PRINTED: 07/25/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105772	A. BUILDING _____ B. WING _____	C 07/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF ST PETE	435 42ND AVE S SAINT PETERSBURG, FL 33705

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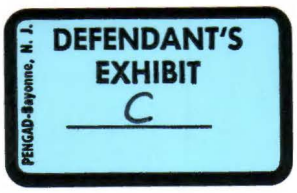
F 000	INITIAL COMMENTS SKILLED NURSING FACILITY CCRs 2014006663, 2014006148, and 2014006263 conducted in conjunction with the Annual Q.I.S. and Life Safety Code surveys (Event I.D.s JGQO11 & JGQO21), both of which had findings. Rehabilitation Center of St. Petersburg is not in compliance with 42 C.F.R. Part 483 Requirements for Long Term Care Facilities. Findings of On-Going Immediate Jeopardy were identified as a result of the complaint surveys at F 224 (J), F 225 (J), F 226 (J), F 323 (J), F 490 (J), F 493 (K), and F 520 (J). Substandard Quality of Care was identified at F 224 (J), F 225 (J), F 226 (J), and F 323 (J). The Administrator was informed of the Immediate Jeopardy on 07/11/2014 at 6:15 p.m.	F 000		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 224		



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

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

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F 224	Continued From page 1 Based on staff interview, record review and review of the facility resident abuse policy, the facility failed to provide goods and care services for the oversight of residents, identified with elopement risk, for 3 (#210, 211 and 212) of 46 Stage II sampled residents. A review of the facility census for 07/11/14, revealed 142 residents currently residing in the facility, per the facility prepared CMS Form 672. For Resident #210, the facility failed to know the whereabouts of a resident determined to be exit seeking for an unknown period of time; the facility failed to document circumstances related to unsafe actions of unsupervised wandering; the facility did not notify the attending physician of unsafe wandering; the facility did not provide adequate supervision or services related to a new admission with documented exit seeking behavior; the facility did not investigate comprehensively how the resident was able to leave the secure floor and exit the facility unsupervised. In addition, for Resident #211, the facility failed to ensure that a timely " Wandering/Elopement Assessment Tool " was completed; that physician orders for a " wander guard " and for staff to check for placement and function every shift was followed; and that the facility process for ensuring a " wander risk " resident's photo was placed timely in the " wander guard " book at the nurse's station. In addition, for Resident #212, the facility failed to ensure that an interim care plan accurately reflected the "wander risk" status for a resident admitted with documentation of known exit seeking behaviors and removal of wander guard behaviors; that a timely." Wandering/Elopement Assessment Tool " was completed; and that	F 224		

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physician orders for a "wander guard " and for staff to check for placement and function every shift was followed.
The facility's failure to demonstrate the necessary goods and care services to ensure the safety of residents with a known elopement risk resulted in findings of Immediate Jeopardy, which is on-going.

Findings include:

1. A review of the facility Wandering, Unsafe Resident policy and procedure, revised 11/2010, documented the policy Statement : " The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. "
The Policy Interpretation and Implementation:
1. " The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement).
2. The staff will assess at -risk individuals for potentially correctible risk factors related to unsafe wandering.
3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues.
4. Interventions to try to maintain safety will be included in the resident's care plan.
5. Nursing staff will document circumstances related to unsafe actions, including wandering by a resident.
6. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior.
7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for

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any resident who is discovered to be missing from the unit or facility. "

A review of the facility Elopement policy and procedure, revised 04/2010, documented the policy statement: " Staff shall investigate and report all cases of missing residents. "
The Policy Interpretation and Implementation:
1. " Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.
2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.
3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Notify the Attending Physician.
4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on a leave or pass; b. If the resident was not on leave/pass, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services; d. If the resident is incapacitated notify the resident ' s representative and law enforcement; e. Provide search teams with resident identification information; and f. Initiate an extensive search of the surrounding area.
5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b.

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Contact the Attending Physician and report findings and conditions of the resident; c. notify the resident's legal representative (sponsor); d. Notify search teams that the resident has been located. "

A review of the facility Abuse Protection and Response Policy, revised 05/12/14, documented the policy of the facility to be: " Abuse, as hereafter defined, will not be tolerated by anyone, including staff, residents, volunteers, family members or legal guardians, friends or any other individuals. The health center Administrator is responsible for assuring that resident safety, including freedom from risk of abuse, holds the highest priority. "
The document defined Neglect: " The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the resident. "
Section VII. Reporting and Response: Policy: " All allegations of possible abuse will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation. Procedure: Any investigation that substantiates abuse, neglect, or exploitation will be reported immediately to the Administrator and/or the Abuse Prevention Coordinator. It will also be reported to other officials, in accordance with State and Federal Law.
Section A. The immediate Report: All allegations of abuse, neglect, exploitation ...must be reported immediately or practicable. This allegation must be reported to the Abuse Hotline within immediately or practicable whenever an allegation is made.

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F 224	Continued From page 5 The Abuse Prevention Coordinator will also submit the Agency for Health Care Administration AHCA Federal Immediate/ 5 day report ... Section B. The Report of Investigation (Five Day Report): The facility Abuse Prevention Coordinator will send the result of the facility investigations to the State Survey Agency within five working days of the incident. " Policy: " Trends of investigative findings will be analyzed and addressed by the QA and Risk Management committee process. " Procedure: " An accurate summary reporting of all investigations conducted by the center will be maintained as a working document of the Quality Assessment and Risk Management Committees. " QA and RM will review and analyze investigations to track and determine presence of any trends. 2. An interview was conducted on 07/11/14 at 7:10 a.m. via phone with Staff Member C (RN C), a Registered Nurse (RN), who confirmed that she was working as the " House Supervisor " for the facility on 06/21/14. She stated that she was called over the intercom by a nurse on the 2nd floor. She believed that the nurse that called her was Staff Member F, a Licensed Practical Nurse (LPN) that was working on the 2nd floor. Staff member C, RN, stated that LPN, F, called to tell her that she could not find Resident # 210. RN, C, further stated that a room to room search of the 2nd floor had been conducted and that a search was in progress for the 1st and 3rd floor. RN, C, stated that she called the Director of Nursing (DON), who instructed her to call the Administrator, which she did. RN, C, stated that staff started to look outside and meanwhile she called Resident #210's emergency contact (EC)	F 224		

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to check to seek if the EC had visited and taken Resident #210 out. Per the RN, C, the EC informed her that he had not taken the resident out of the building. RN, C, stated that meantime, she estimated that approximately 15 minutes had elapsed and that a staff member had found Resident #210 down the road. RN, C, stated that she could not remember who the staff member was that found the resident, but that the staff member came back and gave the resident something to drink and offered the resident something to eat. RN, C, stated that Resident #210 told her he wanted to walk home. RN, C, stated that she informed the resident about signing out when he left the building; RN, C, stated that Resident #210 said he understood. RN, C, stated that she asked Resident #210 a series of questions and that he answered all the questions properly. RN, C, stated that she assessed him and asked the resident if she could supply him with a wander guard. RN, C, stated that Resident #210 said "ok " to the wander guard. RN, C, stated that she did not call the doctor about the event. " Honestly, I do not remember if I did or not, I would have to look at the chart. " RN, C, stated that once we located him, we stopped the phone calls. RN, C, stated " I was not working on Friday " , 06/20/14, when Resident #210 was admitted. I do not know what the set of circumstances were before that (at admission.) " Thinking it was that he left the 2nd floor, I do not know " how he was able to leave. " No training since this happened in regards to a resident at risk for wandering and precautions to take. "

RN, C was asked: " How did he get off the 2nd floor? " She replied: " I do not know how he got off the 2nd floor unit. " " That would have to be investigated. "

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RN, C was asked: " Were you aware he was exit seeking at admission? " She replied: " No " , I was not directly assigned to the resident. She further stated that " not every patient on the 2nd floor needs supervision. "
RN, C was asked: " How does staff know which residents are wanderers or exit seeking? " She replied: " it comes with staff knowing the resident. " " The 2nd floor is an Alzheimer's unit; I am not too familiar with the residents on that floor. " " I do not know what the process is to understand which residents are wanderers or exit seeking. "
RN, C was asked: " The facility uses Agency staff members, how do these staff members know which residents are at risk for wandering? "
RN, C, replied: " I do not know. "
RN, C, confirmed that Resident #210 was " missing " during 06/21/14 and that the Elopement Protocol was initiated.
RN, C, was asked why the event was not documented in Resident #210's clinical chart, the nursing notes or anywhere else. RN, C, replied: " I do not know why a person did not enter the information into the clinical chart."
RN, C, stated that " If I have a resident that I am giving medication to and he is missing, I have a concern. "
Did you know at admission he was a wander risk or exit seeking? RN, C, replied: " I did not know he was identified as a wander risk. " She further stated that she did not know the location of the resident when he was found. She stated he was " hot " when he came back. Not sure of the staff member that found him.
RN, C was asked " Why was a wander tool completed on the resident on 06/23/14? " RN, C, replied: " I do not know why the wander tool was done. I believe that is done on admission, I would

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have to be instructed as to what the process is. Do not know why the Wander tool was not done at admission. "

An interview conducted on 07/08/14 at 12:52 p.m. with LPN, F. She confirmed that she was working during 06/21/14 on the 2nd floor. " He left the facility, he did not sign out. " "One of the care aides located him, sitting at the bus stop a couple of blocks up " , Staff member D, CNA that found the resident. "

A review was completed of the nurse's notes, with LPN, F. She confirmed that the progress notes did not document the resident leaving the facility un-supervised. In review of note for 06/21/14 which documented her assessment of the resident; she did not call the doctor; he has a friend; he was his own person-would be no family to call. She further stated that right before lunch time he was noticed missing. He was found during the lunch period. Estimated the time resident #210 was missing to be 30 minutes. We did a room to room search; immediate grounds search; if the resident is not located, then the search is extended to the area surrounding the facility; that is when he was located at the bus stop. It was warm out that day. (The resident said, I will never do that again, it was hot out there). His skin looked fine.
We have several people that live on the floor that just live here. He is own person; he can make decision on whether he wants to go or not. Any new admission they do an elopement risk screening. "

A review of Resident #210's clinical chart revealed no nurses notes were present documenting information about the resident

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admission on 06/20/14 thru the first entry of 06/21/14 at 4:10 p.m.

A review of Resident #210's clinical chart revealed Narrative nurses notes, entered 06/21/14 at 4:40 p.m.: " No acute distress. Alert with some confusion noted. Head to toe skin check done this shift without areas of mention noted. Ambulating ad lib frequently in corridor, re-directed when observed entering into others rooms. Appetite good consumed 75% of meals served this shift, meals served in room. VS 138/64-98.4-20-82. "

Further review of Resident #210's clinical chart revealed no additional notes on 06/21/14 that would document the unauthorized exit from the 2nd floor, building, or facility grounds, i.e. unsafe wandering.

No documentation on 06/21/14 was present regarding any communication with Resident #210's physician.

A visit to the named sister facility from which Resident #210 was transferred from on 06/20/14 to the current facility was conducted on 07/10/14 at 7:15 p.m. for the purpose of reviewing Resident #210 ' s record.

An interview was conducted on 07/10/14 at 7:23 p.m. with the facility Administrator. He confirmed that he initiated the transfer for Resident #210. He confirmed that Resident #210 was exit seeking during his stay. He stated that the resident would appear to be of the ability to make decisions and then at other times he did not. He stated that he was not sure if the receiving facility knew that the resident was exit seeking; he talked

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to a woman in Admissions at the facility, though he was not sure of her name. He stated that he sent the paperwork over, the H & P, the psych notes and the medication list for the resident. He stated that he was unaware if the receiving facility nurse called for any further details about the resident.

A review of a physician's telephone order, (p.t.o.), dated 06/20/14, signed by the physician, documented: " order received transfer resident to St. Petersburg Rehabilitation; needs secure unit."

