STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105998	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF WINTER HAVEN	**2701 LAKE ALFRED RD WINTER HAVEN, FL 33881**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation of the resident, record review and interview, the facility failed to provide adequate supervision to mitigate the risk of elopement for two (#1, #2) of three sampled residents. Findings included: Observations on 10/15/20 at 9:50 a.m. revealed Resident #1 independently navigating the facility in his manual wheelchair. In an interview with the resident at that time, he confirmed his name in English and when asked where he was going he started to speak in Creole and continued down to the end of the 200 hall. The resident was observed to navigate to the end of the hall to an exit door that had a key pad on the right side of the door. The resident was observed to stretch up from his wheelchair and punch numbers on the key pad. Interview on 10/15/20 at 9:55 a.m. with Staff B revealed that she was not sure what Resident #1 was doing at the end of the hall. Staff B approached the resident and redirected him to the 300 hall (where he resided). This surveyor requested that Staff B ask the resident, in Creole what he was doing at the door. Staff B reported that the resident said that he was trying to open the door. This surveyor requested that Staff B ask the resident why he was trying to open the door. Staff B reported that Resident #1 reported that he was trying to open the door so that he could go to his uncle's house. Staff B revealed that she was not sure if the resident had exit seeking behaviors, as she worked on different units. Review of the Social Service progress note dated 8/14/20 at 16:05 (4:05 p.m.), revealed that the resident, Exited facility through front door on 8/13/20, was witnessed exiting facility by receptionist. Resident assisted back into facility by staff, body check completed with no findings, and no injury noted . Review of progress note from 3/25/20 to time of incident revealed no documentation of the resident's behavior of wandering the halls. Review of the resident's assessments revealed the following: Elopement Risk assessment 4/1/20 score of 3.0 at risk for elopement. Elopement Risk assessment 8/13/20 score of 3.0 at risk for elopement. Elopement Risk assessment 10/6/20 score of 3.0 at risk for elopement. Closer review of each Elopement Risk /assessment revealed that a Yes, to questions 4, 5, or 6 automatically placed the resident AT RISK. For each of the 3 assessments at least one of the three questions was answered with a Yes. Review of the physician's orders revealed an order to check for placement and function of the Wanderguard with order and start dates of 8/13/20. Review of the physician's order dated 9/2/20, read as follows, Q 15 min. checks for safety q shift. Review of Resident #1's Quarterly Minimum Data Set ((MDS) dated [DATE], indicated that the resident exhibited wandering 4 to 6 days out of the week. Review of the resident's care plan related to risk of elopement, initiated 4/7/20 with revision on 8/14/20, revealed interventions that included Electronic monitoring device to left ankle. Ensure in place and functioning every shift, with an initiated date of 6/10/20 and a revision date of 8/14/20; provide every 30 minute monitoring of location with an initiated date of 8/20/20. An interview was conducted on 10/15/20 at 2:08 p.m. with the Director of Nursing (DON), Interim Executive Director (ED), and the MDS Coordinator. The DON reported that she did not believe that Resident #1 had a prior elopement, and prior to the incident the resident was not an elopement risk. She reported that the resident wandered around the building a lot in his wheelchair, but never attempted to elope. She reported that there were instances where the resident was observed poking at numbers on the keypad located on secondary exit doors. She said, These keypads require codes to exit the doors. The resident probably saw someone pushing numbers and mimicked the same thing, but that would not be considered exit seeking behavior. The DON reported that the purpose of a elopement risk assessment is to determine if a resident is at risk for elopement. She reported that if a resident was found to be at risk, Interventions could include putting the resident on 15 minutes checks or to put a Wanderguard on the resident. She reported that The intervention would be resident specific. The MDS Coordinator reported that this resident was discussed at the morning meeting in April related to a fall risk. She reported that the MDS department would have completed the care plan related to elopement and that this care plan was discussed in the morning meeting. She reported that there was no documentation that would indicate that the care plan related to an elopement risk for Resident #1 was presented and discussed at the morning meeting. Additionally the DON reported that Resident #1 Should have had the Wanderguard device applied back in June per the care plan. She said she was Not sure why he did not have one in place at the time of the elopement in August. Interview with the DON on 10/15/20 at 2:47 p.m. revealed that the facility staff were watching where Resident #1 was through-out the building. She reported that she did not think that there was any formal 15 minute, or 20 minutes checks at the time of the incident. If the resident wandered, they would not have known that he was not in the building, and the supervision that was in place was the standard 2-hour checks. She reported that the receptionist was new at the time and did not know what to do when the resident exited the front lobby doors. 2. Review of Resident #2's medical record revealed that she was admitted to the facility on [DATE] for Respite services with [DIAGNOSES REDACTED]. review of the resident's medical record revealed [REDACTED]. Further review of the record revealed that there was no documentation that would indicate that the resident was receiving supervision during her respite stay at the facility. Review of the facility documents revealed that on 10/5/20 the resident eloped from the facility, and an investigation was initiated. On 10/15/20 at 3:18 p.m., an interview was conducted with the Interim Executive Director (ED). He said, Resident #2 was admitted to the facility for Respite care and was very agile and able to ambulate independently. He reported that as a result of the investigation it was found that the resident exited the facility from the front door. He reported that during the time that it was believed that Resident #2 exited the facility, EMT (Emergency Medical Technician) was bringing another resident into the facility, and a family was also coming in for a [MEDICATION NAME] through the front door. He reported that the resident was seen by the Advanced Registered Nurse Practitioner (ARNP), through her office window on the 600 hall. The ARNP called to the nurse's station. The nurse at the station went to the 500 hall exit door and found the resident sitting or standing outside the 500 hall entrance. The ED reported that a Wanderguard alarm was placed on Resident #2 immediately. He reported that the resident came from home for Respite care, and that there was no record of elopement at home. The resident had a baseline care plan in place but did not have had a care plan for elopement as a risk was not identified on the admission and elopement assessments. He reported that the resident would have received routine monitoring, but that she would not have been on 15 minute checks if she was not at risk. She gave no indication that she was an elopement risk. The ED reported that there were two receptionists changing shifts at the front desk at the time of the incident. He reported that someone should have noticed the resident going out of the front door, but that there was a lot going on at the time. He reported that routinely the resident would be under observation of the nurses on that unit, but was not sure why it was not noticed that the resident left the unit. The ED reported that the resident was not out of the building for more than 5 minutes, as it was noted that from the time the resident was identified outside in relation to the time staff went to get her was 5 minutes. He reported that he is not sure how long she was gone out of the building before she was identified outside. 3. Review of the facilities policy titled Plans of Care with an effective date of 11/30/2014 and a revision date of 9/25/2017 , revealed: Develop and implement an individualized person -centered plan of

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) care by the interdisciplinary team Review of the respite service agreement dated 5/22/2019 revealed that 'Facility shall see that Hospice Patient: (1) receives treatments, medications, and diet as prescribed; is kept comfortable, clean, well-groomed, and protected from neglect and intentional harm, including, but not limited to, accident, injury, and infection as required by Federal regulations. Review of the facility policy titled Elopement/Wandering Risk Guidelines with an effective date of 9/21/2016 and a revision date of 8/1/2020 revealed To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions.