| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105234 | A. Building<br>B. Wing | 11/15/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rehabilitation and Healthcare Center of Tampa | 4411 N Habana Ave<br>Tampa, FL 33614 |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999<br><br>Based on interviews with the Administrator, Director of Nurses (DON), Medical Director, facility nurses and aides, Resident #206, a family member of Resident #206, and a Deputy with the local police department; review of facility documents, including policies and procedures on Abuse/Neglect/Exploitation, and training documents, admission documents and hospital records for Resident #206; and observation of the facility including the location of the resident's room and the elevators, and the potential route Resident #206 might have taken during his 5.1 mile walk away from the facility; it was determined the facility failed to identify incidents as reportable to the State Agency for two (#206, #68) of 8 residents sampled for abuse.<br><br>Resident #206 was able to leave the facility by boarding an empty elevator that is code protected to ensure resident safety, ride the elevator to the first floor, get off of the elevator and walk out the front door, unobserved and unquestioned. He had been in the facility from 3:29 p.m. on 10/26/2022 as captured on video in the facility front hall until 3:52 p.m. on 10/26/2022 as captured on video leaving the facility; and not found until 10:30 a.m. on 10/27/2022 in a neighborhood park 5.1 miles away from the facility.<br><br>Facility nursing staff did not notify the Director of Nurses or the Administrator until approximately 6:00 p.m. on 10/26/2022 that the resident's location was not known. The Administrator did not notify Law Enforcement until 6:47 p.m. on 10/26/2022 of the resident's unknown location. The State Agency was not notified of Resident #206's unknown whereabouts for 18 hours until two weeks after the event occurred.<br><br>It was determined that staff had not implemented their training on the elevator protocol when Resident #206 was able to board an empty elevator, confirmed by no staff or visitor reporting they had seen or ridden down on the elevator with Resident #206, and walk out the front door with no staff questioning who he was or where he was going.<br><br>This failure to report an incident to the State Agency when a newly admitted resident was able to leave the facility unsupervised created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #206 and resulted in the determination of Immediate Jeopardy on 10/26/2022. The findings of Immediate Jeopardy were determined to be removed on 11/15/2022 and the severity and scope was reduced to a D.<br><br>Findings included:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the facility's policy on their Abuse Prevention Program revealed the policy statement indicated the Facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of residents' property. These policies guide the identification, management, and reporting of suspected, or alleged, abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burn out, or resident behavior which may increase the likelihood of such events.<br><br>The policy included a definition of neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.<br><br>The policy included the reasonable person concept, used to determine whether the resident has suffered psycho-social harm.<br><br>The policy listed the procedure for staff to follow, according to the policy, in an effort to provide residents, visitors and staff with a safe and comfortable environment. The procedure included relevant points:<br><br>*The designated shift supervisor is identified as responsible for immediate initiation of the reporting process.<br><br>*The Administrator, Director of Nurses and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, abuse, neglect, and exploitation and misappropriation.<br><br>*The Administrator, Director of Nurses and/or designated individual are also ultimately responsible for the following:<br><br>Implementation<br><br>Ongoing monitoring<br><br>Investigation<br><br>Reporting<br><br>Tracking and trending.<br><br>Under the subheading of Reporting, the policy identifies the need for the facility to identify person(s) responsible for the reporting and investigating; that the facility will be in compliance with Federal regulations and State specific reporting requirements; and the facility will submit a report immediately for suspected abuse, neglect, or misappropriation. The immediate report must be filed not later than 24 hours after the allegation is made if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including State Survey Agencies and adult protective services where state law provides for jurisdiction in long-term care facilities.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | At the conclusion of the investigation and within 5 business days of the event, a final report will be submitted detailing the facility findings, to include whether the allegation is substantiated.<br><br>The facility reports alleged violations and substantiated incidents to DPH (Department of Public Health), and all other agencies as required and takes necessary corrective actions depending on the results of the investigation.<br><br>Resident responsible party is notified if the resident lacks capacity; if the resident has capacity the facility will request resident permission prior to notification of next of kin.<br><br>Resident's physician is notified.<br><br>1. A review of the facility's Abuse/Neglect Log for October 2022 on 11/07/2022 revealed the incident related to Resident #206's ability to leave his resident floor unseen, get onto an empty elevator and ride it to the first floor and then walk out of the building unimpeded and unquestioned with his location unknown for 18 hours, was not listed. When the Administrator was asked why this incident would not have been listed on their Abuse/Neglect Log, (on 11/07/2022 in the interview that began at 11:00 a.m.) she reported that she had not viewed the resident's absence from the facility and unknown location as either abuse or neglect by the facility. She reported that once she was notified of the resident's absence, at approximately 6:00 p.m. on 10/26/2022, she reviewed admitting paperwork from the hospital for Resident #206. She reported the Admitting document, the 3008, indicated the resident's Mental/Cognitive Status at Transfer was identified as alert, oriented, follows instructions. She reported that the admitting documents indicated the resident was his own responsible party and she could not deny him his decision and ability to leave the building if he didn't want to remain. She reported that she had been told he told his nurse that he didn't want to be at the facility, and he thought he was going home when he was discharged from the hospital. An additional description of the resident's cognitive status and ability to make decisions is included in the 3008. The Administrator did not refer to it or report that she included that information in her assessment of whether the resident had the cognitive ability to decide that leaving the building without telling anyone was ok. The 3008 form includes a question about the decision-making capacity of the patient; the hospital marked that (Resident #206) required a surrogate. An Emergency contact with name and phone number was listed below the section asking to describe the resident's decision-making capacity.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview conducted with the Administrator on 11/14/2022 beginning at 9:30 a.m., she agreed to read staff statements about their interaction with Resident #206 on 10/26/2022. She confirmed two aides and one nurse were assigned to the unit where Resident #206 would be residing. One aide (CNA) saw the resident when he arrived on to the floor about 3:45 p.m. She reported she knew she wasn't assigned to him. She said later she saw him standing by the elevator, so she assisted him back to his room, and asked him if he needed anything. She reported that he asked for the TV to be turned on, which she did, and she ensured he had the TV remote and his call bell accessible. The resident's nurse, (RN HH) reported she saw the resident when he arrived on the floor initially and after that saw him at the elevator. She reported that she asked him to return to his room so she could get his vitals. She reported in her statement that he seemed angry but agreeable to return to his room. Her statement included no additional comments made by the resident. The lack of the resident's displeasure with being at the facility was not included in RN HH's statement and when that was questioned, the Administrator said that the nurse meant he wanted to leave when she wrote that he seemed angry. The DON added she had gone to the hospital to see Resident #206 on 10/28/2022. She reported the resident told her that he had been tricked, that he hadn't been told he was going to a rehab center as he thought he was going home to his ALF.<br><br>In an interview with RN HH on 11/10/2022 beginning at 12:20 p.m., she reported that she had been on the phone with the doctor for the resident in the B bed as he wasn't doing well, and she saw the new resident in the A bed get up and walk out of the room. She said she spoke to him, letting him know she was his nurse and he said good. She said he said nothing else to her. She said she took his temperature but not the other vitals as the equipment wasn't handy to her. She said he was friendly, clean, but looked more like a visitor than a resident. She said she got busy with the other sick resident and also busy passing medications to her other residents, and she didn't know he had gotten onto the elevator and left the building. She said it wasn't until the aide told her that he wasn't in his room when they delivered the dinner trays that she knew he wasn't around. She said herself and one of the aides looked all around for him on the second floor without success.<br><br>RN HH reported she didn't have the chance to review Resident #206's medications or his admitting paperwork.<br><br>RN HH denied that the resident told her he didn't want to be there and said he only responded to her saying that she was his nurse. She reported that she felt not having a third nurse or a unit manager to observe and assist with the residents was the reason the resident was able to leave the floor unobserved. When asked about staff training on the elevator protocol, she reported that staff are not to walk away from an open elevator as a resident could get onto it.<br><br>Admission documents received by the facility at the time Resident #206 arrived included a list of medications that were ordered for the resident. Medications that the resident should have received before bed included Olanzapine 5 mg for Schizophrenia; Gabapentin 400 mg for neuropathy; Budesonide inhalation for wheezing and shortness of breath; Divalproex sodium 500 mg for seizures; Formoterol 2 ml inhalation for shortness of breath; Lorazepam 1 mg for anxiety; Melatonin 3 mg for insomnia; Metoprolol 25 mg for hypertension and Tizandinine 4 mg for muscle spasms.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the job description for the Unit Manager, undated, revealed in the Summary of the Position, the Unit Manager, (UM-RN) is responsible for overseeing direct nursing care to assigned residents/patients. The UM-RN assumes responsibility and accountability for the nursing care and services provided on the assigned unit. The UM-RN is responsible for and adheres to the standards of care for assigned residents/patients, assists with data collection, monitoring and implementation of physician orders based on individual resident/patient needs, manages the environment to maintain resident/patient safety, and supervises the resident/patient care activity performance by licensed nurses and certified nursing assistants. Under Essential Duties and Responsibilities was a bullet point that read: Oversees the assessments of the resident/patient admission process.<br><br>In an interview with facility staff on 11/14/2022 beginning at 9:30 a.m., the lack of a Unit Manager for the second floor was raised. The Administrator reported that a Unit Manager for the second floor had been hired. The DON reported that unit managers remain until 4 p.m. or 5 p.m. during the week and after that the charge nurse is available to assist the nurse on the floors. She reported that the Unit Managers work the day shift and assist with what needs to be done, including remaining at the nursing station to answer the phone and watch the elevator. She reported without a Unit Manager assigned to the floor, the other Unit Managers from the third and fourth floor were to assist and the DON and ADON were available also.<br><br>In an interview conducted with the resident on 11/07/2022 beginning at 9:10 a.m., he confirmed he had walked out of the Rehab Center and ended up in a park. He confirmed he had been out all night and had had nothing to eat. With a laugh he said he was glad it hadn't rained that night. He reported he had been dropped off at the facility and could not remember how he got up to his room. He reported he had been lying in his bed, but then got up, walked into the hall and no one was around. He said the elevator came up, the door opened, and a staff member got out and walked away and he got onto the elevator. He reported the elevator took him to the first floor and he walked out the front door and no one said anything to him. He said he was trying to get back to his ALF, but he turned the wrong way and walked until he ended up in the park. He confirmed the police confronted him in the park due to what he was wearing, and he told the police that he was short of breath. He was taken back to the hospital that he had left the day before and remained until 11/01/2022 when he was discharged back to his ALF.