STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106074	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Kissimmee Gardens	1120 W Donegan Ave Kissimmee, FL 34741

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility's nursing staff neglected to address escalating exit seeking behaviors for a cognitively impaired resident, failed to provide adequate supervision, and failed to secure an exit door to prevent a vulnerable, cognitively impaired resident from exiting the facility for 1 of 3 residents reviewed for neglect, out of a total sample of 7 residents, (#2). These failures contributed to the elopement of resident #2 and placed him at risk for serious injury/harm/death. While resident #2 was out of the facility unsupervised, there was likelihood he could have fallen, been accosted by unknown persons, become lost or been hit by a car. On 1/14/23 at approximately 5:40 PM, resident #2, a physically and cognitively impaired resident, walked away from the nurses' station on the Pebble Stone Unit, through an occupied unit and exited through a fire egress door that was deactivated and unlocked near the therapy gym. The alarm was deactivated, and staff members were not alerted and unaware resident #2 had left the facility. Resident #2 crossed a 7-lane, high traffic highway and walked approximately 700 feet until he was found near a convenience store by facility staff. At the time the resident was out of the facility, the weather at 5:56 PM on 1/14/23 was 49 degrees ( ) Fahrenheit (F) with winds of 14 miles per hour and the sunset occurred at 5:50 PM. (Retrieved from www.timeanddate.com on 2/18/23). Resident #2 wore a short-sleeve shirt, long pants, hospital gown and was barefoot. The facility was unaware of the resident's whereabouts until approximately 6:10 PM, when facility staff located him across the highway near a convenience store. The facility's failure to provide adequate supervision, address escalating exit seeking behaviors and failure to maintain a secure environment placed all residents who wandered at risk. These failures resulted in Immediate Jeopardy starting on 1/14/23. The Immediate Jeopardy was removed on 1/20/23. The scope and severity of the deficiency was decreased to D, no actual harm, with potential for more than minimal harm, that is not Immediate Jeopardy after verification of the facility's immediate corrective actions. Findings: Cross Reference F689 (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2, a [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included dementia, fracture of left pubis, absence of left great toe, psychosis, anxiety, traumatic brain injury, type 2 diabetes, abnormal posture, difficulty walking, and abnormalities of gait and balance. The admission Minimum Data Set (MDS) with Assessment Reference Date of 1/10/23 revealed resident #2's Brief Interview for Mental Status (BIMS) was not obtained because the resident was rarely or never understood. Instead, a Staff Assessment for Mental Status was conducted, and memory problem was selected for both short and long-term memory. The MDS assessment indicated resident #2 was severely impaired on his cognitive skills for daily decision making. He did not exhibit wandering behaviors in the lookback period. He required limited assistance with transfers and walking in his room and in the corridor or unit. Resident #2 required supervision for locomotion and extensive assistance for dressing. He had unsteady balance during transitions and walking and was only able to stabilize himself with staff assistance. He used a wheelchair for mobility and had one fall with injury since admission. Review of a social services Progress Notes dated 1/11/23 revealed resident #2's room was changed to another unit which provided increased supervision. On 2/05/23 at 12:52 PM, Registered Nurse (RN) Q explained resident #2 was moved to Pebble Stone Unit on 1/11/23, because of his exit seeking behaviors. She stated he tried to open doors, setting the alarm off an exit door by the MDS staff office. She recalled the MDS Coordinator had to assist the resident from the area twice before. RN Q said she placed an electronic wandering device on resident #2 that day. She stated she did not understand why he was moved to Pebble Stone unit and felt he was moved to a less secure area as there were not as many staff on the weekend on this unit. On 2/06/23 at 3:27 PM, RN B recalled she saw resident #2 near the exit door on 1/11/23 when she was performing wound care in a resident's room. She explained the alarm went off, and staff responded and redirected him. She was unable to say what interventions were implemented after resident #2's attempts to exit the facility. She stated she was not aware of any increased supervision interventions for the resident after he tried to exit the facility. Review of resident #2's medical record revealed a care plan for elopement related to impaired safety awareness, created on 1/11/23, that read, Resident wanders aimlessly. The goal listed the resident's safety would be maintained through the review date of 2/02/23. The interventions directed staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book and offer him coffee and a snack. Additional interventions included to place an electronic monitoring device to his right wrist, and to identify patterns of wandering. The care plan did not address any changes to the level of supervision required after resident #2 made attempts to exit the facility. The resident had a psychiatry consult on the day he was exit seeking and was moved to the Pebble Stone unit. The psychiatry note dated 1/11/23 showed, Staff reports that pt (patient) wanders throughout the facility and is at times exit seeking. The note indicated resident #2 was alert and oriented times one, confused, thought association was not intact, insight and judgment was inadequate and thought process non-linear. The note included he was not on any psychotropic medications, had a negative psychiatric history, and no medication changes were needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #2's medical record revealed no evidence of a Change of Condition evaluation, progress notes or an Elopement Risk Evaluation noting the changes in behavior he exhibited which resulted in a change of room from one unit to another on 1/11/23. Review of a Physical Therapy Treatment Encounter Note dated 1/13/23, 2 days after the resident was transferred to Pebble Stone unit read, During gait training, patient frequently tried to elope through emergency doors. On 1/14/23 at 8:06 PM, a Change in Condition form documented the resident had eloped from the facility. Resident #2 .opened the therapy door and went out in the parking lot. When assessed, the resident was noted to exhibit increased confusion or disorientation. The report indicated the physician was notified and no new orders were recommended. An Elopement Risk Evaluation dated 1/14/23 at 7:30 PM, revealed resident #2 was cognitively impaired, independently mobile, had poor decision-making skills, demonstrated exit seeking behaviors, was not aware of to safety needs, and had the ability to exit the facility. The assessment done post elopement inaccurately noted no history of elopement. On 2/04/23 at 5:13 PM, Registered Nurse (RN) B stated she was in a resident's room on 1/14/23 when RN A came to the room and told her resident #2 was missing. She said they quickly headed outside through the therapy door, which was unlocked and wide open. She recalled RN A thought she saw the resident walking south but soon realized there was no one walking in that direction. She said they went back inside the facility where the Manager on Duty organized the search inside the facility. She stated she then returned to