No documentation was present on 06/21/14 regarding any additional measures or monitoring that the facility was taking to ensure the safety of the resident who had just eloped from the facility.

The facility is a three story facility. An observation conducted on 07/08/14, 07/09/14 and 07/10/14 of the 2nd floor, between the approximate hours of 9am to 4 p.m. revealed that the 2nd floor was accessed by staff utilizing a key for the elevator and to leave the 2nd floor staff were observed to escort residents and or families off the floor by utilizing a key to allow the elevator to be retrieved and so persons could exit the floor.

An observation was conducted on 07/11/14 at approximately 9:45 a.m., which included walking west approximately 3 blocks from the facility grounds along 42nd Avenue South, turning and walking approximately 1 more block to a bus stop located next to 4th Street South, a 4 lane road with a middle turning lane. Traffic on the road was observed to be moderate with a posted speed limit of 35 mph. The bench located next to the road, approximately 20 feet from the road,

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was observed not to have trees or shade present, but open to the full sun.
A review of the internet, (print date of 07/21/14), weather history for the St. Petersburg area for the date of 06/21/14 revealed an average maximum temperature of 89 degrees Fahrenheit, maximum humidity rate of 79, wind speed of 7 m.p.h. and sunny.

A review of the internet, Nordevald Software & information services, print date of 07/21/2014, documented information about the Heat Index: The Heat Index is the " feels like, or apparent, temperature. As relative humidity increases, the air seems warmer than it actually is because the body is less able to cool itself via evaporation of perspiration. As the heat index rises, so do health risks. When the heat index is 90-105 degrees F., heat exhaustion is possible. When it is above 105 degrees F., it is probable. Heatstroke is possible when the heat index is above 105 degrees F., and very likely when it is 130 degrees F., and above. Physical activity and prolonged exposure to the heat increases the risks. "

A review of the Heat Index chart documented, if the air temperature was approximately 85-90 degrees F., and the humidity was between 75 and 80, the heat index=between 109 and 113, thus it " feels like " 109-113 degrees F.

A review of the internet, About.com Florida travel and print date of 07/21/2014: " In Florida, more people die from excessive heat than from lightening. The human body temperature rises dangerously when hot days combine with high relative humidity, because perspiration cannot evaporate and cool the body. Elderly persons

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and small children, or persons on certain medications ...are particularly vulnerable to heat stress. "

Further, an observation, conducted on 7/10/2014 at approximately 12:00 p.m. of the facility location, at 435 42nd Avenue South, St. Petersburg, FL 33705, revealed that east of the facility, approximately 2 blocks, was a body of water, a channel between Big Bayou and Little Bayou. If a person were to walk East on the 42nd Avenue sidewalk, they could walk directly into the channel without having to enter any residential yard. The channel, when observed, looked to be approximately 600 yards across to the opposite side. The depth of the channel is unknown, but, observations of boats docked at the sides of the channel revealed various sized boats of average size of approximately 20-30 feet in length.

An interview was conducted on 07/11/14 at 9:45 a.m. with Staff Member D, a Certified Nursing Assistant (CNA), during which she confirmed that she had been working for the facility approximately 2 years. She confirmed that she was working on 06/21/14 on the 2nd floor during the 7am-3pm shift and that on that day; she was supposed to clock out at 1:00 p.m. for the end of her shift. Staff Member D stated that a Restorative Aid came to the floor and asked for Resident #210. She stated that this was some time after lunch, possibly around 12 or 12:30 p.m.. Staff Member D stated that it was at this time that she could not locate Resident #210 and that a room to room search on the 2nd floor was initiated. She stated that the search for the resident was expanded to include the other 2 floors and then the facility grounds. She stated that when Resident #210 was not located in the

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facility or on the facility grounds, the search was expanded to areas close by the facility. Staff Member D stated that she found Resident #210 at a bus stop. She stated that Resident #210 stated that he was trying to go home. She stated that Resident #210 looked tired and that she was able to encourage him to walk back to the facility. She stated that he was sweaty, that she helped him to change his clothes, gave him water and offered him food to eat. Staff member D stated that she clocked out of the facility after finding the resident at 1:29 p.m. Staff member D stated that she did not know that Resident #210 was a wander risk.

An interview was conducted on 07/11/14 at 1:33 p.m. via phone with Staff member E, Licensed Practical Nurse, LPN. LPN, E confirmed that she was the nurse that was present and completed the admission paperwork for Resident #210 on 06/21/14.
LPN, E, was asked: " Do you know why Resident #210 was transferred? (From another nursing facility). " No, I do not know. " " He needed a secure unit. I do not know why he needed the secure unit. " She further stated that she called and confirmed the resident ' s medication orders and treatment orders. She stated that usually, his orders would state if he was to have a wander guard or not. She stated that she did not see any orders for a wander guard.

A review of Resident #210's electronic clinical chart, a demographic/orientation to the facility document, documented that Resident #210 was admitted to the 2nd floor of the facility on 06/20/14. The document stated that the resident

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arrived via "ambulatory" from (__ Rehab), a sister facility to the admitting nursing home (i.e. owned by the same corporation.) The reason for admission as per client or family /caregiver was " facility transfer." Lifestyle of the resident was " uses Alcohol and " current smoker." Bed mobility, Transfer and eating self-performance were documented as " Independent." Dressing and ADL's were documented as " Limited assistance." Toileting and bathing were documented as the resident needed " supervision. "
Section P. Fall Risk, #2. The Cognitive or behavioral status, section bb, asked the question: " Does the resident display any of the following behaviors? Easily distracted, periods of confusion, disorganized speech or flight of ideas, periods of lethargy, wandering, resistive to care or abusive behaviors. This question was answered, "yes."

A review of Resident #210's admission record documented that the original admission date for the resident was 06/20/14; diagnoses included: "other specified rehabilitation procedure; late effects of cerebrovascular disease; alcohol-induced persisting dementia; other persistent mental d/o due conds clase elsw; unspecified essential hypertension; altered mental status. "
The Admission record documented that the resident was admitted from a nursing home.

