STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105407	A. Building B. Wing	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siesta Key Health and Rehabilitation Center	4602 Northgate Court Sarasota, FL 34234

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41155 Based on observation, record review and staff interview the facility failed to provide the necessary repairs to ensure a safe, comfortable, and homelike environment for 1(Resident #910) of 51 residents residing in the facility's memory care unit. The findings included: A review of Resident #905's clinical record revealed a progress note dated 1/7/23 at 7:13 a.m., which noted Resident #905 had destroyed the furniture in his room and smashed the glass window. The maintenance staff secured the window. Resident #905 was sent to the hospital on 1/7/23 at 1:19 p.m. A review of Resident #910's clinical record revealed the resident was admitted to Resident #905's former room on 1/12/23 at 8:00 p.m. On 1/17/23 at 9:50 a.m., Resident #910 was observed in his room in the memory care unit. The room was dark. The window to the outside was missing the glass. It was covered with plywood. On 1/17/23 at 9:05 a.m., in an interview, the Administrator verified Resident #910 was admitted to the room with the broken and boarded window. On 1/19/23 at 9:45 a.m., observation of Resident #910's room with the Regional Director of Maintenance showed the window to the outside was repaired. The Regional Director of Maintenance said the window was replaced on 1/18/23. He confirmed it was not safe for any resident to reside in the room during the time the window was broken and covered with the plywood.

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

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41212 Based on record review and staff interviews, the facility failed to report alleged violations which could constitute neglect to the State Survey Agency for 1 (Resident #800) of 3 sampled residents. The findings included: The facilities policy and procedure on Abuse, Neglect and Exploitation, with revised date 10/1/22 noted neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Reporting/Response; 1) Reporting of all alleged violations to Administrator, state agency, and adult protective services and to all other required agencies (e.g. law enforcement when applicable) with specific timeframes: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in seriously bodily injury. The facility failed to adequately supervise a cognitively impaired resident on the secured unit identified at risk for elopement and exit seeking. On 11/27/22 (unknown time after 3:30 p.m.), Resident #800 walked out of the secured unit and the facility without staff knowledge. The police found Resident #800 on 11/27/22 at 10:30 p.m., walking 2.3 miles from the facility. Review of facilities reportable shows the facility failed to submit the Federal Day 1 and Day 5 report to the Florida State Survey Agency, the Agency for Health Care Administration no call was made to the Florida Department of Children and Families (DCF), the state abuse agency. On 1/17/23 at 3:20 p.m., the Nursing Home Administrator (NHA), said the Interdisciplinary Team had discussed the incident involving Resident #800, and determined the elopement did not meet the criteria for an allegation of neglect. the NHA also verified the facility did not notify DCF.

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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 - Some	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** 41212 Based on observation, record review, and staff interviews, the facility failed to implement processes to ensure adequate supervision of 1 (Resident #800) of 51 cognitively impaired resident at risk for elopement to prevent unsafe wandering and elopement. The facility also failed to ensure adequate interventions to prevent fall with major injury for 1 (Resident #850) of 3 residents reviewed for falls. Resident #800 was a vulnerable [AGE] year-old female who resided on the secured unit (provides specialized care for people with memory issues) of the facility for increased supervision. On 11/27/22 (unknown time after 3:30 p.m.) Resident #800 who was ambulatory, walked out of the secured unit and the facility without staff knowledge. The resident was found by local law enforcement on 11/27/22 at 10:16 p.m., approximately 2.3 miles from the facility. Resident #800 traveled alone in the afternoon and evening along a busy six lanes highway and crossing busy intersections. Resident #800 was missing and wandering alone for approximately six and a half hours. Resident #800 had a likelihood for serious harm, injury, or death, due to risk for serious injury from a fall, being hit by a car from crossing busy streets with a speed limit of 35 miles per hour, getting lost or becoming the victim of a serious crime. The failure to ensure adequate supervision to protect vulnerable residents from unsafe wandering and elopement resulted in a determination of Immediate Jeopardy at a scope and severity of isolated (J) starting on 11/27/22. The Administrator was notified of the Immediate Jeopardy of 1/24/23 at 5:18 p.m. and provided the IJ templates. The Immediate Jeopardy was ongoing. There were 57 other residents the facility identified at risk for elopement. The findings included: Cross reference to F835 and F867. 