her car and left the facility in search of the resident. She entered the a gas station parking lot near the facility and saw the resident walking slowly by the sidewalk close to a convenience store. She remembered he wore red pants, a shirt and a hospital gown on top because it was cold that night. She reported she parked her car and approached resident #2 and he asked if she could take him to his daughter-in-law's house. RN B stated she told the resident to get in her car and she drove back to the facility. She recalled before he left the facility, he was sitting in a chair near the Pebble Stone nurses' station because he needed supervision. She described the road the resident crossed as heavily trafficked and said it was cold and dark that evening. She said, I give thanks to God that nothing happened to him. God protected him. She explained when they returned to the facility, they placed blankets on the resident to warm him up because it was so cold that night. She recalled he was barefoot and his left toe wound was covered by dry, dark scab. She said she had applied skin prep to resident #2's surgical left great toe wound at 1:00 PM that day. She explained the wound did not require a dressing because it was not draining, but he had 2 or 3 staples left, mostly scab. She indicated his family came shortly after he was found, and she completed a written statement. She said she learned after he returned to the facility that he had previously wandered away from his family's home and been hit by a car. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/04/23 at 5:37 PM, RN A explained she was resident #2's assigned nurse on 1/14/23. She recalled during report on 1/12/23, she was told to be careful with him because he needed close attention. She said the resident was confused but responded to his name and recognized his family when they visited. RN A stated he always stayed near the exit doors and verbalized he wanted to leave the facility routinely. She stated all day long he was restless and did not want to stay in one place. She explained other times he was redirectable, and she gave him coffee and snacks and he was content but not that day. RN A acknowledged she did not alert the resident's assigned Certified Nursing Assistant (CNA) to observe him more frequently especially when she was in other resident rooms passing medications. She could not explain why she did not call the physician, his family or talk to his assigned CNA or other staff about his behavior. She said, With the running back and forth that day, I was more focused on getting him back to this room. She explained on the day he eloped, he headed to the door at the end of the hallway each time he walked outside his room but she was able to redirect him back to his room. She noted he would only remain in his room for 15 to 20 minutes. She explained he was a Spanish speaking resident, and she could communicate with him in Spanish. RN A stated on her last medication pass, she noticed resident #2 was very restless, so she had him sit in front of the nurses' station so she could observe him while preparing medications. She recalled she came out of a resident's room after administering medications and resident #2 was no longer sitting at the nursing station. She checked the lobby, then walked to the end of a hallway, turned left towards the therapy gym where she noticed the exit door was opened. She indicated no alarms sounded despite the door being wide open and the resident had a wander guard device. She indicated she informed RN B that resident #2 had left the facility and they proceeded to go outside to look for him. She said shortly after, she received a call from RN B informing she had found the resident. She explained once the resident was returned to the facility, he was shivering as he only wore a short sleeve shirt and was barefoot. She recalled he had a great toe amputation and they covered him with blankets, put socks on, inspected his skin and found no injuries. She said he was placed on one to one supervision. She stated he crossed an 8-lane highway and was found by the convenience store. Thank God he was not hit by a car. He did not know where he was or what he was doing. It was dangerous. On 2/06/23 at 1:38 PM, CNA K stated 1/14/23 was the first time she was assigned to resident #2 and received report at change of shift of no issues. She stated she saw him in his bed and later walking by the nurses' station, limping on one leg, not holding onto anything. She explained he sat in a chair by the nurses' station, would get up and walk back and forth to his room. She stated she did not know she had to pay close attention to him and had no knowledge the resident had tried to leave the facility. She said she did not hear any door alarms but was told the resident was missing and started searching. She noted the last time she saw resident #2 was around 5:45 PM to 5:50 PM and he was sitting by the nurses station. She stated the search lasted approximately 10-15 minutes and when she returned to the unit, she saw resident #2 was returned to the facility and he was shivering. She said she asked herself, how did he make it there? She stated that was a big street and it was very cold outside. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/06/23 at 2:24 PM, CNA I stated resident #2 was on her assignment during her 7:00 AM to 3:00 PM shift on 1/14/23. She stated she worked a double shift until 11:00 PM that day. She indicated she had not had resident #2 assigned to her before. She stated he walked around limping, and tried to open an exit door in the morning and was caught by a CNA in time, so the alarm did not go off. She indicated the nurse gave him medication to calm him down and it helped a little. She said he rested for a few hours and then she noticed he went with the nurse everywhere she went. She indicated she saw him sitting down in a chair across the nurses station at around 5:30 PM and not long after that, she heard the overhead page calling resident #2 to return to his room. She said he left the facility between 5:40-5:45 PM and was found around 6:05 or 6:10 PM. She mentioned everyone was thanking Jesus they found him. She recalled thinking how he could have crossed a big road with 6 lanes. She stated it was not safe for him to be out there and that was the reason they panicked when they learned he was missing. She indicated she only heard the overhead announcement, but not a door alarm. She indicated no alarm was activated and she did not know how he was able to open the door. On 2/06/23 at 9:49 AM, the Director of Maintenance indicated he tested and checked all the exit doors every morning. He stated he pushed the doors for 15 seconds to ensure all magnets were working properly and tested the wander electronic system by each door. He explained the Manager on Duty was responsible to check the doors and test the wander system on the weekends. The Director of Maintenance stated he was out of state the weekend of January 14th but he was informed by the Administrator about the elopement. He indicated on the day of the incident, every nurses station had a key to all screamer alarms. He explained the Friday before the elopement, the door the resident exited from was inspected in the morning and afternoon by his assistant, and no issues were noted. He stated the morning of the incident, the Manager on Duty checked the door, and no issues were reported. He explained there was an electronic monitoring system alarm and a red screamer alarm on the door. He stated he was not sure how resident #2 got out without activating the alarm. The Director of Maintenance stated he did not talk to any staff to understand what exactly happened and he had not participated in the