During an interview conducted on 07/10/14, at approximately 10:50 a.m. with the Admissions Coordinator, she confirmed that she had been employed approximately 1 month. She stated that she would consult all new (resident) referrals to the DON; sometimes the Administrator; they

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make the determination if someone needs the secure unit or not. There are a few residents that live up there on the 2nd floor. They want to be there.

A review of the Resident Transfer form located in Resident #210 ' s clinical chart on 07/10/14 and reviewed, documenting a date of transfer of 06/20/14, signed by an LPN on 06/20/14, documenting the receiving facility to be St. Pete Rehab, documented additional pertinent information: " Ambulates ad lib, Exit seeking can be redirected-Resident very confused to time, place. Resident does use toilet, but has occasional incontinence of bladder; Resident has good appetite and takes fluids well. "
Further review of the form, documented that the resident was transferred from a "sister" facility, i.e. a facility that was owned by the same corporation.
The form documented that the resident had a hospital stay within the last 60 days.
The diagnoses at the time of transfer-AMS (Altered Mental Status); secondary: Late effects CVA.
The form documented the potential for rehabilitation was "poor."
The form documented that Resident #210 had " Mental " impairments.
The form documented the following medications at the time of discharge:
Xanax, 0.5 mg bid.
Norvasc, 5 mg hs.
ASA, 325 mg daily
Lisinopril, 10mg daily
Multi-vitamin with minerals, 1 tab daily.
Flomax, 0.4mg hs
Namenda xR, 14mg, hs x 5 days then; Namenda xR, 21 mg hs x 7 days until July 1st; Namenda

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XR, 28 mg hs , starts July 2nd, B/P weekly on Friday, 7am-3pm.

The form documented that the mental status of the resident was " alert " and " confused."

An interview was completed on 07/10/14 at 11:03 a.m. with the Director of Nurses (D.O.N.). She stated that, sometimes, she will place a resident on the 2nd floor; if the bed situation warrants it. For example if they have no male beds on the 3rd floor. She stated that the 1st floor is for Medicare. Resident # 210 was placed on the 2nd floor due to the lack of beds on the other floors.

If he started showing the behaviors of exit seeking; they will call me and alert me; they will call the doctor and let them; immediately means within the hour; I would expect that they would call the doctor within the hour; they would have to get permission from me to put a wander guard on the resident; they would complete a wander assessment to determine if he is high risk.

Incapacitated means that they cannot make safe decisions for their everyday living; medical needs. I believed that he (Resident #210) could make safe decisions in regards to his medical needs and his everyday living; Today, I do not believe that he can make safe decisions; there has been a change, from my observations of him. I was here on Friday , date of admission; he was walking, talking and continent of bowel and bladder. Now he does not walk around as much; he is in therapy; he just does not do as much as he did when he came in. I do not think he can make decisions; when I ask him a question, he can answer. The DON confirmed that no event

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report was completed in regards to the event that transpired on 06/21/14 with Resident #210 when he went missing from the facility. She stated that he did not sign out. "The resident left the facility; he was missing; they did not know where he went. " But, it was not an elopement. " No we did not call the police." I did not complete an investigation for the event. We did not consider him an elopement. He was a couple of blocks down sitting on the bench.

A review of Resident #210's MDS. Section C-Cognitive Patterns, 5 day Admission information, documented Brief Interview for Mental Status, (BIMS) which was electronically signed as completed on 06/28/14; Resident #210 ' s score was " 9 ", which indicates moderate impairment.
An attempt to interview Resident #210 was conducted on 07/09/14 at 10:33 a.m. The Resident was not able to answer the questions. Resident #210 was dressed for the day; laying on a bed that was made up; watching TV. Resident #210 stated that he had no concerns; but, he appeared to search for answers when asked specific questions. Resident #210 was observed to be currently residing on the 2nd floor of the facility, the secure unit.

A review of the facility census for the 2nd floor, for the date of 07/11/14, revealed a total of 61 beds located on the 2nd floor (secured division of the facility.) A further review of the census document, revealed that 56 residents were residing on the 2nd floor on 07/11/14; 3 of the residents were identified by facility staff as not needing the secured unit; thus, 53 of the remaining residents were identified to need the secure unit.

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In an interview conducted with a physician of Resident #210's primary physician group, on 07/10/14 at 12:41 p.m., he had been seeing the residents at the facility for approximately 1-2 weeks. He stated that he was familiar with Resident #210, that he had visited him 2 times since he had started at the building. He stated that the other doctor, (primary) had seen him earlier. He stated that he was not aware of the resident leaving the facility unsupervised. He stated that he would make some phone calls to other members in the group to find out if they were aware of the concern. He stated that the resident, when he talks to him, stays grumpy and irritable. The resident does not seem aware; he has met him 2 times; he stated that he would suggest that the resident does not have capacity. We should document when the facility calls and notifies us of an event like this. (Follow up call was received from this doctor the following day. He confirmed that the resident's physician practice had no knowledge of the resident unauthorized exit from the facility on 06/21/14).

An interview was conducted on 07/11/14 at 4:20 p.m. with the Medical Director for the building. He stated that he had been the Medical Director for approximately 2 years. The Medical Director was asked if facility staff were responsible to call and inform him of an unauthorized exit from the building by a resident, a resident that was found approximately 3 blocks from the facility. He stated that usually they would call; he stated that that he was not aware of a phone call regarding Resident #210 leaving the facility (unauthorized) on 06/21/14. But, he said he would check with his answering service, they may have knowledge of the phone call. (The Medical Director followed

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up with this conversation on 07/11/14 at 6:55 p.m. to confirm that no phone call had been placed to him or his answering service regarding Resident #210 ' s event on 06/21/14.) The Medical Director stated that he would want to know about an event like this. The Medical Director stated that the 2nd floor of the facility was a secure unit, that it typically meant the residents needed extra supervision.
The Medical Director stated that if someone is not deemed incompetent by paperwork, that does not mean competency.
"I would expect that an event of an unauthorized departure from the facility would be investigated. "
The Medical Director was given an example of a resident coming to the facility with a transfer form that states the resident is "exit seeking", the resident is placed on the 2nd floor of this facility; the resident goes missing the day after admission; staff implement the elopement protocol and the resident is found approximately 3 blocks away from the facility. Is that an elopement? Medical Director stated: "yes, it is."

