name, room number and medical equipment used while in the facility. A review of resident #1's medical records showed that registered nurse (RN) F was the nurse responsible for the discharge. On 7/23/20 at 5:03 PM, RN F said, I verify all that information on medications and discharge paperwork. After verification of the information, it is put in a clear plastic bag that they take home with them. She stated that residents #2 and #3 were both at the facility when resident #1 was discharged from the facility. She said, I am confused I don't know how that happened. She did not explain how resident #2 and #3's personal health information was included in resident #1's bag of medications at discharge. On 7/24/20 at 5:06 PM, in a telephone interview with the assistant director of nursing (ADON) she stated, staff were educated on privacy of records. It is not expected that other residents' medical information be sent with a discharge resident, if it does not belong to them. Review of RN F's education transcript showed a transcript completed for Health Insurance Portability and Accountability Act (HIPAA) regarding privacy on 6/16/2020. The new hire orientation education showed completion of HIPAA privacy and security on 6/19/2020. Review of the facility policy Notice of Privacy Practice showed under Procedure: The Facility Responsibilities: Maintain the privacy of the resident health information.
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record and the facility policy review, the facility failed to provide documented evidence that a bed-hold notice was provided to 1 of 2 residents or their representative upon transfer to the hospital on [DATE], (#8). Findings: Resident #8's medical record revealed the resident was admitted to the facility on [DATE] and transferred to the hospital on [DATE]. The resident's [DIAGNOSES REDACTED]. A nursing progress note dated 3/29/20 at 3:18 AM, read the resident was complaining of chest pain. He is agitated .Pulled out his [MEDICAL CONDITION]. The medical record did not include a copy of the bed hold upon transfer to the hospital form. The medical record did not show any evidence that the facility provided written information to the resident or resident representative of the bed-hold notice or policy. The resident did not return to the facility. On 7/24/20 at 6:35 PM, the unit manger west wing E stated, normally we give the bed-hold to the resident or the family once we do the paperwork for discharge transfer to the hospital. I am unable to locate a copy of the bed-hold for him. On 7/24/20 at 6:44 PM, the director of nursing (DON) stated, my expectation is the resident or family member is given a copy of the bed-hold but if in an emergency the notification can be done, reach out to the family the next day. I wasn't here and unsure what happened in this case. On 7/25/20 at 7:00 AM, the DON said, I am unable to locate transfer form or bed-hold. I have searched. On 7/24/20 at 2:00 PM, a telephone interview with the Admissions Director noted that the facility did not receive any request from the hospital that the resident was ready to return. Review of the facility Bed-hold Policy revealed Resident or Resident Representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed-hold polices, according to Federal and/or State requirements. Under the section of Procedure: At the time of transfer to the hospital to therapeutic leave, the center will provide a copy of notification of bed hold.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record and policy review and interviews with resident, resident family and staff, the facility failed to provide adequate supervision and safe environment for 1 of 14 residents reviewed for risk of actual and potential elopement (#30). These failures contributed to the elopement of resident #30 and placed him at risk for serious injury/impairment/death. While resident #30 was out of the facility in the dark, unsupervised, there was a high likelihood he could have fallen or been hit by a car. On 5/16/2020 at approximately 4:30 AM, resident #30 who was cognitively impaired was not found in the facility. At 4:53 AM, the resident exited the facility through the rear kitchen dark in the dark, unsupervised. He wheeled himself approximately 400 feet through an unlit, uneven parking lot. He was found by the Certified Nursing Assistant (CNA) at 6 AM in his wheelchair with bare feet stuck in the mud by the facility fence. There were 14 residents who were at risk for wandering at that time. The facility's failure to provide adequate supervision, and secure environment resulted in Substandard Quality of Care at the Immediate Jeopardy level. The Immediate Jeopardy began starting on 5/16/20 and removed as of 5/16/20. The facility's corrected the noncompliance at F689 on 5/28/20. At this time, the facility is in substantial compliance with F689. Findings: Resident #30 was admitted to the facility on [DATE] from an acute care hospital. His [DIAGNOSES REDACTED]. The resident's admission Minimum Data Set (MDS) assessment with reference date of 4/08/20 showed his Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. He had not exhibited any wandering behavior at the time of admission and was not deemed at risk for elopement. His locomotion was identified as extensive assist with one person assisting. He was able to move around the facility independently in his wheelchair. The resident was receiving insulin injections daily. A review of the facility's investigation report revealed that resident #30's routinely assigned 11 PM to 7 AM CNA S checked on the resident at the beginning of his shift on 5/16/20 and the resident was in his room. A short time later, resident #30 was observed propelling himself in his wheelchair. During room rounds at approximately 5:15 AM, CNA S did not find resident #30 in his room. He began to search the interior perimeter of the facility and did not locate the resident. He informed resident #30's Licensed Practical Nurse (LPN) T who was an agency nurse. At approximately 6 AM, CNA S located the resident in the unlit rear parking lot in his wheelchair. The resident did not have shoes on, and his wheelchair was stuck in the mud. The resident told CNA S that he wanted to go home and see his wife. The resident was brought back inside at 6:11 AM. The