investigation. He stated he was asked to check the doors multiple times and to audit the doors every day which was the same process he completed before the incident. He stated checking the doors was something that was always done and was documented daily in his maintenance electronic system which he printed daily and provided to the Administrator. He stated someone who had the red screamer key must have opened the door. He said, Someone did it on purpose. He explained a year and a half ago staff used the key to get out and return through that door for smoke breaks. He indicated they did not have cameras in the facility and had requested cameras for resident safety but the request was denied. He noted the nurses had keys to unlock the red box screamer alarms, and all the screamers used the same key. He explained for the alarm not to activate, it had to be disabled using the key and code entered on keypad, there was no other explanation. A report to show time keypad was deactivated was requested but the Director of Maintenance stated they did not have that service and could not show a time log for the door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/07/23 at 10:53 AM, the Medical Director indicated he was not the attending physician for resident #2 but he was informed of resident #2's elopement by the Administrator. He said he did not receive any calls from nurses that day regarding resident #2 behavior issues but resident #2 was mentioned during a stand down meeting before that day with intervention to contact psych. He said he expected nurses to contact the physician if a resident had a change in condition or could be harm to themselves or others. He explained walking barefoot outside after a great toe amputation could pose risk for sutures to open leading to worsening of the wound and infection. He indicated traffic posed a threat of an accident and noted the facility understood the seriousness of what occurred. He stated he learned someone deactivated the alarm, but they did not find who or how exactly. He explained because they did not know how it happened, putting a tamper proof system was required so no human aspect could tamper with it. On 2/05/23 at 3:59 PM, in a telephone interview, resident #2's son stated his father was victim of a hit and run accident in November 2022. He said his father worked as a janitor for [AGE] years, smoked a lot, liked to be outdoors, and used to walk 2 to 4 miles around town before he was struck by a car. He explained after the accident, his father's confusion increased, and he became aggressive, and was incoherent. He indicated no one from the facility asked him anything about his dad after he was admitted . He recalled on 1/14/23 at approximately 7:00 PM, they went to the facility for a regular visit and when they arrived, no one opened the front door right away after they rang the bell. He said they were asked to wait outside and it was a crazy cold night. He stated when they were let in, they were taken to an office and informed that his father had left the facility, crossed the highway and was found by the convenience store. He explained after learning of the incident, he saw his dad and he had 2 blankets over him and shivered and shivered, non-stop. He explained someone told them his dad had a wander bracelet but he was not informed about the device placement. He stated he could not understand how his dad got out because every time they visited, someone had to unlock the door and allow them to enter. He indicated he was frustrated, afraid, nervous and could not comprehend how this had happened in a place that had locked doors. He stated his father was transferred to the hospital from the facility on January 22, 2023 to rule out a stroke but was informed by the hospital that his father had infection to the left great toe wound. He explained his father was still in the hospital at this time. On 2/07/23 at 6:20 PM, the Director of Nursing (DON) explained the elopement assessment was not completed accurately and acknowledged resident #2's history was not considered when completing the evaluation. He explained a review of the hospital records would have provided the whole story. He explained resident #2's family could had been contacted for additional information and acknowledged the facility did not conduct a welcome meeting because they had a high turnover. He recalled resident #2 was moved to a different room because of his exit seeking behavior and the decision to transfer him to the Pebble Stone Unit was made as it was a more visible area and had 2 nurses instead of one. He stated there was always people in that unit and anyone could see and redirect him. When asked about less staff working on the weekends, the DON stated they were more people around on the weekends, including visitors and church members. The DON did not explain why increased supervision was not implemented to ensure the resident did not exit the facility unsupervised. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/06/23 at 4:03 PM, a meeting was held to discuss resident #2's elopement with the Administrator, Director of Nursing and the Regional Director of Clinical Services (RDCS). The Administrator stated on 1/14/23 she received a call from the Manager on Duty at approximately 6:11 PM informing her they were unable to locate resident #2. She asked the Manager on Duty if they had initiated the missing resident search, meaning page overhead, and was told it was done. The Administrator stated she arrived at the facility within 12 minutes of the call and before she arrived she received a second call from the Manager on Duty that the resident had been found and had exited by the therapy door. She explained she checked the affected door and it was completely disarmed. She explained she instructed staff to perform a head count of all their residents and check on residents with electronic wandering devices. She stated she noticed the red screamer alarm was on the off position. She explained whoever opened the door had to enter a code to disarm the door and then used a key to turn the screamer alarm off. She indicated all nurses had the key for the screamer alarms but they had not identified who disarmed the alarms and unlocked the door. The Administrator noted she was the facility's Abuse Coordinator and Risk Manager. She explained neglect occurred when goods and services were withheld for a resident and could potentially cause harm. She mentioned examples of neglect included not providing the level of supervision required. She stated the facility was responsible to control residents' environment to ensure their safety. She explained neglect could be prevented by educating staff, ensuring residents' centered care plan were in place, following policies and procedures and performing checks. Review of the Clinical Nurse I (RN) job description dated September 2018 revealed the primary purpose of the position was to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. The job function read, As Clinical Nurse I-RN, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. The duties and responsibilities included, Provide regular resident status updates to appropriate personnel. Maintain ongoing communications with physicians concerning resident care. Facilitate problem solving and open communications with the unit nursing staff. Review of the policy and procedure titled Abuse, Neglect, Exploitation & Misappropriation revised on 11/16/22 read, Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. The policy defined neglect as . the failure of the center, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Examples include but are not limited to; . Failure to take precautionary measures to protect the health and safety of the resident. Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental, or emotional condition that a prudent person would recognize. Failure to adequately supervise a resident known to wander from the facility without the staff knowledge. The document revealed a list of Prevention systems including, Monitoring of residents who may be at risk is the responsibility of all facility staff. Review of the Facility Assessment Tool updated on 1/09/23 read, If a resident develops a new condition while residing in the center the resident will receive a change in condition assessment by nursing team and the provider is notified. The document revealed the facility had an average of 10-15 residents with behavioral health needs. Factors of the resident population taken into account when the facility determined staffing and resources needed included history of trauma impacting care and resident preferences. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Beginning on 1/18/23, facility nurses were educated by the DON regarding accuracy of elopement evaluations and importance of providing supervision to residents with wandering or exit seeking behaviors. Education included review of completing accurate elopement evaluation, physician notification of change in condition with emphasis on new or increased behaviors of wandering or exit seeking and the importance of implementing the appropriate level of supervision at the time of the residents change in behavior. As of 1/26/23, 23 out of 23 nurses received education from DCS. *Facility staff and contracted staff educated by SSD regarding policy and procedure for abuse and neglect. As of 1/26/23 a total of 107 of 108 staff members, including contracted staff, received education. *On 1/18/23, DON and Administrator were educated by the DNC regarding the process to review admission and readmission charts for accuracy of elopement evaluation and responsibility to provide appropriate interventions and supervision for residents with wandering and exit seeking behaviors. Section added to morning clinical meeting checklist to verify accuracy of elopement evaluation. *On 1/18/23, Ad Hoc Quality Improvement Performance Committee meeting held to review the recommendations from the Root Cause Analysis. Members in attendance included the Medical Director (via telephone), Administrator, DCS, DNC, Regional [NAME] President, SSD, MDS Director, Business Office Manager (BOM), Dietary Manager (CDM), Business Development Liaison, Director of Therapy, Staffing Coordinator, Community Life Coordinator, and Central Supply Coordinator. The committee approved the recommendations. *On 1/19/23, facility held monthly QAPI meeting. Members in attendance included the Medical Director, Administrator, DON, Business Office Manager, SSD, MDS Coordinators, Admission Director, Activities Director, Director of Therapy, Staffing Coordinator, Central Supply Coordinator and Dietary Manager. The IDT reviewed the facility elopement performance plan and the Ad Hoc QAPI meeting minutes from 1/18/23. *On 1/20/23, quality review of new admissions/readmissions since 01/01/23 conducted by DON and DNC to ensure admission elopement evaluations were accurate. *On 1/20/23, the facility door upgrades and functional tests were completed by the contracted vendor. All doors have annunciation on the new installed keypad, a strobe light with alarm on each corridor to indicate if the exit door on that corridor has been breached. There is also an annunciator panel at each nurses station that indicate and sound if a door alarmed. These features along with the mag lock on each door and a secondary screamer was tested . Doors equipped with a Secure Care wandering device are A1, B, C, E. *On 1/20/23, Ad Hoc QAPI meeting held. Members in attendance included the Medical Director, Administrator (via telephone), DON, Business Office Manager, DNC, SSD, MDS Coordinators, Medical Records Coordinator, Customer Service Liaison, Activities Director, Director of Therapy, Staffing Coordinator, Central Supply Coordinator and Clinical Dietary Manager. The team reviewed the final upgrades for the facility doors. *Concierge and/or Manager on Duty to complete quality audits of residents with electronic wandering devices to check for placement and function. Any issues identified to be reported to the Administrator. (continued on next page)

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	106074	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Kissimmee Gardens	1120 W Donegan Ave Kissimmee, FL 34741

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Administrator initiated education with Admissions team and Social Services team to contact resident/responsible party to determine history of wandering and/or elopement from other locations at the time of admission. *On 1/24/23, Director of Maintenance was educated by the Administrator regarding newly installed door alarm system. *DON/designee will continue weekly quality review times 3 months of residents at risk for elopement to ensure policy and procedures in place. New admissions audited by DCS/designee to ensure accurate elopement risk identification, appropriate interventions in place as required and care plan in place as necessary. *Director of Maintenance/designee will continue door and security checks to ensure a secure resident environment. Issues identified will be discussed in the monthly QAPI meeting. Interviews were conducted with 17 facility staff including 11 CNAs, 4 licensed nurses, 1 dietary aide, 1 therapist, and 1 Activities staff between 2/04/23 and 2/08/23. Interviews revealed some therapists did not receive abuse and neglect education after the elopement and not all direct care staff had participated in elopement drills. On 2/04/23 at 11:37 PM, CNA L stated she had not participated in elopement drills after incident. On 2/04/23 at 11:57 PM, CNA M stated she did not work the night incident occurred and learned about elopement the following night. She stated she was not familiar with resident #2 as he was a new resident. She stated the facility sent a registered letter which she signed and returned. She stated she called the facility to inquiry ab [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on observation, interview, and record review, the facility failed to prevent a physically and cognitively impaired resident from exiting the facility unsupervised, failed to conduct assessments to identify risk for elopement and implement appropriate interventions to mitigate elopement risk and failed to provide adequate supervision and secure environment for 1 of 3 residents reviewed for elopement, out of a total sample of 7 residents, (#2). On 1/14/23 at approximately 5:40 PM, resident #2, a physically and cognitively impaired resident, walked away from the nurses' station on the Pebble Stone Unit, through an occupied unit and exited through a fire egress door that was deactivated and unlocked near the therapy gym. The alarm was deactivated, and staff members were not alerted and unaware resident #2 had left the facility. Resident #2 crossed a 7-lane, high traffic highway and walked approximately 700 feet until he was found near a convenience store by facility staff. At the time the resident was out of the facility, the weather at 5:56 PM on 1/14/23 was 49 degrees ( ) Fahrenheit (F) with winds of 14 miles per hour and the sunset occurred at 5:50 PM. (Retrieved from www.timeanddate.com on 2/18/23). Resident #2 wore a short-sleeve shirt, long pants, hospital gown and was barefoot. The facility was unaware of resident's whereabouts until approximately 6:10 PM, when facility staff located him across the highway near a convenience store. These failures contributed to the elopement of resident #2 and placed all residents who