<br><br>Observation of the facility revealed it was a four story L shaped building on the corner of two main streets. The building's parking lot was adjacent to an outpatient building with roads leading past the building to the two main streets. Across the street from the facility was a major hospital with an ER and multiple entrances into the ER and parking lots. The entrance to the facility was approximately 88 feet from the Receptionist Desk, which included an entry hall of 26 feet, which ended in a T intersection. The Elevator was 42 feet from the intersection of the two halls and the reception desk another 20 feet from the elevator. The resident's room on the second floor was two doors down from elevator, with a nursing station in front of the elevators. The staffing sheet for 10/26/2022 did not list a unit manager on duty on the second floor, who would have worked from the nursing station. Two nurses and four aides were assigned to the 3-11 shift on the second floor.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The potential route that the resident took was identified as walking west out of the facility parking lot, and turning north on a four-lane road with a speed limit of 45 mph. The distance between the facility and the park where the Deputy found the resident was 5.1 miles along roads that ranged from two to four lanes, some roads straight and some curvy, with sidewalks that changed from one side of the road to the other and sometimes ended in dirt paths. Walking north would have taken the resident past intersections that widened into multiple lanes with turn lanes. Speed limits ranged from 25 to 45 mph.<br><br>The resident was seen leaving the facility at 3:52 p.m. on video. Shift change occurs at 3:00 p.m. and a smoking break for the residents is planned for 4:00 p.m. The resident reported seeing no staff in the area around the elevator on the second floor, except for the staff member who exited the elevator and walked away from the elevator leaving the door open, and available for Resident #206 to enter, ride to the first floor, and walk out of the building, unnoticed. The resident reported no one on the first floor stopped him or asked where he was going.<br><br>Resident #206 according to hospital records, was admitted on [DATE] with a History and Physical (H&P) documented at 3:54 p.m. The H&P documented the patient as a [AGE] year-old male with past medical history significant for schizoaffective disorder, hypertension, seizure disorder and COPD (chronic obstructive pulmonary disease), presented to the emergency department via EMS from his ALF (Assisted Living Facility) with complaints of worsening weakness. Has extensive psychiatric history and on multiple medications for schizoaffective disorder. Currently patient lethargic and unable to give much history. Audible wheezing throughout his lung fields with poor air movement.<br><br>The Hospital Course as documented in the Discharge Summary dated 10/26/2022 listed diagnoses as COPD with exacerbation with respiratory insufficiency, seizure disorder, schizoaffective disorder, bipolar type, hypertension, and metabolic versus toxic encephalopathy. Treatment during the hospital stay included a psychiatry consult that adjusted medications, resulting in the patient becoming combative and uncooperative on the day of discharge. Both a concern with a history of noncompliance and refusing medications at the ALF as well as a concern with being overmedicated due to lethargy were documented. Physical Therapy had been consulted. The patient was described as lacking insight and good judgement. Initially the discharge plan was to return to the ALF, but the ALF had reportedly felt the patient's needs could not be met at the ALF and they were recommending the resident admit to a skilled nursing facility.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #206 was admitted to the Rehab Center on 10/26/2022 at 3:29 p.m., as captured on video taken in the entrance hall of the facility. The resident was observed to walk into the building following the Transporter who led the resident to the Reception Desk. An interview was conducted with the Admissions Coordinator on 11/06/2022 beginning at 12:05 p.m. She reported remembering when Resident #206 was admitted . She said she happened to be near the reception desk and saw a Transporter walking in with a resident walking behind him, with no assistive device. She said Therapy was contacted for a wheelchair and once they brought a wheelchair to Reception, Resident #206 sat down in it, and she took him up to his room. She confirmed he had admission paperwork with him. She reported once the resident was in his room, she assisted him into his bed and began to familiarize him with the room and his call bell. She said he seemed fine, and he didn't say much, including anything about having been admitted to the facility. She said that she let the nurse know her new admission had arrived and then she left the floor. She reported that she went home a few hours later but was called back in to assist in searching for Resident #206 as he didn't seem to be anywhere in the building. She confirmed assisting in the search, but they were not able to find him that night. She said she went home and when she returned the next morning, she learned his location was still unknown.<br><br>The facility called their Code Silver (Missing Resident) Drill on 10/26/2022 at 6:06 to search inside the building for Resident #206. The Overview for the Missing Resident/Patient Action Plan read: To assist in guiding the facility with suggested activities in response to a missing resident/patient. The form is not intended as an all-inclusive list of actions, rather a prompt of some key areas to review or perform.<br><br>The completed form was reviewed and noted that according to decisions the facility made on the Elopement Decision Tree, reporting to the state agency was not applicable. An interview with the Administrator on 11/07/2022 which began at 11:00 a.m. confirmed that she had not reported the incident related to Resident #206 whose location was unknown for 18.5 hours to the State Agency. She confirmed she had not identified it as an Elopement as the resident was alert and oriented and able to make the decision that he would leave the facility. She reported that she was still investigating the incident and would submit her State report on 11/09/2022, as that would be day 15. A review of the Elopement Decision Tree revealed the first question read: Did a resident /patient leave the premises or a safe area without authorization and/or necessary supervision and was resident at risk for harm or injury? The facility answered NO to this question which guided the facility to stop as this was not considered an elopement. When the Administrator was asked why the question was answered No - as the resident had left the premises, considered a safe area, without authorization or supervision and he was at risk for harm or injury, she reported, on 11/07/2022 in the interview that began at 11:00 a.m., that because the resident's admission documents from the hospital indicated he was alert and oriented and his own person, he had the authority to leave. The Administrator provided the guidance used when investigating an incident to determine whether the resident experienced harm as a result of the incident. The first bullet point asked whether the resident experienced physical, emotional, or mental injury. The facility's documented response read, no injury reported by law enforcement (LE) or hospital. When asked about this statement, the Administrator re-iterated that neither LE nor the hospital found any injury. There was no evidence of a mental health assessment in the hospital notes, so the answer No was not founded on any evidence of an assessment by social services or psychological staff.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | There was a question about the likelihood that the resident could have experienced physical, emotional, or mental injury to which the answer had been documented as No. As the resident had been away from the facility for 18.5 hours, overnight, outside and in a park, there was likelihood that the resident could have experienced physical, emotional, or mental injury. A question asked if the resident was at risk for being hit by a motor vehicle with the answer No, used sidewalks while exiting the premises. The location at which the resident was found was 5.1 miles away. Driving a potential, direct route from the facility to the location in the park where he was found revealed some areas of the route which ranged from narrow two-lane streets to wide busy four lane streets, some without sidewalks, intersections with traffic lights, and turn lanes. Observation of the photo of the resident arriving to the facility could not identify what the resident had on his feet. His pants were long and covered some of his feet, and it was difficult to identify whether the resident had soft moccasin like shoes on or only socks. The guidance document asked about appropriate clothing and the documentation read: resident was wearing long sleeved flannel shirt, long pants, and nonskid socks. There was nothing documented about shoes.<br><br>The Administrator reported, in an interview conducted on 11/07/2022 beginning at 11:00 a.m., she had spoken with the resident on 10/27/2022 when he was at the hospital, and he told her that he was able to get onto the elevator when someone else got off. When a request was made for the policy or protocol for the secured, coded elevator, the Administrator provided an in-service that had been conducted on 10/27/2022 instead.<br><br>In an interview that was conducted with the Administrator on 11/07/2022 beginning at 11:00 a.m., she confirmed in her review of the admitting documents that the resident was alert and oriented and his own person. She reported that his admitting nurse had reported that the resident told her that he didn't know he was being admitted to a rehab facility and he had wanted to go back to his ALF. She reported that he was able to leave the building based on his cognitive status; she couldn't refuse to let him leave as that would violate his rights. The Administrator reported a timeline that had been developed from the staff interviews and video of the resident arriving and leaving. She said that the resident was observed walking into the building at 3:29 p.m. and walking out of the building at 3:52 p.m. She confirmed that the resident's aide initially reported that the resident was not in his room when she went in to deliver his dinner tray. She reported she learned the resident's location was unknown at 6:00 p.m. at which time a Code Silver (Elopement protocol) was called, and staff were asked to conduct an internal search. She reported the internal search was conducted from 6:06 p.m. until 6:13 p.m. She said after learning that the resident was not located in the building, she sent staff out in pairs to drive around the vicinity to look for him. The Administrator confirmed that the initial search of the building took only 7 minutes due to many of the staff having been in the building and joining in the search.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a second interview with the Administrator on 11/14/2022 beginning at 9:30 a.m., when asked if a timeline had been developed from the staff interviews during the time the resident was in the building, the Administrator reported that none of the interviews indicated anyone took the elevator down with the resident, including staff and visitors, and no one admitted to having walked away from the elevator, leaving it open for the resident to get on and leave the floor. The question about how they accessed the elevator was not asked, so it is not known whether the elevator was standing open after someone else walked out of the elevator, or if they knew the code, or if someone had entered the code for them. There was no detailed timeline of who was on the second floor at what time, whether they were on the elevator, got off the elevator or who entered the elevator code to let the visitors off of the floor. The facility questioned visitors to the facility from 10/26/2022 about whether anyone rode in the elevator with them. The audit tool used to document visitor responses to their questioning about the late afternoon of 10/26/2022 only asked if someone rode down on the elevator with them. It didn't ask who input the code to allow them off the elevator, or if the elevator came up to the floor, someone got off which allowed them to get on.<br><br>An interview was conducted with the Medical Director on 11/09/2022 beginning at 8:30 a.m. He reported that the Administrator had notified him of a resident who had left the facility unescorted, but he could not identify the day that he had been made aware. He reported he agreed with the Administrator's decision that the resident was alert and oriented therefore she could not make the resident stay. When asked if the resident's surrogate should have been involved in a decision to leave the facility, he reported that would be best, but he had been told the resident left right away. He said the better way to leave would be for the resident to let his nurse know his plan to leave, sign a document and the nurse should write a note.