During an interview conducted on 07/10/14 at approximately 11:00 a.m., the Administrator stated that he had investigated the 06/21/14 event, but, had not documented the investigation. A letter, was provided to the surveyor on 07/10/14 at approximately 4:00 p.m. which stated the following:

"On 06/21/14 I received a call from the weekend supervisor that Resident #210 was brought back after leaving the facility for a brief time. I was informed that the patient was noted not to be in his room and the unit was searched. It was determined that a church group had left the unit and it was suspected that the resident may have

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left with the group. An immediate search of the facility was conducted and a call placed to the patient ' s contact to determine if he/she took the patient out on a leave. The CNA, G initiated a search of immediate area and found the resident up the street. It was estimated the resident was out of the facility for 15 minutes.
When contacted by the supervisor, I asked her to ask the patient several questions to determine if he is oriented. The supervisor asked the patient numerous questions, all of which he answered correctly. I asked the supervisor if she felt the patient was oriented and she felt that he was. I then asked her to check at the record to determine if incapacity was present. There was no incapacity on the chart. The resident ' s prior living arrangement was an ALF. I instructed the supervisor to notify the patient not to leave the facility without signing himself out and explain that we need to know his whereabouts. I also instructed the supervisor to monitor the patient closely and the resident gave permission to place a wander guard on him. I asked the supervisor to notify me if he made any attempts to leave the facility, again, without signing out. Based on the patient answering several questions correctly, the lack of a physician incapacity, and the supervisor indicating he appeared to be oriented, I felt the patient left the facility without signing out as opposed to eloping.
In discussion with the supervisor and DON post incident it was suspected that the resident exited the unit with a church group who were visiting patients on the unit. The group had access to getting on and off the unit with an elevator key that was issued by the receptionist. The group had exited the unit at approximately the same time that the resident was known to have left the unit. "

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Observations were conducted on 07/08, 07/09 and 07/10/14 of the facility during the survey process at which time camera apparatuses were observed in place on the 1st, 2nd, and 3rd, floor hallways of the facility.

An interview was conducted on 07/11/14 at 2:30 p.m. with the Administrator; he was asked if he or anyone had reviewed the facility cameras to try to determine how the resident had gotten off of the 2nd floor and how he was able to leave the building unauthorized. The Administrator stated: "I did not think to look at the camera" footage.

A review of the Agency system on 07/18/14, to review for submission of allegations of abuse or neglect by the facility, and discussion with the unit responsible for receiving such reports, revealed that as of 06/19/14 no events had been reported to the State or Federal Agency regarding the events surrounding Resident #210 ' s elopement from facility, lack of supervision, or lack of provision of care and services for Resident #210.

3. A review of the record for resident # 211 revealed that she was admitted to the facility on 6/27/14 from another nursing facility. An Admission/Readmission Nursing Evaluation form, with an effective date of 6/27/14 and signature dates by the LPN of 6/28/14 and an RN on 6/30/14 was found in the resident ' s electronic health record. Review of this Admission Nursing Evaluation form revealed that the resident had an admitting diagnosis of " Deconditioning Dementia Psychosis." The form indicated the resident was independent with bed mobility, transfer, ambulation and locomotion and was alert to person with periods of confusion.

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An observation was conducted on 7/11/14 at 1: 45 p.m., Resident # 211 was observed seated in her room in her wheelchair. A Wander guard was observed on the resident's wrist.

A review of progress notes in the resident's record revealed:
6/27/14 20: 27 Narrative Nurses note: " New admission arrived to facility at 5: 30 p.m. Resident alert and orient to self, periods of confusion noted, admitting diagnosis Dementia and Psychosis, denies pain or discomfort. " Continent of B& B, ambulating with a slow steady gait. "
6/30/14 09: 30 Narrative Nurses note: " Late entry for 6/29/14, Resident alert with confusion. Refused all meds x 3 stating ' I ' m not taking any more medicine it ' s just going to poison me ' . Minimal assist with ADL care provided x 1 staff. Mobilizes via w/c able to propel self. Wanders aimless in corridors and into other rooms, redirected at these times. Refused meals stating, ' I ' m not hungry and you ' re not going to shove any of that food in me. '
6/30/14 14: 32 Social Services: " Met with residents this afternoon to introduce self, review rights, abuse, grievance policy, advances directives, and current status. Resident is an 84 year old female admitted to us from (another nursing facility) as she needs a secured unit. Is alert, responds to verbal stimuli with forgetfulness and delayed reactions noted. Is able to communicate her needs. Was cooperative and answered all questions as best she can recall. Has poor recall and insight. Has Dx of Dementia, Psychosis, and Delusions. "
6/30/14 13: 32 Narrative Nurses Note: Resident alert with some confusion noted. All meds accepted except iron this shift. Minimal

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F 224	Continued From page 23 assist with ADL care x 1 staff. Mobilizes via w/c, able to propel self. Aimless wanders in corridors and into others room, redirected at these times. " A review of the electronic health record revealed a " Wandering/ Elopement Assessment Tool " with an effective date of 6/30/14 (three days after admission). Review of this tool indicated the resident was determined to be: " Disoriented (x 2 spheres) Combative/ severely agitated Recent experiences of Change of roommate, room change, admission within the last month, caregiver or staff change, Mobility - independent Diagnosis: Dementia with Psychosis Medications: Taking antipsychotics History of Wandering: Know wanderer/hx of wandering Care plan/recommendations: By this assessment is the resident at risk for wandering? " Yes " If yes, have appropriate interventions been initiated " Secure " Has the care plan been updated and communicated to the staff? " Yes " Has the physician and family been consulted? " No " This form was signed by the Unit Manager on 6/30/14. Review of the interim care plan for resident # 211, dated 6/ 27/14, revealed under the section for " Falls/Safety Risk/Elopement Risk " the following areas were checked : " Keep call bell in reach/ encourage use of call light, Therapy to screen and evaluate as needed, Apply bed/ wheelchair alarm, wander guard if needed, Resident to wear proper footwear and non - skid soles. "	F 224		