1. The facility's Elopements and Wandering Residents policy with a date implemented of 11/27/22, and reviewed/revised of 1/11/23 noted, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and elopement risk. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents and elopement. Staff to confirm doors are secure and no additional individuals exited behind them when exiting secured units. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the clinical record revealed Resident #800 was a vulnerable [AGE] year-old female admitted to the secured unit of the facility on 7/29/22. Diagnoses included Dementia, Bipolar disorder (Mood swings ranging from depressive lows to manic highs), and Schizophrenia (Mental health condition that affects how someone thinks, feels and behaves). On 7/29/22, the facility completed and elopement evaluation which noted the resident had a medical diagnosis of dementia and cognitive impairment, a history of wandering in the past three months, but has not had exit seeking behaviors in the past month. The subsequent elopement assessments, dated 9/11/22, and 10/29/22 noted Resident #800 has had exit seeking behaviors in the past month (tailgating, packing belongings, and/or actively exit seeking). The assessments noted the resident was ambulatory. The Admission Minimum Data Set (MDS) assessment with a reference date 8/5/22 noted Resident #800 required supervision with set up assistance to ambulate on the unit. The admission noted the resident's cognition was severely impaired. The care plan initiated on 9/11/22 noted Resident #800 was at risk for elopement/Exit seeking, aimless wandering due to cognition, and had the potential to approach exit doors. The goal was for the resident not leave the facility unattended. The interventions included to monitor the resident for tailgating when visitors are in the building, and for active exit seeking behavior each shift. The care plan did not describe the process to alert staff of visitors on the unit to monitor the resident for tailgating. Review of the progress notes revealed a late entry dated 11/27/22 at 8:36 p.m., noting the attending physician was notified Resident #800 had eloped. Review of the facility's investigation dated 12/13/22 revealed a Certified Nursing Assistant (CNA) last observed Resident #800 on 11/17/22 at approximately 3:30 p.m., to 3:40 p.m., standing in front of her door. On 11/27/22 between 4:45 p.m., and 5:00 p.m., the CNA and the nurse were not able to locate Resident #800 on the unit for dinner or her afternoon medications. The facility activated their elopement policy and procedure, notified the Administrator, the Director of Nursing and local law enforcement. The investigation noted local law enforcement returned the resident to the facility unharmed on 11/27/22 at approximately 10:30 p.m. The resident was dressed in blue jeggings (looks like a pair of skinny jeans), a three quarter length shirt and foot coverings. The investigation did not describe foot covering. Resident #800 had some discomfort in her feet and some edema (swelling). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The progress note dated 11/27/22 at 10:45 p.m. noted Resident #800's feet were swollen and pink. The resident had an open area under the ball of her right foot which was not new. On 11/27/22 Registered Nurse Staff Y documented on a statement Resident #800 returned to the facility at approximately 10:30 p.m., escorted by two police officers. The resident was wearing yellow gripper socks. The facility's investigation noted, Based on review of facility visitor log the facility had more than the usual number of visitors on 11/27/22 due to the holiday weekend . Signs were present on the doors to the unit advising staff and visitors to ensure doors were securely shut behind them . As a result of the investigation facility concludes [Resident #800] likely tailgated a visitor off the unit and through the front entrance of the facility . The facility's investigation did not address the lack of adequate supervision to prevent the unsafe wandering and elopement. Review