<br><br>On 11/08/22 at 10:24 a.m., an interview was conducted with the Resident #206's family member. He confirmed he heard from the police on 10/26/22 at 10:30 p.m. and again on 10/27/22 at 7:00 am. about his missing brother. He reported that he did not hear from the facility that his family member was able to get out of the facility. The family member had been made aware of where the resident was found and reported that the resident can hardly walk and didn't know how he made it so far. He said even with his walker the resident was unstable and he didn't know if he had his walker with him. He had heard the resident went to the rehab facility and was able to leave from there, which seemed pretty easy. He confirmed he was told they didn't find him until the next morning and then they took him to the hospital. When asked about the resident's cognitive status, the family member reported the resident can make decisions, but his health is bad, so he needs help with medications. He confirmed the resident takes medications for schizophrenia. He reported he was hard to hear and understand as the resident talks so low. He reported the resident can make everyday decisions, but long-term or involved decisions, like understanding if he doesn't go to rehab, he may not be able to stay at the ALF, are hard for him. The family member reported that he told Resident # 206 to go to rehab or the ALF wouldn't take him back. He reported that the hospital never called him to let him know that they were sending the resident to a rehab facility. He confirmed he was the resident's Health Care Surrogate and Power of Attorney.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on 11/08/22 at 10:55 AM with the Deputy who found Resident # 206 mid-morning on 10/27/2022. The Deputy reported that the call identified a missing adult/endangered, white male, about 60-years old, walking around with his pants down, exposing his buttocks. He said the resident was wearing a blue t-shirt and blue pants, that could be identified as scrubs. The resident was found near a park in a neighborhood, and he looked disoriented. The resident was able to tell him his name and date of birth, and then told the deputy that he was short of breath. The deputy reported that they called the EMS who took him to the hospital that he had been discharged from.<br><br>Facility immediate actions to remove the Immediate Jeopardy included:<br><br>The facility reported that they were made aware at the exit conference held on 11/09/2022 for the Recertification and Complaint Surveys that there was an allegation of Neglect, related to Resident #206.<br><br>The facility submitted a Federal Immediate Report on 11/09/2022 and confirmed that the Administrator was responsible for submitting reports to the State Agency. The Administrator reported she was finishing the 5 day report.<br><br>The Administrator reported the incident to the State Agency on 11/09/2022. The agency didn't accept the report with the comment, based on the information provided, a report for investigation is not being accepted because the concerns do not rise to the level of reasonable cause to suspect harm.<br><br>The Abuse Registry was notified on 11/09/2022 of the allegation of Neglect.<br><br>The Administrator and Director of Nursing and all facility staff were educated on State and Federal reporting requirements.<br><br>The Administrator and Director of Nursing reviewed their job descriptions and re-signed them as indicating they had been re-educated on their responsibilities.<br><br>IDT will review new admissions historical information, preadmission screen, and the 3008 for inconsistencies in cognition and will place the resident 1:1 upon admission to evaluate elopement status and safeguards are put in place.<br><br>Facility staff were educated on reporting those residents who exhibit exit seeking behaviors to ensure the appropriate immediate interventions be initiated. Staff were educated on reporting any resident who voices a desire to leave or go home. Staff are asked to remain with the resident to ensure their safety until an evaluation of the resident's desire is conducted by the nurse.<br><br>Aides are to report to their nurses who are to report to their Nursing Supervisor, Director of Nurses or Administrator. All staff are to report to their direct supervisors who are to report to the Administrator or Director of Nurses.<br><br>Facility staff interviewed on 11/15/2022 related to reporting incidents alleging neglect were found to be knowledgeable about their responsibility.<br><br>The facility produced documentation to show that 88 % of the staff had received training, and that the facility would inservice staff not trained as they reported for duty.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interviews were conducted with 14 staff, 5 licensed nurses, 5 CNAs and 4 other staff. The staff members were able to state that they had been trained and were knowledgeable about the new policies.<br><br>2. On 11/7/22 at 10:22 a.m., Resident #68 stated that a Certified Nursing Assistant had yelled at her. The resident said she requested a salad for dinner and received a salad for lunch then again for dinner. The resident stated she informed the Certified Nursing Assistant, CNA, (resident did not [TRUNCATED] |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16723<br><br>Based on a review of facility's investigation of an event that occurred on 10/26/2022 when Resident #206 was able to enter a coded elevator that stood open, ride the elevator to the first floor, exit the elevator and walk out the front door of the building unescorted and not questioned by staff, a review of hospital records including admission records to the facility; interview with Resident #206, a family member of Resident #206, the Medical Director, the Administrator, Director of Nurses (DON), and facility staff; and observation of the facility, the resident's room and location of the elevators and the potential route that Resident #206 walked, it was determined that the facility failed to fully investigate the reason why one (Resident #206) of 8 residents sampled for abuse was able to leave the facility through an elevator described as secured by the use of a code to enter, with his location unknown for 18.5 hours.<br><br>Resident #206, a vulnerable male known to use a walker to ambulate safely, was found 18.5 hours after he was caught on camera exiting the facility, 5.1 miles from the facility in a neighborhood park.<br><br>This failure to complete a thorough investigation in a timely manner to determine the cause of the event and prevent a recurrence resulted in findings of Immediate Jeopardy due to the likelihood that another resident could leave the facility by the same means. The Immediate Jeopardy began on 10/26/2022 and was determined to be removed on 11/15/2022 and the severity and scope was reduced to a D.<br><br>Findings included:<br><br>A review was conducted of the facility's policy on their Abuse Prevention Program. The Policy statement read: The facility has designated and implemented processes which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff burn out, or resident behavior which may increase the likelihood of such events. The policy included a section on Definitions which defined Neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy included a section on the Procedure in an effort to provide residents, visitors and staff with a safe and comfortable environment. Point #3 read: The Administrator, DON (Director of Nurses) and/or designated individual are responsible for the investigation and reporting of suspected, or alleged, abuse, neglect, and exploitation and misappropriation. The Administrator, DON, and/or designated individual are also ultimately responsible for the following:<br><br>Implementation<br><br>Ongoing monitoring<br><br>Investigation<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Reporting<br><br>Tracking and trending.<br><br>The section under Investigation provided guidance: An Event Report is initiated; NHA or designate is notified and, in collaboration with Risk Management Specialist will initiate and conclude a complete and thorough investigation within the specified timeframe. The Investigation may include, but may not be limited to:<br><br>Resident statements/interviews<br><br>Employee statements/interviews<br><br>Visitor statements/interviews<br><br>Observation of resident (s), staff, environment<br><br>Document review, i.e., chart reviews, policy review, education programs, appropriate resource review (such as medical literature); and<br><br>Re-enactment of event.<br><br>A review was conducted of the Job Description for the Facility Risk Manager. In the interview with the Administrator which was conducted on 11/07/2022 beginning at 11:00 a.m., the Administrator confirmed that she was the Risk Manager for the facility. The Summary of the Position contained in the Job Description for the Risk Manager read: The Risk Manager is responsible for planning, organizing, and coordinating all aspects of the Clinical Risk Management program within the facility. The Risk Manager collaborates with the NHA (nursing Home Administrator), Facility Staff, Physicians, Residents and Families to make available the provision of quality care by the identification of potential and actual problems with subsequent formulation of solutions to alleviate these problems through the facilities internal risk management/quality assurance program. Under Essential Duties and Responsibilities, a bullet point indicated: Manages, analyzes, and trends resident, patients, and employee events. Under Abilities, a bullet point indicated: The ability to tell when something is wrong or is likely to go wrong. It does not involve solving the problem, only recognizing there is a problem.<br><br>A review of the Facility Assessment, dated 11/23/2021, revealed a section describing categories of residents defined by physical disabilities which included residents at risk of elopement. At the time of the assessment there were 15 residents identified as being at risk for elopement. At the time of the incident which occurred on 10/26/2022 when Resident #206 was able to walk onto an empty elevator and then out the front door unimpeded, there were 18 residents assessed as being at risk for elopement or exit seeking behavior.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the category used to define what equipment the facility had available or planned to obtain equipment that would be used to assist these residents identified as elopement risks was conducted. To maintain a safe environment for residents at risk of elopement, the facility had a door security system, with delay egress; acute awareness of those residents at risk and who required supervision. Mirrors and monitors were added at the front desk for maintaining a secured environment. A change in the assessment and risk identification was noted. There was no reference to the use of a coded elevator, with only staff having knowledge of the code, to maintain the safety of the residents at risk for elopement.<br><br>A review of the facility's Abuse/Neglect Log for October 2022 on 11/07/2022 revealed the incident related to Resident #206's ability to leave his resident floor unseen, get onto an open and empty, potentially secured elevator and ride it to the first floor and then walk out of the building unimpeded and unquestioned with his location unknown for 18.5 hours, was not listed. When the Administrator was asked why this incident would not have been listed on their Abuse/Neglect Log, (on 11/07/2022 in the interview that began at 11:00 a.m.) she reported that she had not viewed the resident's absence from the facility and unknown location as either abuse or neglect by the facility. She reported that once she was notified of the resident's absence, at approximately 6:00 p.m. on 10/26/2022, she reviewed admitting paperwork from the hospital for Resident #206. She reported the Admitting document, the 3008, indicated the resident's Mental/Cognitive Status at Transfer was identified as alert, oriented, follows instructions. She reported that the admitting documents indicated the resident was his own responsible party and she could not deny him his decision and ability to leave the building if he didn't want to remain. She reported that she had been told he told his nurse that he didn't want to be at the facility, and he thought he was going home when he was discharged from the hospital.<br><br>A review was conducted of the admitting documents from the hospital which included the 3008. On page 1 of 2 pages of the 3008, Section C. Decision making capacity (patient) was marked as requires a surrogate. Section D listed an Emergency Contact and phone number. Section E Medical Condition on the 3008 listed Weakness as the diagnosis. Section G Patient Risk Alerts listed falls. Page 2 of the 3008 Section S Physical Function identified the resident as ambulating independently, self-transfers, no devices in use (such as a wheelchair) and full weight bearing ability on left and right sides. Section U of the 3008 Mental/Cognitive Status at Transfer identified the resident as Alert, oriented, follows instructions.