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F 224	Continued From page 24 An interview with the MDS person, on 7/11/14 at 2: 07. p.m. revealed that the comprehensive care plans were not completed yet for the resident as " she hasn't been here 21 days yet so no comprehensive care plans but she has the interim care plan. " A review of verbal admission orders from the physician, dated 6/27/14, revealed " Wander guard, Check Q shift for function and placement." A review of documentation in the resident's chart, paper and electronic records, revealed that there was no documentation for June 27, 2014, June 28, 2014, June 29, 2014 or June 30 2014 of the facility checking for placement of the wander guard every shift. An interview was conducted with the Unit Manager on the secured unit, on 7/11/14 at 7: 40 p.m. She stated that documentation for the wander guard checks would be on the Treatment Record in the resident's chart. She stated it is placed on the Treatment Record when the order is received. She reviewed the chart and confirmed there was no entry on the Treatment Record for the wander guard and no documentation that the wander guard was checked for placement each shift from June 27, 2014 through June 30, 2014. Per interview with the Assistant Director of Nursing and the 3 p.m. to 11 p.m. Nurse Supervisor, on 7/11/14, at approximately 8: 00 p.m. revealed that all residents with wander guards are in the wander guard books. There are two books, one kept at the front lobby desk and one kept at the 1st floor nurse's station. Each book contains a list of all residents with wander guards and a picture of each resident with a wander guard. Review of both books with the Nurse Supervisor and the Assistant Director of Nursing revealed no picture of Resident # 211 in either book.	F 224		

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4. A review of the record for Resident # 212 revealed that he was admitted to the facility on 6/23/14 from another nursing facility. Review of documentation from the other nursing facility, found in Resident # 212's record, revealed that the resident, on 6/22/14 and 6/23/14 (prior to admission at current facility), exited and/or attempted to exit the other facility multiple times and removed his wander guard at least twice, the last time by biting it off.

An observation was conducted on 7/11/14 at 7: 50 p.m., Resident # 212 was observed ambulating independently down the hall of the secured unit. The resident was noted to have a Wander guard on his right wrist. Resident # 212 stated that he was " doing well."
A review of the Admission/Readmission Nursing Evaluation , with an effective date of 6/23/14 an signature dates from the LPN and the Unit Manager on 6/25/14 and 6/27/14, revealed that the resident had admitting diagnoses of " fall, hematoma, brain bleed. " The evaluation indicated that the resident was independent in bed mobility, transfer, ambulation and locomotion and alert to person, time and situation with a note indicating " resident is confused at times."
Further diagnoses found in the resident ' s record indicated that the resident also had diagnoses of Bipolar disorder and Schizophrenia.
A review of the Admission/ Readmission Nursing Evaluation and the nursing narrative notes in the resident ' s record revealed no indication that the resident was considered to be exit seeking, a wanderer, or at risk for elopement. An Activity/ Recreation progress note, dated 6/24/14 at 11: 59 stated, " Welcomed him to our facility and took his picture for our wander guard book, wander

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F 224	Continued From page 26 guard in place per unit manager. " A " Wandering/ Elopement Assessment tool " was found in the resident's record with an effective date of 6/24/14. The assessment tool indicated: " Orientation - Disoriented (x 2 spheres) Recent Experiences - Change of roommate, admission within the last month, caregiver or staff change, Mobility - Independent (no assist) Diagnosis- Early Dementia. Medications- Taking antipsychotics History of wandering - known wanderer / history of wandering Care plan/ Recommendations: By this assessment, is the resident at risk for wandering? - Yes If yes, have appropriate interventions been initiated? - Yes Has the care plan been updated and communicated to the staff? - Yes Has the physician and family been consulted? - Physician /self A review of the interim care plan, dated 6/23/14, did not indicate that the resident was a wanderer, exit seeking or an elopement risk. Review of the section for "Falls/Safety Risk/Elopement Risk indicated check marks only in the areas of " keep call bell in reach/ encourage use of call list, Therapy to screen and evaluate as needed Apply bed alarm if needed, and Resident to wear proper footwear and non - skid soles. " A comprehensive care plan for "Elopement " indicating that the resident "was at risk for elopement due to: is exit seeking, verbalizes desire to leave and has the means to do so, is ambulatory, impaired cognition" was not completed until 7/7/14.	F 224		

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F 224	Continued From page 27 A review of admission physician orders, dated 6/23/14, revealed an order for " Wander guard check placement and function Q shift. " A review of the resident ' s record, including the Treatment Record, revealed no documentation from June 23- June 30, 2014 that the placement of the wander guard had been checked each shift as ordered. " An interview was conducted with the Unit Manager, on 7/11/14 at 7: 28 p.m. She stated that the documentation for checking placement of the wander guard each shift was written on the Treatment Record when the order was received. She reviewed the resident's record and confirmed that there was no documentation that placement was checked from June 23, 2014- June 30, 2014. On 7/11/14 at 9: 25 p.m., the Director of Nursing provided two sheets of paper, one entitled " 2014 June Wander guard check list " and the other entitled " 2014 July Wander guard checklist. " She stated that these sheets were kept " right next to the wander guard book at the 1st floor nurses station " and the central supply person, checked the functionality of each wander guard daily and documented it on these sheets. She provided documentation that the function of the wander guards were checked daily for Resident's # 211 and # 212 in June 2014. She stated that the nurses checked for placement. She stated that the order for "wander guard check Q shift for function and placement " for both Residents # 211 and # 212 was written incorrectly and that it should only be once a day.	F 224		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 28 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident record review,	F 225		

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resident interview, review of facility policies and procedures and staff interviews, it was determined that the facility failed to have evidence of a comprehensive investigation of an event involving a lack of supervision and monitoring devices which resulted in an elopement event where Resident #210 was able to leave a secure floor, unwitnessed; able to leave the facility and facility grounds, unwitnessed. The facility definition for Neglect included the following: " the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the resident. "
The facility failed to have evidence of reporting to the abuse hotline and the state agency an event which met definition of neglect by facility policy for 1 (#210) of 46 Stage II residents. A review of the facility census for 07/11/14, revealed 142 residents currently residing in the facility, according to the CMS Form 672.
The failure to identify, thoroughly investigate and report an allegation of neglect for a resident with a known history of exit seeking behaviors, resulted in findings of Immediate Jeopardy, which was on-going.