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) facility's Policy and Procedure for Missing patient/resident revised 8/23/17 defined elopement as, . occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury. A review of the nursing progress note dated 5/16/20 at 7:55 AM, read 'the CNA (identified as CNA S) stated when he started his morning rounds at 5 AM he noticed that resident #30 was not in his room. The CNA notified the nurse that he was missing and began looking for the resident all over the building. The CNA stated that he found the resident in the parking lot. The resident stated that he was trying to go home, and he had been trying to speak to his wife. The resident was placed on 1:1 supervision. A wander bracelet was also placed on the resident.' The facility identified that the resident had wandered into the unlocked dining room and entered the kitchen through the door in the dining room that was not locking properly. He wandered through the unlit kitchen and exited through the rear service door of the kitchen at 4:53 AM. The facility was unaware of the resident's location for more than an hour after he was not found in his room. On 7/24/20 at 12:53 PM, the administrator explained that resident #30's CNA S was doing his rounds at approximately 4:30 AM on 5/16/20 and did not see resident #30. She explained that after reviewing the facility's video, the resident had exited through the rear door of the kitchen at 4:53 AM. At the time, resident #30 was not assessed as an elopement risk. Because he got out of the facility, we considered it an elopement. She said the investigation revealed that resident #30 was determined to be at home and did not want to be at the facility. She added the root cause was the entry door to the dining room was not locked and the kitchen door was not locking properly. On 7/23/20 at 3:00 PM, the surveyor and maintenance director retraced the likely path that resident #30 took when he exited the facility unsupervised. The resident resided on the West wing near the activity and dining room. From his room he wheeled himself through the area into the unlocked dining room. He then entered the kitchen through the unlocked door and entered the dark kitchen. It was noted that the walk-in refrigerator and walk-in freezer were not locked. There were multiple hazardous equipment present including tables stoves, ovens, knives, and carts which he navigated around in the dark. He would have remained in the unlit kitchen for approximately 1 hour. The resident then exited the dark kitchen on the east side of the building at 4:53 AM. He wheeled himself in the unlit parking lot with cracked, uneven pavement, broken curbs and some cement debris in the grassy area. He continued toward the front of the building which was approximately 379 Feet from the exit door. The parking lot and facility driveway led toward a major 7 lane heavily trafficked highway. A review of the facility's video recording of the resident's exit showed the back entrance/kitchen door opened at 4:53 AM and the resident in a wheelchair exiting. The poor-quality video showed the resident mobilizing in his wheelchair down the gravely parking lot until 4:56 AM when he was no longer visible. The maintenance director said that there was a camera outside the therapy entrance which would have given a better view of the back-parking lot, however it had been damaged by a hurricane some years ago. The video showed on 5/16/20 at 1:52 AM car lights flashed at the camera. On 7/23/20 at 4:40 PM, licensed practical nurse (LPN) T stated When I came on my shift, (11 PM on 5/15/20) I saw resident #30 in his bed. He just looked at me and did not answer. She said that CNA S approached her at 4:30 AM, to inform that resident #30 was not in his room. He also told CNA Z and they both started searching for the resident in other rooms. I was starting my medication pass at this time. CNA S came back a short time later and told me he could not find the resident. CNA S then went outside of the facility and found the resident outside in his wheelchair. LPN T stated that she did not follow the missing resident/elopement procedure. On 7/23/20 at 11:03 PM, during a phone interview, CNA S said that he had worked the 11 PM to 7 AM shift on 5/16/20 and was resident #30's CNA since his admission. He said that the resident was always up and out of his bed, in and out of his room roaming the halls. He never entered other resident rooms. On 5/16/20, he was up as usual in and out of his room, in the hallway and sometimes at the nurses' station. At 1-2 AM he was in his room. Around 4-4:30 AM, resident #30 was not in his bed. CNA S said he did not alert the nurse right away that he did not see the resident. He stated that he checked both sides building. I did a sweep of everywhere. I told CNA Z and we checked all the rooms. I went outside the door by the therapy area which was on the other side of the facility. He was not there. I did not want to panic anyone because I was not sure. I then let the nurse know and we all began to look for him. CNA S said that the procedure for missing persons was not implemented. He said at 6:00 AM, he found the resident sitting in his wheelchair with bare feet at the end of the parking lot near the facility fence. He was stuck in the mud. On 7/23/20 at 3:28 PM, the dietary cook V said she worked on 5/16/20. She arrived at the facility about 5:45 AM and parked in the back-parking lot. The lot was dark and there were only 3-4 cars parked there. She entered the back door of the kitchen using her key. The lights were not on. She did not see the resident when