<br><br>Another document sent in the admission packet, the Pre-Admission Screening Tool, dated 10/25/2022, was reviewed and noted to describe the resident's Cognition/Behavior. The form documented the resident's current cognition level as A&Ox1-2 (alert and oriented x one to two). (Alert and oriented x 3 indicates an individual that is oriented on three levels: person, place, and time. The nurse documenting on the Pre-Admission Screening Tool did not explain which orientation the resident was missing.) The form answered No to confused and mobile, with a note on the form indicating a confused and mobile patient would be considered an elopement risk. The form described the patient as so sweet despite psych (psychiatric) history. His mobility status was described as ambulatory, with minimum assistance, with no weight bearing precautions but having had recent falls. The pre-admission screening did not list the resident as requiring oxygen.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | According to the interview with the Administrator on 11/07/2022 beginning at 11:00 a.m. her preliminary investigation once she was notified that a newly admitted resident had not remained in the facility was based on one section of the 3008 which described the resident as alert, oriented, follows instructions. Even though the 3008 included additional information on the resident's ability to make decisions with the emergency contact name and phone number listed below that information. The hospital's pre-screening information from the hospital included the admission diagnosis as weakness and falls, a description of the resident as alert and oriented x 2, minimal assistance needed for ambulation, and having had recent falls.<br><br>In an interview conducted with the resident on 11/07/2022 beginning at 9:10 a.m., he confirmed he had walked out of the facility and ended up in a park. He confirmed he had been out all night and had had nothing to eat. With a laugh he said he was glad it hadn't rained that night. He reported he had been dropped off at the facility and could not remember how he got up to his room. He reported he had been lying in his bed, but then got up, walked into the hall and no one was around. He said the elevator came up, the door opened, and a staff member got out and walked away and he got onto the elevator. He reported the elevator took him to the first floor and he walked out the front door and no one said anything to him. He said he was trying to get back to his ALF (Assisted Living Facility), but he turned the wrong way and walked until he ended up in the park. He confirmed the police confronted him in the park due to what he was wearing, and he told the police that he was short of breath. He was taken back to the hospital that he had left the day before and remained until 11/01/2022 when he was discharged back to his ALF.<br><br>Resident #206 was admitted to the facility on [DATE] at 3:29 p.m., as captured on video taken of the entrance of the facility. The resident was observed to walk into the building following the Transporter who led the resident to the Receptionist Desk.<br><br>In an interview was conducted with the Admissions Coordinator on 11/06/2022 beginning at 12:05 p.m. she reported remembering when Resident #206 was admitted . She said she happened to be near the Receptionist's desk and saw a Transporter walking in with a resident walking behind him, with no assistive device. She said therapy was contacted for a wheelchair and once they brought a wheelchair to reception, Resident #206 sat down in it, and she took him up to his room. She confirmed he had admission paperwork with him. She reported once the resident was in his room, she assisted him into his bed and began to familiarize him with the room and his call bell. She said he seemed fine, and he didn't say much, including anything about having been admitted to the facility. She said that she let the nurse know her new admission had arrived and then she left the floor. She reported that she went home a few hours later but was called back in to assist in searching for Resident #206 as he didn't seem to be anywhere in the building. She confirmed assisting in the search, but they were not able to find him that night. She said she went home and when she returned the next morning, she learned his location was still unknown.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview conducted with the Administrator on 11/14/2022 beginning at 9:30 a.m., she agreed to read staff statements about their interaction with Resident #206 on 10/26/2022. She confirmed two aides, and one nurse were assigned to the unit where Resident #206 would be residing. One aide (CNA QQ) saw the resident when he arrived on to the floor about 3:45 p.m. She reported she knew she wasn't assigned to him. She said later she saw him standing by the elevator, so she assisted him back to his room, and asked him if he needed anything. She reported that he asked for the TV to be turned on, which she did, and she ensured he had the TV remote and his call bell accessible. The resident's nurse, (RN HH) reported she saw the resident when he arrived on the floor initially and after that saw him at the elevator. She reported that she asked him to return to his room so she could get his vitals. She reported in her statement that he seemed angry but agreeable to return to his room. Her statement included no additional comments made by the resident. The resident's displeasure with being at the facility was not included in RN HH's statement and when that was questioned, the Administrator said that the nurse meant he wanted to leave when she wrote that he seemed angry.<br><br>The DON added she went to the hospital to see Resident #206 on 10/28/2022. She said the resident told her he had been tricked, that he hadn't been told he was going to a rehab center as he thought he was going home to his ALF.<br><br>In an interview with RN HH on 11/10/2022 beginning at 12:20 p.m., she reported that she had been on the phone with the doctor for the resident in the B bed as he wasn't doing well, and she saw the new resident in the A bed get up and walk out of the room. She said she spoke to him, letting him know she was his nurse and he said good. She said he said nothing else to her. She said she took his temperature but not the other vitals as the equipment wasn't handy to her. She said he was friendly, clean, but looked more like a visitor than a resident. She said she got busy with the other sick resident and also busy passing medications to her other residents, and she didn't know he had gotten onto the elevator and left the building. She said it wasn't until the aide told her that he wasn't in his room when they delivered the dinner trays that she knew he wasn't around. She said herself and one of the aides looked all around for him on the second floor without success.<br><br>RN HH reported she didn't have the chance to review Resident #206's medications or his admitting paperwork.<br><br>RN HH denied that the resident told her he didn't want to be there and said he only responded to her saying that she was his nurse. She reported that she felt not having a third nurse or a unit manager to observe and assist with the residents was the reason the resident was able to leave the floor unobserved. When asked about staff training on the elevator protocol, she reported that staff are not to walk away from an open elevator as a resident could get onto it.<br><br>Admission documents received by the facility at the time Resident #206 arrived included a list of medications that were ordered for the resident. Medications that the resident should have received before bed included Olanzapine 5 mg for Schizophrenia; Gabapentin 400 mg for neuropathy; Budesonide inhalation for wheezing and shortness of breath; Divalproex sodium 500 mg for seizures; Formoterol 2 ml inhalation for shortness of breath; Lorazepam 1 mg for anxiety; Melatonin 3 mg for insomnia; Metoprolol 25 mg for hypertension and Tizandinine 4 mg for muscle spasms.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | At the time of the resident's ability to board the elevator unobserved and exit the elevator and out through the front door, visitors were not required to wear name badges identifying them as visitors. During the Recertification Survey, done in conjunction with the survey team's investigation of the incident with Resident #206 and his unknown location for 18 hours after being admitted to the facility, staff were observed to be working without identification badges.<br><br>The Administrator reported, in an interview conducted on 11/07/2022 beginning at 11:00 a.m., she had spoken with the resident on 10/27/2022 when he was at the hospital, and he told her that he was able to get onto the elevator when someone else got off. When a request was made for the policy or protocol for the secured, coded elevator, the Administrator provided an in-service that had been conducted on 10/27/2022 instead. The in-service document dated 10/27/2022 listed objectives for the training. She confirmed there wasn't a specific or formal policy for maintaining the safety of the elevator that included the situation that allowed Resident #206 to get on an unsecured elevator and leave the building unescorted and without staff knowledge. The objectives of the in-service were: elevator code should not be shared with residents or families; any staff member who gives code to unauthorized persons will be subject to disciplinary action or possible termination; alarms should be checked and verified that residents are not exit seeking. Even though the resident told the Administrator that he was able to get onto the elevator when someone else got off, the information that staff need to watch the elevator door close before walking away to ensure a resident doesn't get onto it was not included in the in-service.<br><br>On 11/14/2022 at approximately 9:30 a.m., the Administrator reported that a new Elevator Management Process had been developed on 11/10/2022 and staff had been in-serviced on the objectives listed on the 10/27/2022 in-service as well as on the new process developed on 11/10/2022. The Elevator Management Process, dated 11/10/2022, read: Facility has educated staff on resident, vendor, and staff safety with regards to elevator management. Facility staff should check before and after entering/exiting facility elevators to ensure resident/s or unauthorized person/s do not attempt to tailgate or entry/exit to elevator. Unauthorized person refers to anyone without an employee name badge or visitors sticker. Person/s without an employee badge or visitors sticker will be referred to front desk to check in, if on a unit, the person/s will need to be referred to a Nurse and/or supervisor.<br><br>In an interview with the Administrator which occurred on 11/14/2022 beginning at 9:30 a.m., the timeline that had been developed to investigate the resident's ability to leave the facility through a secured elevator and out the front door without being questioned, was reviewed. The Administrator reported that the resident was observed walking into the building on 10/26/2022 at 3:29 p.m. and walking out of the building at 3:52 p.m. She confirmed that the resident's aide told her nurse that the resident was not in his room when she went in to deliver his dinner tray. She reported she was notified at 6:00 p.m. that the resident's location was unknown. She reported she reviewed admission documents for the resident's cognition and determined the resident had not eloped as he was alert and oriented. However, a Code Silver (Elopement protocol) was called, and staff were asked to conduct an internal search for the resident. She reported the internal search was conducted from 6:06 p.m. until 6:13 p.m. She said after learning that the resident was not located in the building, she sent staff out in pairs to drive around the vicinity of the facility to look for him. The Administrator confirmed that the initial search of the building took only 7 minutes due to many of the staff having been in the building and joining in the search.<br><br>(continued on next page) |

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| | 105234 | A. Building<br>B. Wing | 11/15/2022 |