of the visitors' log from 11/20/22 through 11/27/22 did not show documentation of increased visitors on the secured unit. On 11/20/22, and 1/22/22, one visitor was documented on the log for the secured unit. On 11/21/22, and 11/24/22: 12 visitors were documented on the log. On 11/23/22, nine visitors were documented on the log. On 11/27/22, four visitors were documented on the log. The corrective actions noted on the investigation dated 12/13/22 included: The use of a Visitor tag to identify visitors in the facility. Visitors directed to return tag prior to leaving the facility when signing out on visitor's log. Staff was educated not to provide the door codes to visitors. On 1/18/23 at 9:50 a.m., the receptionist said on 11/27/22 he had to leave the facility at 2:00 p.m. and notified the nurse supervisor who instructed him to leave the key fob (opens the door remotely) on the counter at the reception. The receptionist said when he returned an hour later, the reception desk was unattended, and the key fob was on the counter. He said Resident #998 used the key fob to let him back in the building. On 1/23/23 at 1:40 p.m., Resident #998 said he was at the front desk area on 11/27/22 when he saw the receptionist outside. The key fob was unattended on the counter, and he used it to let the receptionist in the building. He said there was no staff attending the front door of the facility when he used the key fob to let the receptionist in. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/18/23 at 2:13 p.m., in a telephone interview, former Resident #920 said on 11/27/22 when Resident #800 went missing, he used the key fob left unattended at the reception to let his visitor out. He sat outside for a few minutes and put the key fob back on the desk. He said he did not see the receptionist at any time when he had the key fob or returned it. Resident #920 said it was early evening. On 1/18/23 at 4:32 p.m., in a telephone interview the nurse supervisor said on 11/27/22 the receptionist told her he had to leave. She could not remember the exact time. She told him she would be right up. She said she could not remember telling him to leave the key fob unattended. She sat at the reception for approximately 15 to 20 minutes then left to help a resident. When she came back, the receptionist was already back. He was gone for maybe an hour. On 1/19/23 at 3:40 p.m., the Administrator said as part of the corrective actions, staff was to make sure each visitor is provided a visitor sticker. He said staff was to make sure all visitors sign out before letting them out of the door. The Administrator said Resident #800 tailgated a visitor out of the facility when the front desk was attended. He said Resident #800 did not elope when the key fob was left unattended on the counter hence the implementation of the visitors' stickers, and making sure all visitors sign out to ensure no resident tailgate visitors. Review of the facility's visitor's log with the Administrator from 11/28/22 through 1/19/23 revealed approximately 364 visitors signed in but did not sign out when leaving the facility. The Administrator verified staff did not ensure each visitor signed out of the facility as per their corrective actions. On 1/23/23 at 11:05 a.m., the Nursing Home Administrator (NHA) said, I never counted the number of visitors coming into the building during the investigation to determine if there was an actual increase of visitors. I just reached the conclusion based on the observation of more traffic in the facility that day. 30599 2. Resident #850 was a [AGE] year-old- male admitted to the facility on [DATE] from an acute care hospital. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #850 had no pain and was not receiving any pain medications. The resident required extensive physical assistance of two persons for bed mobility, transfer. The resident was not stable moving from seated to standing position. Resident #850's care plan initiated on 10/24/22 read, At high risk for falls and fall related injury r/t [related to] Difficulty in walking, history of falls, impaired mobility, weakness, A-Fib [Atrial Fibrillation], HTN [Hypertension], Anemia, Alcohol Dependence withdrawal, Wernicke's Encephalopathy (Degenerative brain disorder). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The interventions as of 10/24/22 included to ensure the call light was within reach and encourage the resident to use the call light for assistance with standing, transferring and ambulation; Needs a safe environment with even floors free from spills and/or clutter, a working and reachable call light, bed in low position. Upon the initial Therapy evaluation on 10/6/22, Resident #850 complained of pain and was not able to bear weight on his right lower extremity. Resident #850 continued to complain of pain with therapy sessions from 10/6/22 through 10/23/22. On 10/24/22, an X-ray of the right hip showed Resident #850 had a right subcapital (neck) fracture of the femur of indeterminate age. Resident #850 was transferred to the hospital and underwent a surgical repair of the fracture. Review of the facility's incident reports revealed on 11/14/22 at 4:20 a.m., Nurse walked by room and noted the resident [Resident #850] on the floor on the right back at the foot of residents[sic] bed in room [Room #]. The room had adequate lighting but there was liquid on the floor and the resident's brief was on the floor near resident. Resident was able to move extremities, but later began to c/o [complain of] increased pain to right hip. Resident states desire to go to hospital. Dr. notified Resident unable to give description. The incident report documented Resident #850 was alert and oriented to person, place, and time. Predisposing factors to the fall was documented as Wet floor. Predisposing Physiological Factors were documented as, Incontinent and Recent change in condition. Predisposing Situation Factors were documented as, Ambulating without assistance. On 1/20/23 at 1:10 p.m., Resident #850 was observed in his room. The resident was hard of hearing. All questions had to be written on a note pad. Resident #850 read the questions out loud and answered. Resident #850 verified he fell on ce since his admission. He said he was trying to get up to go to the bathroom when he fell . The resident said the call light was too far, he could not reach it to call for assistance. On 1/20/23 at approximately 2:00 p.m., the Director of Nursing (DON) said the interdisciplinary team determined the root cause of Resident #850's fall was he did not use his call light. The DON said other than the progress notes and the communication form he had no other documentation pertaining to an investigation of the resident's fall. The DON verified he had no documentation to show the resident's call light was within reach at the time of the fall. Resident #850 was admitted to the hospital on 11/14/22 and underwent a second surgery to his right hip. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Orthopedic Surgeon Documented on 11/15/22, . [AGE] year-old, Caucasian male recently had surgery for a femoral neck fracture with myself. He did well in the immediate postoperative period; however, he fell at his assisted living facility and sustained a periprosthetic fracture immediately below my hip replacement . I recommended removing the loose arthroplasty [joint replacement], which was now loose after the fracture .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review, resident and staff interview, the facility failed to show effective coordination of care to promptly address multiple complaints of pain during therapy for 1 (Resident #850) of 3 sampled residents. The findings included: Clinical record review revealed Resident #850 was admitted to the facility on [DATE] with diagnoses including alcohol withdrawal, muscle weakness, and difficulty walking. On 10/6/22 a Physical Therapy evaluation documented Resident #850 was having pain in his right leg . The evaluation noted nursing was to address the pain. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted Resident #850 had no pain and was not receiving any pain medications. The resident required extensive physical assistance of two persons for bed mobility, transfer. The resident was not stable moving from seated to standing position. Review of the Physical Therapy progress notes revealed documentation on 10/6/22, 10/10/22, 10/11/22, 10/14/22, 10/16/22, 10/18/22, 10/19/22, 10/20/22, 10/21/22, 10/23/22, and 10/24/22 Resident #850 was experiencing pain to the right lower extremity, and nursing was to address the pain . On 10/10/22 the therapist documented nursing was to address Resident #850's pain on movement to the right lower extremity. On 10/14/22 the therapist documented, increased pain in right hip on movement, X ray taken. The clinical record lacked documentation of an X-ray of the right hip until 10/24/22, 10 days after the therapist documented an X-ray was taken. Review of the results of diagnostic testing revealed on 10/24/22 at 8:32 p.m., Resident #850 had an X-ray of both hips which showed a Right subcapital fracture of the femur age indeterminate. Resident #850 was transferred to the hospital and underwent a surgical repair of the right hip fracture. On 1/23/22, review of the facility's investigation, and witness statements related to Resident #850's right hip fracture with the Administrator revealed: On 10/24/22, Licensed Practical Nurse (LPN) Staff J documented a signed statement stating, On 10/14/22 Physical Therapy reported that patient was experiencing right sided pain hip and leg. I reported to the ARNP [Staff S, Nurse Practitioner] She evaluated the patient no new orders obtained. There was no documentation in the clinical record LPN Staff J reported Resident #850's complaint of pain to Nurse Practitioner Staff S. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/22 at 2:45 p.m., Staff J verified she signed the witness statement on 10/24/22. Staff J verified the lack of documentation she reported Resident #850's complaint of right hip and leg pain to Advanced Practice Registered Nurse Staff S. On 10/25/22, the Director of therapy signed a statement which read, Patient seen on 10/14/22 for PT treatment. Patient c/o [complained of] Rt hip pain on movement-(10/10) Notified Nurse in charge [Staff J]. as per Nurse x-ray ordered. On 10/25/22 the Certified Occupational Therapy Assistant, wrote a witness statement noting Resident #850 was seen on 10/18/22 for ADL's (Activities of daily living) while seated . pt c/o [patient complained of] pain to RLE (Right lower extremity) in which RLE appeared to have a skin tear to shin . I explained to nurse [Staff J] on the unit that patient was complaining of pain to RLE. [Staff J] then advised [Staff S] of patient's pain and it was assessed. Nurse updated me on the outcome and explained that patient said at the time of the Nurse practitioner's assessment that he had no pain and only a skin tear to the shin area and appears to be ok . An undated typed statement signed by Physical Therapy Assistant, Staff U read, Patient began to complain of pain in the right lower extremity. 10/18/22 with excessive external rotation and significant discomfort with active range of motion and with all functional mobility and transfers . Review of Physical Therapy Assistant Staff U's treatment encounter dated 10/18/22 showed no documentation Resident #850 had, Excessive external rotation and significant discomfort with active range of motion, and with all functional mobility and transfers. There was no documentation the abnormalities Staff U documented on the statement were reported to the nursing staff for further evaluation. On 1/23/23 at 12:07 p.m., Advanced Practice Registered (APRN) Nurse, Staff S stated no one told her Resident #850 had been having pain in his right leg or hip and was unable to bear weight on his right lower extremity. She said, if told, she would have always aired on the side of caution, obtain an x-ray or send the resident to the emergency room to be evaluated. The APRN said she assessed Resident #850 on 10/13/22 and 10/20/22 and he showed no signs of pain. She said Resident #850 was lying in bed at the time she assessed him and would not have had pain without movement. On 1/23/22 at 11:00 a.m., the Director of Physical Therapy (PT) said Resident #850 had been having pain in his right hip since the initial PT assessment on 10/6/22. The PT director said the resident had not been able to bear weigh on his right leg since 10/6/22. The PT Director said she spoke to Resident 850's nurse on 10/14/22. The nurse said they were getting an X-ray of the resident's right hip. On 1/23/22 at 12:30 p.m., the Director of Nursing (DON) said he was not made aware Resident #850 was experiencing pain until 10/24/22 when the X-ray of the right hip was done. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/23 at 2:00 p.m., the DON said the facility policy is to complete a pain assessment quarterly or with new onset of pain or changes in condition. Upon review of Resident #850's clinical record, he verified on 10/22/22 Resident #850 was experiencing some pain, and he completed a pain assessment. He said he would normally document the location of the pain on the assessment form. The DON could not recall where the resident was having pain, and why he completed the pain assessment. On 1/23/23 at 3:00 p.m., the Administrator conducted a joint interview with the Director of Physical Therapy and several other therapists, including Staff U. Staff U verified on 10/24/22, he completed therapy with Resident #850. He said he was doing isometric exercises (affected joint does not move) at the time because the resident could not tolerate putting weight on his right leg. Review of the emergency room (ER) physician progress note dated 10/24/22 revealed documentation, This is a [AGE] year-old male with a medical past history of dementia . presents to the emergency department after being brought from his facility due to right leg pain. Patient reports that he fell 6 weeks ago and has been causing worsening pain. Patient right leg is shortened and externally rotated, and x-ray in the ER confirming right subcapital femoral neck fracture . Does not complain of pain at this current time .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siesta Key Health and Rehabilitation Center	4602 Northgate Court Sarasota, FL 34234