she drove into the parking lot. On 7/23/20 at 4:48 PM, Dietary Aide U was interviewed by phone. She said I come in between 5:30 -6 AM. I park in the back lot and come in through the therapy door, someone lets me in. Then I go out the same door, knock on the kitchen back door and wait until someone opens the door. It was so dark; I was not able to see anything. She was working the morning (5/16/20) that resident #30 got out of the building. She said he was found in the back far side of parking lot. A telephone call to the resident's wife on 7/23/20 at 4:47 PM noted that she was informed of the resident trying to leave the facility on 5/16/20. She stated that he was missing and was found outside the building. She said he was on his way to the major highway located near the facility as he knew how to get home. A review of the Facility Assessment last updated on 5/16/20 noted that the facility offered care and services for residents with cognitive impairment, anxiety and psychiatric diagnosis. The facility began putting corrective actions into place on 5/16/20 and came into substantial compliance on 5/28/20. The facility's corrective actions included the following: * Review of the facility corrective measures implemented by the facility revealed the following: *On return to the facility on [DATE], resident #30 had a head to toe assessment with no injuries. He was placed on 1:1 supervision and the physician was notified. He was seen by the nurse practitioner on 5/16. Lab work was obtained. A wander alert bracelet was applied. An elopement care plan was initiated. * On 5/16/20, a screamer alarm was added to the entry door to the dining room. The door was locked when staff not present. The door handle with a new lock was installed on the kitchen door from the dining room. *Dietary staff were educated on 5/16/20 to report any malfunctioning equipment or knobs. *On 5/16/20 the Wander Alarm company checked the alarm systems on all doors. *The Federal 5-day Abuse report was submitted on 5/16/20. *An adverse incident report was submitted to the State Agency on 5/29/20. *Staff received education starting on 5/16/20 through 5/28/20 on Elopement Policy and Procedures, Wander Guard system, missing resident policy, elopement drills with post-test completed. *On 5/16/20, the facility reviewed all residents for elopement and did not identify any additional residents. All progress notes and clinical documentation were reviewed during the daily clinical meetings, any missing data was discussed, and care plans were updated/and initiated if indicated immediately. * Elopement drills were done on 3 shifts for 7 days then weekly for 1 month, then monthly as of July 2020. Door audits/wander guard checks were done daily by maintenance staff and any concerns addressed at QAPI meetings. *An ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held on 5/16/20 to address elopement issues and an action plan was initiated. The committee reviewed staff training and education. The QAPI committee met weekly through 6/18/20. *On 7/24/20 tour of the facility the Director of Maintenance verified that all work on doors was complete. The front lobby door was monitored by receptionist during the day and locked when the receptionist left. The facility had a total of 10 exterior alarmed doors, that activated with wander bracelets. The alarm was added to the dining room door that was locked in the evening. Only staff had codes to the doors. *Elopement Quality reviews to be completely weekly and brought to the weekly QAPI meetings through 6/11/20. Reduction in frequency to be determined by QAPI Committee. *Interviews conducted by the survey team with 24 staff from 7/23/20 at 10:48 AM to 7/25/20 at 11:20 AM revealed they were knowledgeable of the elopement prevention policies and procedures. *The survey team validated the facility's corrective actions during the survey and determined that F689 was past noncompliance.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate dispensing of discharge medications for 1 of 5 residents of a total sample of 23 residents reviewed for medication orders, (#1). Findings: Resident #1 was admitted to the facility on [DATE] and discharged home on[DATE]. Her [DIAGNOSES REDACTED]. Resident #1 provided a blister pack to the survey agency with 25 sealed pills of the medication [MEDICATION NAME] 10 milligrams belonging to resident #2 that were given to her upon discharge. Further review of medical records for Resident #1 showed registered nurse (RN) F discharged resident #1 on 7/1/20. On 7/23/20 at 5:03 PM, RN F said, I verify all the information on medications and discharge paperwork. After verification of the information it is put in a clear plastic bag that they (resident) take home with them. She stated that resident #2 was in the facility at the time of resident #1's discharge. She said, I am confused I don't

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) know how that happened. On 7/23/20 at 11:14 AM, the director of nursing (DON) stated that the nurse should have reviewed the medications with the discharge resident and their family. The nurse is responsible to give the resident all the discharge instructions and have the resident sign. Medications given to a discharged resident should have been verified as for that particular resident and not any other residents' medications. The nurse should have verified the medications with the discharge orders and the resident's physician list. In a telephone interview on 7/24/20 at 5:06 PM, the assistant director of nursing (ADON) stated, that staff were educated on the discharge process. The process included discharge instructions of medications provided to the residents and how to take the medications. It is not an expectation that other residents' medications are sent with the discharge resident if it does not belong to them. Review of RN F's orientation for new hire showed completion for transfers and discharge process on 6/19/2020.