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| Rehabilitation and Healthcare Center of Tampa | 4411 N Habana Ave<br>Tampa, FL 33614 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the Overview for the Missing Resident/Patient Action Plan read: To assist in guiding the facility with suggested activities in response to a missing resident/patient. The form is not intended as an all-inclusive list of actions, rather a prompt of some key areas to review or perform. The completed form was reviewed and noted that according to decisions the facility made on the Elopement Decision Tree, reporting to the state agency was not applicable. An interview with the Administrator on 11/07/2022 which began at 11:00 a.m. confirmed that she had not reported the incident related to Resident #206 whose location was unknown for 18.5 hours to the State Agency. She confirmed she had not identified it as an Elopement as the resident was alert and oriented and able to make the decision that he would leave the facility. She reported that she was still investigating the incident and would submit her State report on 11/09/2022, as that would be day 15.<br><br>A review of the Elopement Decision Tree revealed the first question: Did a resident /patient leave the premises or a safe area without authorization and/or necessary supervision and was resident at risk for harm or injury? The facility answered NO to this question which guided the facility to stop as this was not considered an elopement. When the Administrator was asked why the question was answered No, as the resident had left the premises, considered a safe area, without authorization or supervision and he was at risk for harm or injury, she reported, on 11/07/2022 in the interview that began at 11:00 a.m., that because the resident's admission documents from the hospital indicated he was alert and oriented and his own person, he had the authority to leave. The Administrator provided the guidance used when investigating an incident to determine whether the resident experienced harm as a result of the incident. The first bullet point asked whether the resident experienced physical, emotional, or mental injury. The facility's documented response read, no injury reported by law enforcement (LE) or hospital. When asked about this statement, the Administrator re-iterated that neither LE nor the hospital found any injury. There was no evidence of a mental health assessment in the hospital notes, so the answer No was not founded on any evidence of an assessment by social services or psychological staff. There was a question about the likelihood that the resident could have experienced physical, emotional, or mental injury to which the answer had been documented as No. As the resident had been away from the facility for 18.5 hours, overnight, outside and in a park, there was likelihood that the resident could have experienced physical, emotional, or mental injury. A question asked if the resident was at risk for being hit by a motor vehicle with the answer No, used sidewalks while exiting the premises. The location at which the resident was found was 5.1 miles away. Driving a potential, direct route from the facility to the location in the park where he was found revealed some areas of the route which ranged from narrow two-lane streets to wide busy four lane streets, some without sidewalks, intersections with traffic lights, and turn lanes. Observation of the photo of the resident arriving to the facility could not identify what the resident had on his feet. His pants were long and covered some of his feet, and it was difficult to identify whether the resident had soft moccasin like shoes on or only socks. The guidance document asked about appropriate clothing and the documentation read: resident was wearing long sleeved flannel shirt, long pants, and nonskid socks. There was nothing documented about shoes.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In the interview with the Administrator on 11/14/2022 beginning at 9:30 a.m., when asked if a timeline had been developed from the staff interviews during the time the resident was in the building, the Administrator reported that none of the interviews indicated anyone had taken the elevator down with the resident, including staff and visitors, and no one admitted to having walked away from the elevator, leaving it open for the resident to get on and leave the floor. The Administrator reported that the Director of Nurses had phoned those visitors who had signed the visitor log on 10/26/2022 during the time period that Resident #206 had arrived at and then left the facility. The DON confirmed she was not able to contact every visitor, but no visitor said they rode down on the elevator with someone else. The question about how they accessed the elevator was not asked, so it is not known whether the elevator was standing open after someone else walked out of the elevator, or if the visitors knew the code, or if someone had entered the code for them.<br><br>There was no detailed timeline of who was on the second floor at what time, whether they were on the elevator, got off the elevator or who entered the elevator code to let the visitors off the floor. There was no set of questions used to fully investigate staff statements or to ensure that the statements were complete and could identify who was the last person to leave the elevator, allowing it to remain open and providing an empty, unsecured elevator for Resident #206 to enter, ride to the first floor and walk out of the building unimpeded.<br><br>Resident #206 had been living in a local ALF prior to a hospitalization for increasing weakness. According to hospital records, the resident was admitted on [DATE] with a History and Physical (H&P) documented at 3:54 p.m. The H&P documented the patient as a [AGE] year-old male with past medical history significant for schizoaffective disorder, hypertension, seizure disorder and COPD (chronic obstructive pulmonary disease), presented to the emergency department via EMS from his ALF (Assisted Living Facility) with complaints of worsening weakness. Has extensive psychiatric history and on multiple medications for schizoaffective disorder. Currently patient lethargic and unable to give much history. Audible wheezing throughout his lung fields with poor air movement. The Hospital Course as documented in the Discharge Summary dated 10/26/2022 listed diagnoses as COPD with exacerbation with respiratory insufficiency, seizure disorder, schizoaffective disorder, bipolar type, hypertension, and metabolic versus toxic encephalopathy. Treatment during the hospital stay included a psychiatry consult that adjusted medications, resulting in the patient becoming combative and uncooperative on the day of discharge. Both a concern with a history of noncompliance and refusing medications at the ALF as well as a concern with being overmedicated due to lethargy were documented. Physical Therapy had been consulted. The patient was described as lacking insight and good judgement. Initially the discharge plan was to return to the ALF, but the ALF had reportedly felt the patient's needs could not be met at the ALF and they were recommending the resident admit to a skilled nursing facility.<br><br>An interview was conducted with the Medical Director on 11/09/2022 beginning at 8:30 a.m. He reported that the Administrator had notified him of a resident who had left the facility unescorted, but he could not identify the day that he had been made aware. He reported he agreed with the Administrator's decision that the resident was alert and oriented therefore she could not make the resident stay. When asked if the resident's surrogate should have been involved in a decision to leave the facility, he reported that would be best, but he had been told the resident left right away. He said the better way to leave would be for the resident to let his nurse know his plan to leave, sign a document and the nurse should write a note.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 11/08/22 at 10:24 a.m., an interview was conducted with the Resident #206's family member. He confirmed he heard from the police on 10/26/22 at 10:30 p.m. and again on 10/27/22 at 7:00 am. about his missing brother. He reported that he did not hear from the facility that his family member was able to get out of the facility. The family member had been made aware of where the resident was found and reported that the resident can hardly walk and didn't know how he made it so far. He said even with his walker the resident was unstable and he didn't know if he had his walker with him. He had heard the resident went to the rehab facility and was able to leave from there, which seemed pretty easy. He confirmed he was told they didn't find him until the next morning and then they took him to the hospital. When asked about the resident's cognitive status, the family member reported the resident can make decisions, but his health is bad, so he needs help with medications. He confirmed the resident takes medications for schizophrenia. He reported he was hard to hear and understand as the resident talks so low. He reported the resident can make everyday decisions, but long-term or involved decisions, like understanding if he doesn't go to rehab, he may not be able to stay at the ALF, are hard for him. The family member reported that he told Resident # 206 to go to rehab or the ALF wouldn't take him back. He reported that the hospital never called him to let him know that they were sending the resident to a rehab facility. He confirmed he was the resident's Health Care Surrogate and Power of Attorney.<br><br>An interview was conducted on 11/08/22 at 10:55 AM with the Deputy who found Resident # 206 mid-morning on 10/27/2022. The Deputy reported that the call identified a missing adult/endangered, white male, about 60-years old, walking around with his pants down, exposing his buttocks. He said the resident was wearing a blue t-shirt and blue pants, that could be identified as scrubs. The resident was found near a park in a neighborhood, and he looked disoriented. The resident was able to tell him his name and date of birth, and then told the deputy that he was short of breath. The deputy reported that they called the EMS who took him to the hospital that he had been discharged from.<br><br>Observation of the facility revealed it was a four story L shaped building on the corner of two main streets. The building's parking lot was adjacent to an outpatient building with roads leading past the building to the two main streets. Across the street from the facility was a major hospital with an ER and multiple entrances into the ER and parking lots. The entrance to the facility was approximately 88 feet from the Receptionist Desk, which included an entry hall of 26 feet, which ended in a T intersection. The Elevator was 42 feet from the intersection of the two halls and the reception desk another 20 feet from the elevator. The resident's room on the second floor was two doors down from elevator, with a nursing station in front of the elevators. The staffing sheet for 10/26/2022 did not list a unit manager on duty on the second floor, who would have worked from the nursing station. Two nurses and four aides were assigned to the 3-11 shift on the second floor. The census on the second floor on 10/26/2022 was 44 residents. Access to the resident floors, above the main floor, was by way of two elevators, both of which were in front of the nursing stations. The elevators had a coded access to enter on the second, third, and fourth floors. The code was not to be given to anyone, including medical professionals, vendors, or visitors. Only staff were to have the code and were to provide access to the elevators when an authorized person requested to leave the floor.<br><br>The day, 10/26/2022, was warm and sunny with temperatures between a high of 79 and 82 degrees F between noon and 6 p.m., according to the website providing Past Weather in [NAME]. Overnight, the temperature ranged from 73 to 75 degrees F. It was a clear evening and night.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The potential route that the resident took was identified as walking west out of the facility parking lot, and turning north on a four-lane road with a speed limit of 45 mph. The distance between the facility and the park where the Deputy found the resident was 5.1 miles along roads that ranged from two to four lane [TRUNCATED] |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16723<br><br>Based on interviews with Resident #206, a family member of Resident #206, facility staff, the Medical Director, and a Deputy with the local police department; a review of facility documents, including admission documents for Resident #206, hospital records for Resident #206, facility policies, and training documents; and observation of the facility entrance, the resident's room, and the potential route the resident took once he left the facility, it was determined that the facility failed to provide adequate supervision to one resident (Resident #206) of 4 residents sampled for accidents/supervision, when after less than 25 minutes in the facility, the resident was able to get on an empty elevator that had a coded entry to ensure resident's safety, ride the elevator to the ground floor and walk, unescorted and unimpeded out the front door of the facility. The resident's image was caught on camera at 3:52 p.m. on 10/26/2022 exiting the building, alone. Notification to Administrative Staff by the staff who were to supervise him occurred at 6:00 p.m., two hours after the resident's departure from the facility. Law Enforcement was not notified of the resident's unauthorized departure from the facility with location unknown until 6:47 p.m.<br><br>Facility staff did not notify the hospital from which he had been discharged at 3:30 p.m. that afternoon, and which was across the street from the facility, until 8:30 p.m. The resident was not found until 10/27/2022 at 10:30 a.m.; 18.5 hours after he was observed, on camera, leaving the facility.<br><br>It was determined that staff had not implemented their elevator protocol when Resident #206 was able to board an empty elevator, confirmed by no staff or visitor reporting they had seen or ridden down on the elevator with Resident #206, and walk out the front door with no staff questioning who he was or where he was going.<br><br>This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #206 and resulted in the determination of Immediate Jeopardy on 10/26/2022. The findings of Immediate Jeopardy were determined to be removed on 11/15/2022 and the severity and scope was reduced to a D.