wandered at risk for serious injury/serious harm/death and resulted in Immediate Jeopardy starting on 1/14/23 and was removed 1/20/23. Findings: Cross Reference F600 Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included dementia, fracture of left pubis, absence of left great toe, psychosis, traumatic brain injury, type 2 diabetes, abnormal posture, difficulty walking, and abnormalities of gait and balance. The Florida Agency for Health Care Administration 5000-3008 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 1/03/23 revealed resident #2 was not ambulatory and required assistance of one staff person for transfers. The document indicated the resident was alert, disoriented but could follow simple instructions. The Admission/Readmission Data Collection evaluation dated 1/03/23 revealed resident #2 was oriented to person only, did not use an assistive device for mobility, had left great toe amputation, and was not at risk for elopement. Review of an admission Elopement Risk Evaluation dated 1/03/23 inaccurately noted the resident was not cognitively impaired, independently mobile, had no poor decision-making skills and did not have the ability to exit the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an Elopement Risk Evaluation dated 1/10/23 revealed resident #2 was cognitively impaired, independently mobile and exhibited poor decision-making skills. The document indicated resident #2 had not demonstrated exit seeking behaviors, was aware of safety needs, had no history of elopement and did not have the ability to exit the facility. Based on these answers, the resident was not determined to be at risk for elopement. The document directed staff to complete form quarterly and with a significant change. The evaluation form indicated if the resident was deemed at risk, a prevention protocol should be initiated immediately and documented in the care plan. Review of a social service Progress Notes dated 1/11/23 revealed resident #2's room was changed to another unit which provided increased supervision. A psychiatry New evaluation note dated 1/11/23 revealed Staff reports that pt (patient) wanders throughout the facility and is at times exit seeking. The note indicated resident #2 was alert and oriented times one, confused, thought association was not intact, insight and judgment was inadequate and thought process non-linear. The note included he was not on any psychotropic medications, had a negative psychiatric history, and no medication changes were needed. Review of resident #2's medical record revealed no evidence of a Change of Condition evaluation, progress notes or an Elopement Risk Evaluation noting the changes in behavior he exhibited which resulted in a change of room from one unit to another on 1/11/23. A care plan for elopement related to impaired safety awareness, created on 1/11/23, read, Resident wanders aimlessly. The goal listed the resident's safety would be maintained through the review date of 2/02/23. The interventions directed staff to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books and offer him coffee and a snack. Additional interventions included to place an electronic monitoring device to his right wrist, to identify patterns of wandering. The document read, Is wandering purposeful, aimless, or escapist? Is resident looking for something? The care plan directed staff to intervene as appropriate. There were no interventions noted for increased supervision. A care plan for risk for falls related to deconditioning, weakness, recent trauma, left pelvic fracture, head injury and toe amputation, was initiated on 1/05/23 and read, Actual fall with skin tear, poor communication/comprehension, unsteady gait, confusion- never asks for help, low BIMS (Brief Interview for Mental Status). An intervention dated 1/07/23 directed staff to place resident in clear/observation area near nurse station. The admission Minimum Data Set (MDS) with Assessment Reference Date of 1/10/23 revealed resident #2 BIMS was not obtained because the resident was rarely or never understood. Instead, a Staff Assessment for Mental Status was conducted, and memory problem was selected for both short and long-term memory. The MDS assessment indicated resident #2 had severely impaired cognitive skills for daily decision making, did not exhibit wandering behaviors in the lookback period, required limited assistance with transfers and walking in his room/unit, and required supervision for locomotion. The assessment noted the resident had unsteady balance and walking and was only able to stabilize himself with staff assistance. He used a wheelchair for mobility and had one fall with injury since admission. He did not receive antipsychotic, antidepressant or antianxiety medications during the 7-day lookback period. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #2's medical record revealed an incomplete Psychosocial Evaluation dated 1/10/23 at 9:10 PM. Section A. Community Life was completed but not section B. Social Services which included questions such as Have you ever been through anything life threatening or traumatic? or any social/behavioral/emotional concerns. Review of a Physical Therapy Treatment Encounter Note dated 1/13/23 read, Patient demonstrated partial carryover due to new learning abilities. During gait training, patient frequently tried to elope through emergency doors. Review of resident #2's medical record revealed a Change in Condition form dated 1/14/23 at 8:06 PM, that read, Disoriented patient opened the therapy door and went out in the parking lot. When assessed, the resident was noted to exhibit increased confusion or disorientation. The report indicated the physician was notified and no new orders were recommended. An Elopement Risk Evaluation dated 1/14/23 at 7:30 PM, revealed resident #2 was cognitively impaired, independently mobile, had poor decision-making skills, demonstrated exit seeking behaviors, was oblivious to safety needs, and had the ability to exit the facility. The assessment done post elopement inaccurately noted no history of elopement. On 2/04/23 at 5:13 PM, Registered Nurse (RN) stated she applied skin prep to resident #2's surgical left great toe wound on the day he eloped at 1:00 PM. She explained the wound did not require a dressing because it was not draining, but he had 2 or 3 staples left, mostly scab. She noted she was in another resident's room when RN A came to the room and told her resident #2 had left the facility. She said they quickly headed outside through the therapy door, the same door resident #2 had exited which unlocked and wide open. She recalled RN A thought she saw the resident walking south but soon realized there was no one walking in that direction. She said they went back inside the facility where the Manager on Duty organized the search inside the facility. She stated she then returned to her car and left the facility in search of the resident. She entered the a gas station parking lot near the facility and saw the resident walking slowly by the sidewalk close to a convenience store. She remembered he wore red pants, a shirt and a hospital gown on top because that night was a bit cold. She reported she parked her car and asked resident #2, What are you doing? She said he asked her if she could take him to his daughter-in-law's house. RN B stated she told the resident to get in her car and she drove back to the facility. She recalled before he left the facility, he was sitting in a chair near the Pebble Stone nurses' station because he needed supervision. She described the road the resident crossed as heavily trafficked and said it was cold and dark that evening. She said, I give thanks to God that nothing happened to him. God protected him; He protected all of us. She explained when they returned to the facility, they placed blankets on the resident to warm him up because it was so cold that night. She recalled he was barefoot and his left toe wound was covered by eschar. She indicated his family came shortly after he was found, and she completed a written witness statement. She said she learned after he returned to the facility that he had previously wandered away from his family's home and been hit by a car. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/04/23 at 5:37 PM, RN A explained she was resident #2's assigned nurse on 1/14/23 and had taken care of him two times before the incident. She recalled during report on 1/12/23, she was told to be careful with him because he needed close attention. She said the resident was confused but responded to his name and recognized his son and daughter in law when they visited. RN A stated he always stayed near the exit doors and verbalized he wanted to leave the facility routinely. She stated all day long he was restless and did not want to stay in once place. She explained other times she was assigned to his care, he was redirectable, and she gave him coffee and snacks and he was content but not that day. RN A acknowledged she did not alert the resident's assigned Certified Nursing Assistant (CNA) to observe him more frequently especially when she was in other resident rooms passing medications. She said, With the running back and forth that day, I was more focused on getting him back to this room. She explained on the day he eloped, he headed to the door at the end of the hallway each time he walked outside his room but she was able to redirect him back to his room. She explained he was a Spanish speaking resident, and she could communicate with him in Spanish. She explained when redirecting resident #2 away from the exit doors she would tell him he needed to raise his legs and rest and he complied but only stayed in his room for 15 to 20 minutes. RN A stated on her last medication pass, she noticed resident #2 was very restless, so she had him sit in front of the nurses' station so she could observe him while preparing medications. She recalled she came out of a resident's room after administering medications and resident #2 was no longer sitting at the nursing station. She checked the lobby, then walked to the end of a hallway, turned left towards the therapy gym where she noticed the exit door was opened. She indicated no alarms sounded despite the door being wide open and the resident had a wander guard device. RN A stated she walked outside, looked in the parking lot and returned back inside and found RN B in a resident's room. She indicated she informed RN B that resident #2 had left the facility and they proceeded to go outside to look for him. She explained they looked for him in the near vicinity then came back to the facility and RN B got in her car and she went in another staff person's car to search for the resident. She said shortly after, she received a call from RN B informing she had found the resident. She explained once the resident was returned to the facility, he was shivering as he only wore a short sleeve shirt and was barefoot. She recalled he had a great toe amputation and they covered him with blankets, put socks on, inspected his skin and found no injuries. She said he was placed on one to one supervision. She stated he crossed an 8-lane highway and was found by the convenience store. Thank God no one hit him. He did not know where he was or what he was doing. It was dangerous. On 2/04/23 at 8:57 PM, CNA D explained she worked on 1/14/23, the evening the resident eloped. She heard the missing resident announcement and began search of rooms, and closets. She explained after resident #2 returned, she was assigned to provide one to one supervision. She described the elopement and said, it could have been worse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/04/23 at 10:26 PM, the Activities Director stated she was the Manager-on-Duty on 1/14/23. She recalled before the elopement, resident #2 participated in activities such as coffee social and listening to Hispanic music. She stated he was initially brought to activities by wheelchair but a few days after admission, he walked to activities. She recalled on 1/14/23, resident #2 participated in Bingo, from 2:30 to 4 PM, and towards the end, he stood up by himself and said he wanted to go to the bathroom and left the room. She explained at about 6:10 PM, she heard noise outside her office and thought she heard the nurse say she was worried. She said she did not see anyone outside the office and quickly walked toward the therapy gym and saw the exit door open. She explained staff were aware of his wandering because he was transferred from River Rock Unit to Pebble Stone Unit to be closer to the nurses' station. She stated he had tried to open exit doors before and had an electronic wandering device. She stated she panicked, walked down the ramp to the parking lot, looked around but did not see anyone. She then went back into the facility and had to pull the exit door to close it. She recalled she went to resident #2's room, did not find him there and did not see his assigned nurse. She said she put the pieces together, picked up the phone and paged the elopement code announcement. She remembered she called the resident's name and for him to return to room number and mentioned his room, 3 times. She explained this alerted staff he was missing. She noted even though she had not confirmed he was missing, she assumed this was the situation. She stated she called the Administrator from her cell phone after she paged the elopement code and informed she thought resident #2 had left the facility. She explained a few minutes after she spoke with the Administrator, RN B returned with resident #2. She recalled he was shivering and had a blue gown covering his shoulders. She explained resident #2's family came in a few minutes after the incident to visit him and the Administrator met with them in her office. She indicated she, along with RN A, were present when the Administrator explained what had just happened to his family. She recalled the resident's daughter in law told them he had been hit by a car before when he had wandered away from the family home. She acknowledged the elopement process was not followed on 1/14/23 even though they had elopement drills before the incident happened. On 2/05/23 at 12:12 PM, resident #2's elopement route was retraced by the state agency surveyors. Resident #2 left the nurses' station area at approximately 5:40 PM, walked through west side of the Pebble Stone Unit hallway, turned left and walked towards the therapy gym. He arrived at an exterior exit door, approximately 170 feet away from the nurses' station and exited the unalarmed and unlocked door onto a ramp which led to the parking lot. Resident #2 walked an additional 110 feet as he crossed the parking lot, and through a grassy area to reach the sidewalk next to a heavily traveled highway. He traveled along the sidewalk approximately 91 feet and crossed a busy 7-lane highway with a median road, and walked 118 feet to the other side. It is unknown if the resident crossed at the traffic lights. He walked an additional 202 feet to reach the location he was found near the convenience store and gas station at approximately 6:20 PM. Photographic evidence was obtained of the hazards outside the facility including a ditch with a steep embankment near the sidewalk, broken glass, broken benches with sharp edges, uneven pavement, and homeless peddlers. On 2/05/23 at 12:52 PM, RN Q explained she worked half a day with resident #2 on 1/11/23, the day he was transferred to the Pebblestone unit