Findings include:

A review of the facility Abuse Protection and Response Policy, revised 05/12/14, documented the policy of the facility to be: " Abuse, as hereafter defined, will not be tolerated by anyone, including staff, residents, volunteers, family members or legal guardians, friends or any other individuals. The health center Administrator is

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responsible for assuring that resident safety, including freedom from risk of abuse, holds the highest priority. "
The document defined Neglect: " The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the resident. "
Section VII. Reporting and Response: Policy: " All allegations of possible abuse will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation. Procedure: Any investigation that substantiates abuse, neglect, or exploitation will be reported immediately to the Administrator and/or the Abuse Prevention Coordinator. It will also be reported to other officials, in accordance with State and Federal Law. "
Section A. The immediate Report: " All allegations of abuse, neglect, exploitation ...must be reported immediately or practicable. This allegation must be reported to the Abuse Hotline within immediately or practicable whenever an allegation is made.
The Abuse Prevention Coordinator will also submit the Agency for Health Care Administration AHCA Federal Immediate/ 5 day report ... "
Section B. The Report of Investigation (Five Day Report): " The facility Abuse Prevention Coordinator will send the result of the facility investigations to the State Survey Agency within five working days of the incident. "

Policy: " Trends of investigative findings will be analyzed and addressed by the QA and Risk Management committee process. "
Procedure: " An accurate summary reporting of

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al investigations conducted by the center will be maintained as a working document of the Quality Assessment and Risk Management Committees. QA and RM will review and analyze investigations to track and determine presence of any trends. "

During a review of the facility ' s adverse protocol, provided to the survey team on 07/10/14 at approximately 4:00 p.m. by the Administrator, he stated that the facility utilized the State requirements for adverse incidents. The paperwork that was provided was " Assisted Living Facility-How to Determine if an Incident is " Adverse " (400.423, F.S.), the document was not dated.
Review of the document presented, page 2 stated: Automatically defined as Adverse: Any one of the following is automatically defined as an " adverse incident " and must be reported on the 1-Day Adverse Incident Report to the Agency within one business day of the occurrence of the incident:
· Abuse, neglect or exploitation as defined in s.415.102, F.S., (Vulnerable Adult).
· Resident elopement (based on the facility ' s definition of elopement.)
· An event that is reported to law enforcement.
Continue the internal investigation and within 15 days of the occurrence of the incident and submit the completed 15 -day Adverse Incident Report.

During an interview conducted on 07/10/14 at approximately 11:00 a.m., the Administrator stated that he had investigated a 06/21/14 event regarding #210, but, had not documented the investigation. A letter was provided to the surveyor on 07/10/14 at approximately 4:00 p.m. which stated the following:

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"On 06/21/14 I received a call from the weekend supervisor that Resident #210 was brought back after leaving the facility for a brief time. I was informed that the patient was noted not to be in his room and the unit was searched. It was determined that a church group had left the unit and it was suspected that the resident may have left with the group. An immediate search of the facility was conducted and a call placed to the patients contact to determine if he/she took the patient out on a leave. The CNA, G initiated a search of immediate area and found the resident up the street. It was estimated the resident was out of the facility for 15 minutes.
When contacted by the supervisor I asked her to ask the patient several questions to determine if he is oriented. The supervisor asked the patient numerous questions, all of which he answered correctly. I asked the supervisor if she felt the patient was oriented and she felt that he was. I then asked her to check at the record to determine if incapacity was present. There was not incapacity on the chart. The resident ' s prior living arrangement was an ALF. I instructed the supervisor to notify the patient not to leave the facility without signing himself out and explain that we need to know his whereabouts. I also instructed the supervisor to monitor the patient closely and the resident gave permission to place a wander guard on him. I asked the supervisor to notify me if he made any attempts to leave the facility again without signing out. Based on the patient answering several questions correctly, the lack of physician incapacity, and the supervisor indicating he appeared to be oriented, I felt the patient left the facility without signing out as opposed to eloping.
In discussion with the supervisor and DON post

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incident it was suspected that the resident exited the unit with a church group who were visiting patients on the unit. The group had access to getting on and off the unit with an elevator key that was issued by the receptionist. The group had exited the unit at approximately the same time that the resident was known to have left the unit."

After review of the document, it was noted that the facility document indicated a different CNA, G, than the CNA who stated that she found the resident, CNA- D; the facility had no witness statements attached to the form; the facility had not reviewed the camera footage; the facility did not attempt to review the resident record to identify concerns; the facility did not identify lack of supervision; the facility did not identify an elopement as per their policy.

A review of Resident #210 ' s clinical chart revealed no documentation of the resident leaving the facility or that a search was conducted and the resident was found off of facility grounds next to a bus stop.

The facility is a 159 bed, three story facility. An observation conducted on 07/08/14, 07/09/14 and 07/10/14 of the 2nd floor, between the approximate hours of 9am to 4 p.m. revealed that the 2nd floor was accessed by staff utilizing a key for the elevator and to leave the 2nd floor staff were observed to escort residents and or families off the floor by utilizing a key to allow the elevator to be retrieved and so persons could exit the floor.