<br><br>Findings included:<br><br>Resident #206 had been living in a local Assisted Living Facility (ALF) prior to a hospitalization for increasing weakness. According to hospital records, the resident was admitted on [DATE] with a History and Physical (H&P) documented at 3:54 p.m. The H&P documented the patient as a [AGE] year-old male with past medical history significant for schizoaffective disorder, hypertension, seizure disorder and COPD [chronic obstructive pulmonary disease], presented to the emergency department via EMS [Emergency Medical Services] from his ALF with complaints of worsening weakness. Has extensive psychiatric history and on multiple medications for schizoaffective disorder. Currently patient lethargic and unable to give much history. Audible wheezing throughout his lung fields with poor air movement.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Hospital Course as documented in the Discharge Summary dated 10/26/2022 listed diagnoses as COPD with exacerbation with respiratory insufficiency, seizure disorder, schizoaffective disorder, bipolar type, hypertension, and metabolic versus toxic encephalopathy. Treatment during the hospital stay included a psychiatry consult that adjusted medications, resulting in the patient becoming combative and uncooperative on the day of discharge. Both a concern with a history of noncompliance and refusing medications at the ALF as well as a concern with being overmedicated due to lethargy were documented. Physical Therapy had been consulted. The patient was described as lacking insight and good judgement. Initially the discharge plan was to return to the ALF, but the ALF had reportedly felt the patient's needs could not be met at the ALF and they were recommending the resident admit to a skilled nursing facility.<br><br>A review was conducted of the admitting documents from the hospital which included the 3008. On page 1 of 2 pages of the 3008, Section C. Decision making capacity (patient) was marked as requires a surrogate. Section D listed an Emergency Contact and phone number. Section E Medical Condition on the 3008 listed Weakness as the diagnosis. Section G Patient Risk Alerts listed falls. Page 2 of the 3008 Section S Physical Function identified the resident as ambulating independently, self-transfers, no devices in use (such as a wheelchair) and full weight bearing ability on left and right sides. Section U of the 3008 Mental/Cognitive Status at Transfer identified the resident as Alert, oriented, follows instructions.<br><br>Another document sent in the admission packet the Pre-Admission Screening Tool, dated 10/25/2022, described the resident's current cognition level as A&Ox1-2 (alert and oriented x one to two). (Alert and oriented x 3 indicates an individual that is oriented to three axes, person, place, and time. The nurse documenting on the Pre-Admission Screening Tool did not explain which orientation the resident was missing.) The form described the resident as not confused and mobile as the form indicated a confused and mobile patient would be considered an elopement risk. There was no assistive device in use when he walked into the facility. The pre-admission screening did not list the resident as requiring oxygen. His mobility status was also described as ambulatory, with minimum assistance, with no weight bearing precautions and having had recent falls.<br><br>Resident #206 was admitted to the facility on [DATE] at 3:29 p.m., as captured on video taken of the entrance of the facility. The resident was observed to walk into the building following the Transporter who led the resident to the Receptionist Desk.<br><br>In an interview was conducted with the Admissions Coordinator on 11/06/2022 beginning at 12:05 p.m. she reported remembering when Resident #206 was admitted . She said she happened to be near the Receptionist's desk and saw a Transporter walking in with a resident walking behind him, with no assistive device. She said therapy was contacted for a wheelchair and once they brought a wheelchair to reception, Resident #206 sat down in it, and she took him up to his room. She confirmed he had admission paperwork with him. She reported once the resident was in his room, she assisted him into his bed and began to familiarize him with the room and his call bell. She said he seemed fine, and he didn't say much, including anything about having been admitted to the facility. She said that she let the nurse know her new admission had arrived and then she left the floor. She reported that she went home a few hours later but was called back in to assist in searching for Resident #206 as he didn't seem to be anywhere in the building. She confirmed assisting in the search, but they were not able to find him that night. She said she went home and when she returned the next morning, she learned his location was still unknown.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview conducted with the resident on 11/07/2022 beginning at 9:10 a.m., he confirmed he had walked out of the facility and ended up in a park. He confirmed he had been out all night and had had nothing to eat. With a laugh he said he was glad it hadn't rained that night. He reported he had been dropped off at the facility and could not remember how he got up to his room. He reported he had been lying in his bed, but then got up, walked into the hall and no one was around. He said the elevator came up, the door opened, and a staff member got out and walked away and he got onto the elevator. He reported the elevator took him to the first floor and he walked out the front door and no one said anything to him. He said he was trying to get back to his ALF, but he turned the wrong way and walked until he ended up in the park. He confirmed the police confronted him in the park due to what he was wearing, and he told the police that he was short of breath. He was taken back to the hospital that he had left the day before and remained until 11/01/2022 when he returned to his ALF.<br><br>The History and Physical from Resident #206's second admission to the hospital, on 10/27/2022, documented his elopement from the facility, that he had been found by the police wandering, and found in respiratory distress, hypoxic, and therefore taken to the emergency room (ER). The resident had been discharged on [DATE] on room air, but on 10/27/2022 the doctor documented, despite drips and nebs (medication doses and nebulizer treatments) he remained wheezing and hypoxic. The exam in theER on [DATE] documented mild distress, the patient was not alert and oriented, but cooperative without the appropriate mood and affect.<br><br>Observation of the facility revealed it was a four story L shaped building on the corner of two main streets. The building's parking lot was adjacent to an outpatient building with roads leading past the building to the two main streets. Across the street from the facility was a major hospital with an ER and multiple entrances into the ER and parking lots. The entrance to the facility was approximately 88 feet from the Receptionist Desk, which included an entry hall of 26 feet, which ended in a T intersection. The Elevator was 42 feet from the intersection of the two halls and the reception desk another 20 feet from the elevator. The resident's room on the second floor was two doors down from elevator, with a nursing station in front of the elevators. The staffing sheet for 10/26/2022 did not list a unit manager on duty on the second floor, who would have worked from the nursing station. Two nurses and four aides were assigned to the 3-11 shift on the second floor. The census on the second floor on 10/26/2022 was 44 residents. Access to the resident floors, above the main floor, was by way of two elevators, both of which were in front of the nursing stations. The elevators had a coded access to enter on the second, third, and fourth floors. The code was not to be given to anyone, including medical professionals, vendors, or visitors. Only staff were to have the code and were to provide access to the elevators when an authorized person requested to leave the floor.<br><br>The day, 10/26/2022, was warm and sunny with temperatures between a high of 79 and 82 degrees F between noon and 6 p.m., according to the website providing Past Weather in [NAME]. Overnight, the temperature ranged from 73 to 75 degrees F. It was a clear evening and night.<br><br>The potential route that the resident took was identified as walking west out of the facility parking lot, and turning north on a four-lane road with a speed limit of 45 mph. The distance between the facility and the park where the Deputy found the resident was 5.1 miles along roads that ranged from two to four lanes, some roads straight and some curvy, with sidewalks that changed from one side of the road to the other and sometimes ended in dirt paths. Walking north would have taken the resident past intersections that widened into multiple lanes with turn lanes. Speed limits ranged from 25 to 45 mph.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The resident was seen leaving the facility at 3:52 p.m. on video. Shift change occurs at 3:00 p.m. and a smoking break for the residents is planned for 4:00 p.m. Residents are aware they can congregate at the back door to the smoking area on the first floor which is around the corner from the reception desk and elevator. The resident reported seeing no staff in the area around the elevator on the second floor, except for the staff member who exited the elevator and walked away from the elevator leaving the door open, and available for Resident #206 to enter, ride to the first floor, and walk out of the building, unnoticed. The resident reported no one on the first floor stopped him or asked where he was going.<br><br>An interview was conducted with the resident's admitting nurse, RN HH (Registered Nurse) on 11/10/2022 beginning at 12:20 p.m. She confirmed she worked the 7-3 shift and then agreed to stay to cover the 3-11 shift on the second floor on 10/26/2022. She reported that the second floor is very busy, with no unit manager and two nurses with usually four or five aides. She reported she had three admissions and one discharge during her two shifts, with two of the admissions and the discharge occurring during the first shift. She reported the Director of Nurses (DON) helped her with one of the admissions and she was told the ADON (Assistant Director of Nurses) would help her with another admission, but then the new admission went missing. RN HH confirmed she worked the shorter hall, which has poor sight of the elevator, unless someone is standing right in front of it. She said the nurse who works on the longer hall can see into the elevator, to see who is getting onto it, but only if they are standing in the first part of the hall. She added when either nurse is passing medications, they go into the resident's room and then they can't monitor the elevator. RN HH said without a unit manager, the nurses or aides have to answer the phone at the nurses' station, input the elevator code for someone asking to leave the floor, and ensure that no one gets on the elevator that isn't supposed to. RN HH reported that the resident in (room #) was not doing well and she was on the phone with the doctor. She said the new resident in 212A, Resident #206, was in his bed when she was on the phone with the doctor, and she saw the resident get up out of bed and walk out of the room. She said she spoke to him, letting him know she was his nurse and he said good. She said he said nothing else to her. She said she took his temperature but not the other vitals as the equipment wasn't handy to her. She said he was friendly, clean, but looked more like a visitor than a resident. She said she got busy with the other sick resident and also busy passing medications to her other residents, and she didn't know Resident #206 had gotten onto the elevator and left the building. She said it wasn't until the aide told her that he wasn't in his room when they delivered the dinner trays that she knew he wasn't around. She said herself and one of the aides looked all around for him on the second floor without success. RN HH reported she never had the chance to review his medications or admitting paperwork. She denied that the resident told her that he didn't want to be there, and said he only responded to her saying that she was his nurse. She reported that she felt not having a third nurse or a unit manager to observe and assist with the residents was the reason the resident was able to leave the floor unobserved. When asked about staff training on the elevator protocol, she reported that staff are not to walk away from an open elevator as a resident could get onto it. She wasn't sure if that information was actually part of the training or not.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the job description for the Unit Manager, undated, revealed in the Summary of the Position, the Unit Manager, RN (UM-RN) is responsible for overseeing direct nursing care to assigned Residents/Patients. The UM-RN assumes responsibility and accountability for the nursing care and services provided on the assigned unit. The UM-RN is responsible for and adheres to the standards of care for assigned Residents/Patients, assists with data collection, monitoring and implementation of physician orders based on individual resident/patient needs, manages the environment to maintain resident/patient safety, and supervises the resident/patient care activity performance by licensed nurses and certified nursing assistants. Under Essential Duties and Responsibilities was a bullet point that read: Oversees the assessments of the resident/patient admission process.