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41212 Based on record review, review of the facility's policies and procedures, resident, and staff interviews the facility failed to monitor and evaluate the effectiveness of corrective actions implemented related to adequate supervision of cognitively impaired residents at risk for elopement and exit seeking behaviors. Resident #800 was a vulnerable [AGE] year-old female who resided on the secured unit (provides specialized care for people with memory issues) of the facility for increased supervision. On 11/27/22 (unknown time after 3:30 p.m.) Resident #800 who was ambulatory, walked out of the secured unit and the facility without staff knowledge. The resident was found by local law enforcement on 11/27/22 at 10:16 p.m., approximately 2.3 miles from the facility. Resident #800 traveled alone in the afternoon and evening along a busy six lanes highway and crossing busy intersections. Resident #800 was missing and wandering alone for approximately six and a half hours. Resident #800 had a likelihood for serious harm, injury, or death, due to risk for serious injury from a fall, being hit by a car from crossing busy streets with a speed limit of 35 miles per hour, getting lost or becoming the victim of a serious crime. On 11/28/22 the facility developed a performance improvement plan with action steps to prevent further unsafe wandering and elopement of residents identified at risk for elopement with exit seeking behavior. The facility failed to fully implement and monitor the corrective actions to determine the effectiveness of the process implemented to prevent further unsafe wandering and elopements. The failure to have an effective Quality Assurance and Performance Improvement (QAPI) program resulted in a determination of Immediate Jeopardy (IJ) at a scope and severity of isolated (J) starting on 11/27/22. The Administrator was notified of the Immediate Jeopardy on 1/24/23 at 5:18 p.m. and provided the IJ templates. There were 57 other residents the facility identified at risk for elopement. The findings included: Cross reference to F689 and F835. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's 2022 Quality Assurance & Performance Improvement (QAPI) Plan stated: The QAPI plan . is designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility. Address gaps in systems or processes . Establish clear expectations around safety, quality, rights, choice and respect. Systematic Analysis and Systemic Action. The QAA (Quality Assessment and Assurance) Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements . The facility's Quality Assurance and Performance Improvement (QAPI) policy (no implementation date) stated, Program Systematic Analysis and Systemic Action. The facility takes actions aimed at performance improvement as documented in QAA committee meeting minutes and action plans. Performance/success of the actions will be monitored and documented in subsequent QAA Committee or sub-committee meetings . The facility's Administrator job description signed on 6/20/22 noted the Administrator is responsible for the QA (Quality Assurance) program. Review of the facility's incidents, and investigations revealed on 11/27/22 sometimes after 3:30 p.m., to 3:40 p.m., Resident #800 who was cognitively impaired, and ambulatory walked out of the secured unit and the facility without staff knowledge. The resident was found by local law enforcement on 11/27/22 at 10:16 p.m. Resident #800 was 2.3 miles from the facility and traveled alone in the afternoon and evening along a busy six lanes highway and crossed busy intersections. The facility completed an investigation and determined Resident #800 tailgated a visitor through the front door on 11/27/22 due to an increased number of visitors during the holiday weekend. On 11/28/22 the Quality Assurance and Performance Improvement (QAPI) team, including the Director of Nursing, and Administrator participated in an ad hoc (unplanned) meeting to discuss Resident #800's elopement. The QAPI team developed a plan that included to assure residents safety with focused areas to include residents at risk for elopement. The action steps included initiation and continued staff education on elopement policy and drills. New process implemented for visitors to be provided visitor name tag. On 1/18/23 at 9:50 a.m., the receptionist said on 11/27/22 he had to leave the facility at 2:00 p.m. and notified the nurse supervisor who instructed him to leave the key fob (opens the door remotely) on the counter at the reception. The receptionist said when he returned an hour later, the reception desk was unattended, and the key fob was on the counter. He said Resident #998 used the key fob to let him back in the building. On 1/18/23 at 2:13 p.m., in a telephone interview, former Resident #920 said on 11/27/22 when Resident #800 went missing, he used the key fob left unattended at the reception to let his visitor out. He sat outside for a few minutes and put the key fob back on the desk. He said he did not see the receptionist at any time when he had the key fob or returned it. Resident #920 said it was early evening. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/18/23 at 4:32 p.m., in a telephone interview the nurse supervisor said on 11/27/22 the receptionist told her he had to leave. She could not remember the exact time. She told him she would be right up. She said she could not remember telling him to leave the key fob unattended. She sat at the reception for approximately 15 to 20 minutes then left to help a resident. When she came back, the receptionist was already back. He was gone for maybe an hour. On 1/19/23 at 2:00 p.m., the Assistant Director of Nursing said she was responsible to ensure all staff were educated on the corrective actions after Resident #800's elopement. She provided 20 in-service education sign-in sheets from 11/28/22 through 1/16/23. Two of the 20 sign-in sheets dated 12/8/22 did not document a topic for the in-service. One of the in-service education sheets only noted the participants were educated on Abuse, Neglect, and exploitation. Six of the sign-in sheets noted the topic was elopement policy/drills/abuse and neglect/Door codes not to be given to visitors. The in-services did not address the new process implemented for visitors to be provided with visitor name tag and ensure visitors sign-in and out. The Assistant Director of Nursing (ADON) said the facility utilizes agency nurses and Certified Nursing Assistants (CNAs). She said she educated the agency staff on the new process during the general orientation but did not document. On 1/19/23 at 3:40 p.m., during a review of the QAPI program, the Administrator said as part of the corrective actions, staff was to make sure each visitor is provided a visitor sticker. He said staff was to make sure all visitors sign out before letting them out of the door. The Administrator said Resident #800 tailgated a visitor out of the facility when the front desk was attended. He said Resident #800 did not elope when the key fob was left unattended on the counter hence the implementation of the visitors' stickers, and making sure all visitors sign out to ensure no resident tailgate visitors. Review of the facility's visitor's log with the Administrator from 11/28/22 through 1/19/23 revealed approximately 364 visitors signed in but did not sign out when leaving the facility. The Administrator verified staff did not ensure each visitor signed out of the facility as per their corrective actions. On 1/19/23 at 3:00 p.m., review of the visitors' log from 11/20/22 through 11/27/22 did not show documentation of increased visitors on the secured unit. On 11/20/22, and 1/22/22, one visitor was documented on the log for the secured unit. On 11/21/22, and 11/24/22: 12 visitors were documented on the log. On 11/23/22, nine visitors were documented on the log. On 11/27/22, four visitors were documented on the log. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator said the QAPI team met again on 12/21/22 to discuss the results of audits and corrective actions. He could not provide documentation of tracking and evaluation of interventions implemented to determine if corrective actions were successful to prevent further unsafe wandering and elopement. There was no audit of the visitor's log to ensure staff followed the process to prevent the unsafe wandering of the facility for residents at risk for elopement and exit seeking. The Administrator said, We have had no other elopement. If you're asking if our plan has worked, no one had gotten out. On 1/19/23 at 5:10 p.m., the Regional Director of operations said the facility did not have an analysis of the information collected from the audits to determine if the process in place had achieved 100 % compliance. On 1/23/23 at 11:05 a.m., the Administrator said he determined Resident #800 tailgated a visitor out of the facility due to the increased number of visitors during the holiday weekend. He said, I never counted the number of visitors coming into the building during the investigation to determine if there was an actual increase of visitors. I just reached the conclusion based on the observation of more traffic in the facility that day.