because of exit seeking behaviors. She stated he tried to open doors, setting the alarm off an exit door by the MDS office. She recalled the MDS Coordinator had to assist the resident from the area twice before. She explained she placed an electronic wandering device on resident #2 that day. She stated she did not understand why he was moved to Pebble Stone unit and felt he was moved from a safer to a more dangerous location. When asked if she brought her question to management she said, Management had already made the decision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/05/23 at 3:59 PM, in a telephone interview, resident #2's son stated his father was victim of a hit and run accident in November 2022. He said his father worked as a janitor for [AGE] years, smoked a lot, liked to be outdoors, and used to walk 2 to 4 miles around town before he was struck by a car. He explained after the accident, his father's confusion increased, and he became aggressive, and was incoherent. He indicated no one from the facility asked him anything about his dad after he was admitted . He recalled on 1/14/23 at approximately 7:00 PM, they went to the facility for a regular visit and when they arrived, no one opened the front door right away after they rang the bell. He said they were asked to wait outside and it was a crazy cold night. He stated when they were let in, they were taken to an office and informed that his father had left the facility, crossed the highway and was found by the convenience store. He explained after learning of the incident, he saw his dad and he had 2 blankets over him and shivered and shivered, non-stop. He explained someone told them his dad had a bracelet but seemed something was wrong, and a nurse came to change it. He stated he was not informed about the electronic wandering device placement prior to that night. He explained they were told they would have to find him another place because of what he did. He stated he could not understand how his dad got out because every time they visited, someone had to unlock the door and allow them to enter. He indicated he was frustrated, afraid, nervous and could not comprehend how this had happened in a place that had locked doors. He explained after the incident the family was told his father did not qualify for the services at the facility because of what he did and was now considered a high risk individual requiring the services of a locked unit. He stated they were informed the facility was looking for a locked facility but the closest one was in [NAME], which was too far and a burden considering the heavy traffic to [NAME]. He stated his father was transferred to the hospital from the facility on January 22, 2023 to rule out a stroke but was informed by the hospital that his father had infection to the left great toe wound. He explained his father was still in the hospital at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/06/23 at 9:49 AM, the Director of Maintenance stated his responsibilities included resident safety, repairs to the building, fire drills, and testing of exit doors. He indicated he tested and checked all the exit doors every morning. He stated he pushed the doors for 15 seconds to ensure all magnets were working properly and tested the wander electronic system by each door. He explained the Manager on Duty was responsible to check the doors and test the wander system on the weekends. The Director of Maintenance stated he was out of state the weekend of January 14th but he was informed by the Administrator about the elopement. He stated the facility had a prior elopement through the same door resident #2 exited but the alarm activated that time. He indicated on the day of the incident, every nurses station had a key to all screamers. He explained the Friday before the elopement, the door the resident exited from was inspected in the morning and afternoon by his assistant, and no issues were noted. He stated the morning of the incident, the Manager on Duty checked the door, and no issues were reported. He explained there was an electronic monitoring system alarm and a red screamer alarm on the door. He stated he was not sure how resident #2 got out without activating the alarm. The Director of Maintenance stated he did not talk to any staff to understand what exactly happened and he had not participated in the investigation. He stated he was asked to check the doors multiple times and to audit the doors every day which was the same process he completed before the incident. He stated checking the doors was something that was always done and was documented daily in his maintenance electronic system which he printed daily and provided to the Administrator. He stated someone who had the red screamer key must have opened the door. He said, Someone did it on purpose. He explained a year and a half ago staff used the key to get out and return through that door for smoke breaks. He indicated they did not have cameras in the facility and had requested cameras for resident safety but the request was denied. He noted the nurses had keys to unlock the red box screamer alarms, and all the screamers used the same key. He explained for the alarm not to activate, it had to be disabled using the key and code entered on keypad, there was no other explanation. A report to show time keypad was deactivated was requested but the Director of Maintenance stated they did not have that service and could not show a time log for the door. On 2/06/23 at 10:38 AM, the Director of Therapy stated resident #2 was confused and wandered but was redirectable during therapy. She explained he needed maximum cues to get things done but did them. She noted he was doing well and showed improvement in strengthening but not cognitively. She indicated during an Interdisciplinary Team (IDT) meeting they discussed the resident wandered but had not tried to exit. She shared the facility was supposed to have a Journey Home meeting for newly admitted residents but they did not always happen. She indicated resident #2 was ambulatory when he was admitted but his balance was off. She indicated resident #2 was absolutely not safe to be outside unsupervised. She explained resident #2 limped because of his amputated left great toe which affected his balance. She indicated he was supposed to be partial weight bearing on his left side, but he did not comply. She said, God was looking after him; his cognition was so bad he wouldn't even know a car if it came at him. He was probably roaming. She indicated he did not have shoes on at the time of the event which could have led to a fall or infection. She responded, I was pretty mad about that because I had told several CNAs to keep his shoes on. She stated they had a phone meeting with his family the Monday after he eloped to discuss his discharge plan, which was tentatively set for the following Tuesday. She stated she felt the facility was trying to get him out of there. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/06/23 at 1:38 PM, CNA K stated 1/14/23 was the first time she was assigned to resident #2 and received report at change of shift of no issues. She stated she saw him in his bed and later walking by the nurses' station, limping on one leg, not holding onto anything. She explained he sat in a chair by the nurses' station, would get up and walked back and forth to his room. She stated she did not know she had to pay close attention to him and had no knowledge the resident tried to leave the facility earlier that day. She recalled she assisted a resident with her dinner meal with the door closed and when she opened the door, she saw 2 nurses running down the hallway. She remembered CNA I told her resident #2 was missing. She said she did not hear any door alarms and started searching for the resident. She stated she walked outside and searched the entire parking lot with CNA T, then walked to the front of the facility but did not see the resident. She stated the last time she saw resident #2 was around 5:45 to 5:50 PM and he was sitting by the nurses station. She stated the search lasted approximately 10-15 minutes and when she returned to the unit, she saw resident #2 was returned to the facility and he was shivering. She said she asked herself, how did he make it there? She stated that was a big street and it was very cold outside. On 2/06/23 at 2:24 PM, CNA I stated resident #2 was on her assignment during her 7:00 AM to 3:00 PM shift on 1/14/23. She stated she worked a double shift until 11:00 PM that day. She indicated she had not had resident #2 assigned to her before. She stated he walked around limping, and tried to open an exit door in the morning and was caught by a CNA in time, so the alarm did not go off. She indicated the nurse gave him medication to calm him down and it helped a little. She said he rested for a few hours and then she noticed he went with the nurse everywhere she went. She indicated she saw him sitting down in a chair across the nurses station at around 5:30 PM and not long after that, she heard the overhead page calling resident #2 to return to his room. She said he left the facility between 5:40-5:45 PM and was found around 6:05 or 6:10 PM. She mentioned everyone was thanking Jesus they found him. She recalled thinking how he could have crossed a big road with 6 lanes. She stated it was not safe for him to be out there and that was the reason they panicked when they learned he was missing. She indicated she only heard the overhead announcement, but not a door alarm. She indicated no alarm was activated and she did not know how he was able to open the door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106074	A. Building B. Wing	02/08/2023

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/06/23 at 4:03 PM, a meeting was held to discuss resident #2's elopement with the Administrator, Director of Nursing and the Regional Director of Clinical Services (RDCS). The Administrator stated on 1/14/23 she received a call from the Manager on Duty at approximately 6:11 PM informing her they were unable to locate resident #2. She asked the Manager on Duty if they had initiated the missing resident search, meaning page overhead, and was told it was done. The Administrator stated she arrived at the facility within 12 minutes of the call and before she arrived she received a second call from the Manager on Duty that the resident had been found and had exited by the therapy door. She explained she checked the affected door and it was completely disarmed. She explained she instructed staff to perform a head count of all their residents and check on residents with electronic wandering devices. She the door had been checked that day by the Manager on Duty and the door was locked and alarms were armed. She stated she noticed the red screamer alarm was on the off position. She explained whoever opened the door had to enter a code to disarm the door and then used a key to turn the screamer alarm off. She indicated all nurses had the key for the screamer alarms. She stated she checked all exterior exit doors in the facility at that time. She stated when she returned to her office, the resident's family had arrived for their usual evening visit. She said she met with the family and informed them the resident had exited the facility unsupervised, had an electronic wandering device and was found by facility staff. She indicated she told them they would find a secure location for him and he would be placed on one to one supervision. She explained that same night, she collected statements from all staff present at the time of the elopement. She explained they initiated an investigation and reported to the appropriate authorities. She provided copy of the timeline they created based on the findings of their investigation. Discrepancies were noted between their timeline and the witness statements she collected from their staff. She stated the outcome of their investigation was substantiated because the facility door was under the facility's control. The RDCS stated resident #2's assigned nurse kept him under closer supervision and acknowledged the supervision provided by the staff did not work that evening. She stated she truly believed the supervision would have been effective if the door alarm had not been disabled. The Administrator acknowledged the potential and actual hazards resident #2 could have encountered along the path he walked such as broken glass, uneven pavement, ditch by the parking lot, busy road, and cold temperature. On 2/07/23 at 10:53 AM, the Medical Director indicated he was not the attending physician for resident #2 but he was informed of resident #2's elopement by the Administrator. He said he did not receive any calls from nurses that day regarding resident #2 behavior issues but resident #2 was mentioned during a stand down meeting before that day with intervention to contact psych. He said he expected nurses to contact the physician if a resident had a change in condition or could be harm to themselves or others. He explained walking barefoot outside after a great toe amputation could pose risk for sutures to open leading to worsening of the wound and infection. He indicated traffic posed a threat of an accident and noted the facility understood the seriousness of what occurred. He stated he learned someone deactivated the alarm, but they did not find who or how exactly. He explained because they did not know how it happened, putting a tamper proof system was required so no human aspect could tamper with it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/07/23 at 6:20 PM, the Director of Nursing (DON) explained the admitting nurse did not understand how to properly compete the admission assessment. He stated he noted the initial assessment for resident #2 was completed incorrectly, and he was not assessed correctly. He explained a review of the hospital records would have provided the whole story. He explained resident #2's family could had been contacted for additional information and acknowledged the facility did not conduct a welcome meeting because they had a high turnover. He recalled resident #2 was moved to a different room because of his exit seeking behavior and the decision to transfer him to the Pebble Stone Unit was made as it was a more visible area and had 2 nurses instead of one. He stated there was always people in that unit and anyone could see and redirect him. When asked about less staff working on the weekends, the DON stated they were more people around on the weekends, including visitors and church members. On 2/08/23 at 10:20 AM, the Social Services Director stated they had initial meetings called Journey to Home attended by Department Heads to learn about newly admitted residents. She noted it took them a while to talk to resident #2's family as they were not able to reach his son. She indicated she spoke with resident #2's son and learned he wanted to take him home after therapy was completed and found out his dad liked to walk around but he never mentioned he left his house or wandered. She said she did not know he was hit by a car before the elopement. and recalled during clinical meeting it was mentioned he had an accident but not he was struck by a car. She indicated it was a cold night and busy intersection where he crossed. She stated she did not foresee or thought something like this was going to happen. Review of the policy and procedure Elopement/Wandering Risk Guideline revised on 8/01/ [TRUNCATED]