<br><br>In an interview with facility staff on 11/14/2022 beginning at 9:30 a.m. the lack of a Unit Manager on the second floor was raised. The Administrator reported that a Unit Manager for the second floor had been hired. The DON reported that unit managers remain until 4 or 5 p.m. during the week and after that the charge nurse is available to assist the nurses on the floors. She reported that the Unit Managers work the day shift and assist with what needs to be done, including remaining at the nursing station to answer the phone and watch the elevator. She reported without a Unit Manager assigned to the floor, the other Unit Managers from the third and fourth floor were to assist and the DON and ADON were available also.<br><br>An interview was conducted with the facility's Medical Director on 11/09/2022 beginning at 8:30 a.m. He reported that the Administrator had notified him of a resident who had left the facility unescorted, but he could not identify the day that he had been made aware. He reported that he agreed with the Administrator's decision that the resident was alert and oriented therefore she could not make him stay. When asked if the resident's surrogate should have been involved in a decision to leave the facility, he reported that would be best, but he had been told the resident left right away. He said the better way to leave would be for the resident to let his nurse know his plan to leave, sign a document and the nurse should write a note.<br><br>In an interview with Staff R, Licensed Practical Nurse (LPN) on 11/07/2022 beginning at 9:15 a.m., the LPN reported that he knows not to let residents onto the elevator. He described another resident as watching the elevator and when that resident thinks he can sneak on to it, he self-propels his wheelchair quickly onto the elevator. He reported they try to have someone at the nursing station to watch the elevator to make sure a resident doesn't get on. He confirmed when staff are on the elevator, they need to ensure any resident that gets on the elevator is escorted or can say where he is going. He confirmed that staff are to ensure the elevator door closes prior to leaving the area to ensure no resident gets on the empty elevator.<br><br>Staff S, RN was interviewed on 11/07/2022 beginning at 9:20 a.m. He reported that he was not aware of how the resident was able to leave the facility, but figured the resident was able to get onto the elevator with other residents and staff.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted with Staff NN, Certified Nursing Aide (CNA) on 11/09/2022 beginning at approximately 12:00 p.m. She reported that she only works the 7 to 3 shift, and she wasn't at the facility when the new admission (Resident #206) arrived. She reported she had received training on the elevator in the past and knows not to give out the code. She reported that staff are told to only let residents onto the elevator that are with staff or if they know the resident is alert and oriented and allowed to leave the floor. She reported that some residents who are alert and oriented can sign out on the floor and leave the building and some of the smokers, being alert and oriented, are allowed to leave the floor unescorted as they are known to be going down to smoke.<br><br>The Administrator was interviewed on 11/07/2022 beginning at 11:00 a.m. about Resident #206 and his ability to leave the facility 23 minutes after having arrived. She reported that the resident's absence was not considered an elopement as the resident was alert and oriented and had told staff he did not know he was coming to a rehab facility, and he didn't want to be at a rehab facility.<br><br>The facility called their Code Silver (Missing Resident) Drill on 10/26/2022 at 6:06 to search inside the building for Resident #206. The Overview for the Missing Resident/Patient Action Plan read: To assist in guiding the facility with suggested activities in response to a missing resident/patient. The form is not intended as an all-inclusive list of actions, rather a prompt of some key areas to review or perform. The completed form was reviewed and noted that according to the Elopement Decision Tree, reporting to the state agency was not applicable. A review of the Elopement Decision Tree revealed the first question read: Did a resident /patient leave the premises or a safe area without authorization and/or necessary supervision and was resident at risk for harm or injury? The facility answered NO to this question which guided the facility to stop as this was not considered an elopement.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | When the Administrator was asked why the question was answered No, as the resident had left the premises, considered a safe area, without authorization or supervision and he was at risk for harm or injury, she reported, on 11/07/2022 in the interview that began at 11:00 a.m., that because the resident's admission documents from the hospital indicated he was alert and oriented and his own person, he had the authority to leave. The Administrator provided the guidance used when investigating an incident to determine whether the resident experienced harm as a result of the incident. The first bullet point asked whether the resident experienced physical, emotional, or mental injury. The facility's documented response read, no injury reported by law enforcement (LE) or hospital. When asked about this statement, the Administrator re-iterated that neither LE nor the hospital found any injury. There was no evidence of a mental health assessment in the hospital notes, so the answer No was not founded on any evidence of an assessment by social services or psychological staff. There was a question about the likelihood that the resident could have experienced physical, emotional, or mental injury to which the answer had been documented as No. As the resident had been away from the facility for 18.5 hours, overnight, there was some likelihood that the resident could have experienced physical, emotional, or mental injury. A question asked if the resident was at risk for being hit by a motor vehicle with the answer No, used sidewalks while exiting the premises. The location at which the resident was found was 5.1 miles away. Driving a potential, direct route from the facility to the location in the park where he was found revealed some areas of the route which ranged from narrow two-lane streets to wide busy four lane streets, some without sidewalks, intersections with traffic lights, and turn lanes. Observation of the photo of the resident arriving to the facility could not identify what the resident had on his feet. His pants were long and covered some of his feet, and it was difficult to identify whether the resident had soft moccasin like shoes on or only socks. The guidance document asked about appropriate clothing and the documentation read: resident was wearing long sleeved flannel shirt, long pants, and nonskid socks. There was nothing documented about shoes.<br><br>A request was made for the facility policy on the timeline to complete a new admission assessment. The Administrator provided the policy, Admission/Readmission Data Collection, which read: The Resident's Admission/Readmission Data Collection will provide a comprehensive description of the Resident's status on admission. The assessment can be used for Residents who have left the facility and return with a significant change of condition. The assessment is designed to identify past history, current findings and factors that may put the Resident at risk. The baseline plan of care must be created in the system after completion of the assessment. Document in the Nurses Progress Notes every shift for a minimum of 72 hours on all new admissions to identify changes in status post admission. The entire admission/readmission data collection must be completed for the assessment to be comprehensive. The assessment must be completed within 72 hours of admission.<br><br>The Administrator reported, in an interview conducted on 11/07/2022 beginning at 11:00 a.m., she had spoken with the resident on 10/27/2022 when he was at the hospital, and he told her that he was able to get onto the elevator when someone else got off. When a request was made for the policy or protocol for the secured, coded elevator, the Administrator provided an in-service that conducted on 10/27/2022 instead.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | She provided an in-service document dated 10/27/2022 with listed objectives and confirmed there wasn't a specific or formal policy for maintaining the safety of the elevator. The objectives of the in-service were: elevator code should not be shared with residents or families; any staff member who gives code to unauthorized persons will be subject to disciplinary action or possible termination; alarms should be checked and verified that residents are not exit seeking. Even though the resident told the Administrator that he was able to get onto the elevator when someone else got off, that information that staff need to watch the elevator door close before walking away to ensure a resident doesn't get onto it was not included in the in-service.<br><br>In an interview that was conducted with the Administrator on 11/07/2022 beginning at 11:00 a.m., she confirmed in her review of the admitting documents that the resident was alert and oriented and his own person. She reported that his admitting nurse had reported that the resident told her that he didn't know he was being admitted to a rehab facility and he had wanted to go back to his ALF. She reported that he was able to leave the building based on his cognitive status; she couldn't refuse to let him leave as that would violate his rights. The Administrator reported a timeline that had been developed from the staff interviews and video of the resident arriving and leaving. She said that the resident was observed walking into the building at 3:29 p.m. and walking out of the building at 3:52 p.m. She confirmed that the resident's aide initially reported that the resident was not in his room when she went in to deliver his dinner tray. She reported she learned the resident's location was unknown at 6:00 p.m. at which time a Code Silver (Elopement protocol) was called, and staff were asked to conduct an internal search. She reported the internal search was conducted from 6:06 p.m. until 6:13 p.m. She said after learning that the resident was not located in the building, she sent staff out in pairs to drive around the vicinity to look for him. The Administrator confirmed that the initial search of the building took only 7 minutes due to many of the staff having been in the building and joining in the search.<br><br>In a second interview with the Administrator on 11/14/2022 beginning at 9:30 a.m., when asked if a timeline had been developed from the staff interviews during the time the resident was in the building, the Administrator reported that none of the interviews indicated anyone took the elevator down with the resident, including staff and visitors, and no one admitted to having walked away from the elevator, leaving it open for the resident to get on and leave the floor. The Administrator reported that the Director of Nurses had phoned those visitors who had signed the visitor log on 10/26/2022 during the time period that Resident #206 had arrived at and then left the facility. The DON confirmed she was not able to contact every visitor, but no visitor said they rode down on the elevator with someone else. The question about how they accessed the elevator was not asked, so it is not known whether the elevator was standing open after someone else walked out of the elevator, or if they knew the code, or if someone had entered the code for them. There was no detailed timeline of who was on the second floor at what time, whether they were on the elevator, got off the elevator or who entered the elevator code to let the visitors off of the floor. The facility questioned visitors to the facility from 10/26/2022 about whether anyone rode in the elevator with them. The audit tool used to document visitor responses to their questioning about the late afternoon of 10/26/2022 only asked if someone rode down on the elevator with them. It didn't ask who input the code to allow them off the elevator, or if the elevator came up to the floor, someone got off which allowed them to get on.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 11/08/22 at 10:24 a.m., an interview was conducted with the Resident #206's family member. He confirmed he heard from the police on 10/26/22 at 10:30 p.m. and again on 10/27/22 at 7:00 am. about his missing brother. He reported that he did not hear from the facility that his family member was able to get out of the facility. The family member had been made aware of where the resident was found and reported that the resident can hardly walk and didn't know how he made it so far. He said even with his walker the resident was unstable and he didn't know if he had his walker with him. He had heard the resident went to the rehab facility and was able to leave from there, which seemed pretty easy. He confirmed he was told they didn't find him until the next morning and then they took him to the hospital. When asked about the resident's cognitive status, the family member reported the resident can make decisions, but his health is bad, so he needs help with medications. He confirmed the resident takes medications for schizophrenia. He reported he was hard to hear and understand as the resident talks so low. He reported the resident can make everyday decisions, but long-term or involved decisions, like understanding if he doesn't go to rehab, he may not be able to stay at the ALF, are hard for him. The family member reported that he told Resident # 206 to go to rehab or the ALF wouldn't take him back. He reported that the hospital never called him to let him know that they were sending the resident to a rehab facility. He confirmed he was the resident's Health Care Surrogate and Power of Attorney.<br><br>An interview was conducted on 11/08/22 at 10:55 AM with the Deputy who found Resident # 206 mid-morning on 10/27/2022. The Deputy reported that the call identified a missing adult/endangered, white male, about 60-years old, walking around with his pants down, exposing his buttocks. He said the resident was wearing a blue t-shirt and blue pants, that could be identified as scrubs. The resident was found near a park in a neighborhood, and he looked disoriented. The resident was able to tell him his name and date of birth, and then told the deputy that he was short of breath. The deputy reported that they called the EMS who took him to the hospital that he had been discharged from.<br><br>Admission documents received by the facility at the time Resident #206 arrived on 10/26/2022 included a list of medications that were ordered for the resident. Medications that the resident should have received before bed included Olanzapine 5 mg for Schizophrenia; Gabapentin 400 mg for neuropathy; Budesonide inhalation for wheezing and shortness of breath; Divalproex sodium 500 mg for seizures; Formoterol 2 ml inhalation for shortness of breath; Lorazepam 1 mg for anxiety; Melatonin 3 mg for insomnia; Metoprolol 25 mg for hypertension and Tizandinine 4 mg for muscle spasms.<br><br>An interview was conducted on 11/08/22 at 11:50 a.m. with Staff P, RN who reported she was not aware that a resident had been able to leave the building unescorted. She reported that she doesn't usually work the short hall where the resident was admitted . She confirmed she had not received Elopement training recently. She was aware the elevator code changed about two weeks ago, and they are not to share the code with anyone. She reported they must enter the code for any resident or visitor that wants to get onto the elevator. She reported that she usually learned about new admissions any time during her shift. She said she would then let the aides know someone is coming and they arrive usually by the end of the shift.<br><br>An interview was conducted on 11/08/22 at 12:00 p.m. with Staff L, an aide on the floor where Resident #206 was admitted . She reported that she was a float aide. She confirmed there were several Silver Alert drills in the last couple of weeks. She reported she wasn't at the facility on the day that the resident left. She hadn't heard any details about the resident and how he left. She confirmed she knows about the elevator and how they can't give the code out or let residents onto it, especially if you don't know the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 11/08/22 at 12:15 p.m., Staff LL, an aide who reported she usually worked the 7-3 shift on the 200 floor was interviewed. She reported [TRUNCATED] |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311<br><br>Based on observations, record review and interview the facility failed to monitor and maintain adequate nutritional status to maintain weights for one resident (#149) of four residents reviewed for nutrition.<br><br>Findings included:<br><br>Observations of Resident #149 on 11/06/22 at 12:35 p.m. revealed the resident lying on his bed. The resident was noted to have a thin body. Continued observation revealed the resident had his uneaten midday meal on the over bed table located next to the bed. Interview with the resident, at this time, revealed he would not eat the meal because the meat was too tough. The resident reported he had already requested a peanut butter and jelly sandwich and was waiting for it to come up from the kitchen.<br><br>Review of Resident #149's Admission Record revealed this resident was admitted to the facility on [DATE]. Review of the medical record revealed Resident #149 had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive impairment), with diagnoses that included: cerebral infraction, diabetes mellitus, hyperlipidemia, hypertension, dysphagia oropharyngeal phase and stage 3 kidney disease.<br><br>Review of the Resident #149's weight record revealed a weight dated 10/15/22 of 137.4 pounds and on 11/7/22 the weight of 135.6 pounds. The weight record did not reveal an admission weight or any other weekly weights.<br><br>Review of the Admission Nutritional Assessment, dated 10/5/22, revealed at the time of the assessment a weight of 147.4 pounds, dated 9/12/22, with documentation indicating hospital undated wts (weights) used to calculate needs intake not adequate to meet estimated needs for desired weight gain. Requesting boost. No wt available, nsg (nursing) notified.<br><br>Based on the information present in the record on 09/12/2022, the resident weighed 147.4 lbs. On 11/07/2022, the resident weighed 135.6 pounds which is a -8.01 % loss.<br><br>Review of the care plan, dated 9/14/22 with a revision on 10/6/22, related to the history of weight loss resulting in low body weight showed interventions included to Observe/document as indicated meal consumption, amount assistance needed with meal, tolerance to diet/fluids.<br><br>An interview on 11/09/22 at 8:58 a.m. with the Registered Dietician (RD), revealed for new admissions weights are to be taken upon admission within 48-72 hours of the admission, then weekly weights for 4 weeks. She reported weights are monitored by the RD and Certified Dietary Manager by giving the nursing staff a list of residents who need to be weighed and then they provide her with the weights. She reported that she will then check the weights and get re-weights if needed. She reported that she is unaware as to why there were no weekly weights for Resident #149. The RD reported that she could not recall why his initial nutritional assessment was not completed until three weeks after the resident's admission.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled, Weight Management, with an effective date of October 2021, revealed: Weights are completed on admission and readmission, then weekly for 4 weeks, then monthly unless physician orders more frequently. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999<br><br>Based on observation, record review, and interview the facility failed to 1) provide isolation precautions for one resident (#68) out of six residents diagnosed with a highly transmissible microbial Candida Auris infection, and 2) failed to confirm the rationale for one resident (#48) being on isolation indefinitely out of five residents sampled for urinary catheter/urinary tract infections.<br><br>Findings included:<br><br>1. On 11/7/22 at 10:22 a.m., an interview was conducted inside Resident #68's room with the resident. The area outside of the room did not indicated any personal protective equipment (PPE) was necessary while in the resident's room.<br><br>A review, on 11/7/22 at 2:08 p.m., of Resident #68's November 2022 Medication Administration Record (MAR) indicated staff had documented during the day, evening, and night shift for Isolation: Enhanced Barrier Precautions for Candida Auris - every shift for colonization of C Auris. Must wear gloves, (and) gown for high touch activities.<br><br>A review of the medical record for Resident #68 revealed a physician order, dated 10/26/22 at 10:12 a.m., instructed staff to observe Isolation: Enhanced Barrier Precautions for Candida Auris, every shift for colonization of C Auris. Must wear gloves (and) gown for high touch activities.<br><br>An observation was conducted on 11/07/22 at 2:09 p.m., of the area outside of Resident #68's room. The observation did not identify any personal protective equipment (PPE) or isolation sign on the door. The door to the resident's room was closed and unlabeled as to the room number. The room next to Resident #68's room was labeled with necessary precautions and with a door hanger holding gowns and gloves.<br><br>A review of the Admission Record indicated Resident #68 was recently readmitted on [DATE]. The Admission Record included diagnoses not limited to unspecified cerebral infarction, Multiple Sclerosis, and Type 2 Diabetes Mellitus without complications. The 5-day Minimum Data Set (MDS) dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.<br><br>On 11/8/22 at 5:11 p.m., the Director of Nursing (DON) reviewed Resident #68's physician orders and stated Staff O, Licensed Practical Nurse (LPN) tried to update the order as she had seen colonized so the order was discontinued while trying to update. She reported the PPE door hanging caddy broke (prior to survey, on 11/6/22) and had been removed at that time. The DON stated all residents with Candida Auris (6 in total) came from the hospital. She reported she reached out to the Department of Health today and they recommended keeping enhanced barrier precautions for even colonization. She stated even without a caddy there should have been a precaution sign up, as there was PPE available for the room next to Resident #68.<br><br>The Center for Disease Control and Prevention (CDC) indicated that Candida Auris was a drug-resistant germ that spreads in healthcare facilities. The CDC reports the following information:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105234 | A. Building<br>B. Wing | 11/15/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rehabilitation and Healthcare Center of Tampa | 4411 N Habana Ave<br>Tampa, FL 33614 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - It causes serious infections. C. Auris can cause bloodstream infections and even death, particularly in hospital and nursing home patients with serious medical problems. More than 1 in 3 patients with invasive C. Auris infection (for example, an infection that affects the blood, heart, or brain) die.<br><br>- It's often resistant to medicines.<br><br>- It can spread in hospitals and nursing homes. C. Auris has caused outbreaks in healthcare facilities and can spread through contact with affected patients and contaminated surfaces or equipment. C. Auris can live on surfaces for several weeks.<br><br>- For healthcare workers, clean hands correctly and use precautions like wearing gowns and gloves to prevent spread.<br><br>The CDC made the following recommendations of colonization residents, located at https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html#transmission:<br><br>- Duration of precautions - Patients in healthcare facilities often remain colonized with C. Auris for many months, perhaps indefinitely, even after an acute infection (if present) has been treated and resolves. CDC recommends continuing Contact Precautions or Enhanced Barrier Precautions, depending on the healthcare setting, for the entire duration of all inpatient healthcare stays, including those in long-term healthcare facilities.<br><br>The policy titled, Isolation Precautions - Categories of Transmission- Based Infections, effective October 2021, instructed the facility to In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.<br><br>20311<br><br>2. Review of Resident #48's Admission Record revealed she was readmitted to the facility on [DATE] with diagnoses including: contractures of multiple sites, dementia, and was currently receiving hospice services. Review of the MDS, dated [DATE], indicated Resident #48 had a BIMS score of 01 (Severe Cognitive Impairment).<br><br>Observation of the resident's room door on 11/06/22 at 12:30 p.m. revealed an isolation sign posted on the resident's door. An interview at this time with Staff G, Certified Nursing Assistant (CNA), revealed she did not know what the isolation sign meant on the resident's room door.<br><br>An interview on 11/09/22 at 12:51 p.m. with Staff CC, Licensed Practical Nurse (LPN) revealed Resident #48 had ESBL (extended spectrum beta-lactamase) in the urine, and had been on isolation for more than two months for precautions.<br><br>An interview on 11/09/22 at 12:55 p.m. with Staff II, Registered Nurse (RN)/Unit Manager revealed the resident had recurring infections and this was the reason for isolation and the catheter.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the care plan, dated 10/26/22, indicated Resident #48 was at risk for infection resident has ESBL in urine, presence of [indwelling] catheter intervention enhanced barrier precaution d/t (due to) ESBL in urine & presence of [indwelling] catheter.<br><br>A review of Resident #48's physician order, dated 9/5/22, revealed, Isolation: enhanced barrier precautions for ESBL in urine every shift indefinite.<br><br>A review of the most recent laboratory results, dated 9/26/22, revealed, ESBL Confirmation + Pos (positive).<br><br>An interview on 11/09/22 at 1:15 p.m. with the Assistant Director of Nursing (ADON) revealed she was not sure as to why the resident was on isolation indefinitely, or why there were no other labs since 9/26/22.<br><br>An interview with the ADON on 11/09/22 at 3:58 p.m. revealed the resident being on isolation indefinitely is appropriate per the ARNP (Advanced Registered Nurse Practitioner) and she confirmed there was no rationale present in Resident #48's record that would warrant the resident being on isolation indefinitely. |