An observation was conducted on 07/11/14 at approximately 9:45 a.m., which included walking

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approximately 3 blocks from the facility grounds along 42nd Avenue South, turning and walking approximately 1 more block to a bus stop located next to 4th Street South, a 4 lane road with a middle turning lane. Traffic on the road was observed to be moderate with a posted speed limit of 35 mph. The bench located next to the road, approximately 20 feet from the road, was observed not to have trees or shade present, but open to full sun.

A review of temperature history for the St. Petersburg area for the date of 06/21/14 revealed a documented temperature of 89 degrees, and sunny.

A review of the internet, Nordevald Software & information services, print date of 07/21/2014, documented information about the Heat Index: The Heat Index is the " feels like, or apparent, temperature. As relative humidity increases, the air seems warmer than it actually is because the body is less able to cool itself via evaporation of perspiration. As the heat index rises, so do health risks. When the heat index is 90-105 degrees F., heat exhaustion is possible. When it is above 105 degrees F., it is probable. Heatstroke is possible when the heat index is above 105 degrees F., and very likely when it is 130 degrees F., and above. Physical activity and prolonged exposure to the heat increases the risks. "

A review of the Heat Index chart documented, if the air temperature was approximately 85-90 degrees F., and the humidity was between 75 and 80, the heat index=between 109 and 113, thus it " feels like " 109-113 degrees F.

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A review of the internet, About.com Florida travel and print date of 07/21/2014: " In Florida, more people die from excessive heat than from lightening. The human body temperature rises dangerously when hot days combine with high relative humidity, because perspiration cannot evaporate and cool the body. Elderly persons and small children, or persons on certain medications ...are particularly vulnerable to heat stress. "

Further, an observation, conducted on 7/10/2014 at approximately 12:00 p.m. of the facility location, at 435 42nd Avenue South, St. Petersburg, FL 33705, revealed that east of the facility, approximately 2 blocks, was a body of water, a channel between Big Bayou and Little Bayou. If a person were to walk East on the 42nd Avenue sidewalk, they could walk directly into the channel without having to enter any residential yard. The channel, when observed, looked to be approximately 600 yards across to the opposite side. The depth of the channel is unknown, but, observations of boats docked at the sides of the channel revealed various sized boats of average size of approximately 20-30 feet in length.

An interview attempt was conducted on 07/09/2014 10:33 AM with Resident #210. Resident #210 was not able to answer the questions. Resident was dressed for the day; laying on a bed that was made up; watching TV. Resident stated that he had no concerns; but, he appeared to search for answers when asked specific questions. Resident #210 was observed to be currently residing on the 2nd floor of the facility, the secure unit.

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A review of Resident #210 ' s MDS. Section C-Cognitive Patterns, 5 day Admission information, documented Brief Interview for Mental Status, (BIMS) which was electronically signed as completed on 06/28/14; Resident #210 ' s score was " 9 " , which reflected moderate impairment.

A review of the admission record documented that the original admission date for Resident #210 was 06/20/14; diagnoses included: " other specified rehabilitation procedure; late effects of cerebrovascular disease; alcohol-induced persisting dementia; other persistent mental d/o due conds clase elsw; unspecified essential hypertension; altered mental status. "
The Admission record documented that the resident was admitted from a nursing home.

A review of the Resident Transfer form located in Resident #210 ' s clinical chart on 07/10/14 and reviewed, documenting a date of transfer of 06/20/14, signed by an LPN on 06/20/14, documenting the receiving facility to be St. Pete Rehab, documented additional pertinent information: " Ambulates ad lib, Exit seeking can be redirected-Resident very confused to time, place. Resident does use toilet, but has occasional incontinence of bladder; Resident has good appetite and takes fluids well. "
Further review of the form, documented that the resident was transferred from a " sister " facility, i.e. a facility that was owned by the same corporation.
The form documented that the resident had a hospital stay within the last 60 days.
The diagnoses at the time of transfer-"AMS (Altered Mental Status); secondary: Late effects

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CVA."
The form documented the potential for rehabilitation was " poor " .
The form documented that Resident #210 had " Mental " impairments.
The form documented the following medications at the time of discharge:
Xanax, 0.5 mg bid.
Norvasc, 5 mg hs.
ASA, 325 mg daily
Lisinopril, 10mg daily
Multi-vitamin with minerals, 1 tab daily.
Flomax, 0.4mg hs
Namenda xR, 14mg, hs x 5 days then; Namenda xR, 21 mg hs x 7 days until July 1st; Namenda XR, 28 mg hs , starts July 2nd, B/P weekly on Friday, 7am-3pm.
The form documented that the mental status of the resident was " alert " and " confused " .

A visit to the named sister facility from which Resident #210 was transferred from on 06/20/14 to the current facility was conducted on 07/10/14 at 7:15 p.m. for the purpose of reviewing Resident #210 ' s record.

An interview was conducted on 07/10/14 at 7:23 p.m. with the facility Administrator. He confirmed that he initiated the transfer for Resident #210. He confirmed that Resident #210 was exit seeking during his stay. He stated that the resident would appear to be of the ability to make decisions and then at other times he did not. He stated that he was not sure if the receiving facility knew that the resident was exit seeking; he talked to a woman in Admissions at the facility, though he was not sure of her name. He stated that he sent the paperwork over, the H & P, the psych notes and the medication list for the resident. He

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stated that he was unaware if the receiving facility nurse called for any further details about the resident.

A review of a physician ' s telephone order, (p.t.o.), dated 06/20/14, signed by the physician, documented: " order received transfer resident to St. Petersburg Rehabilitation; needs secure unit. "

An interview was conducted on 07/11/14 at 7:10 a.m. via phone with Staff Member C (RN C), a Registered Nurse (RN), she confirmed that she was working as the " House Supervisor " for the facility on 06/21/14, she stated that she was called over the intercom by a nurse on the 2nd floor, she believed that the nurse that called her was Staff Member F, a Licensed Practical Nurse (LPN) that was working on the 2nd floor. Staff member C, RN stated that LPN, F, called to tell her that she could not find Resident # 210. RN, C, further stated that a room to room search of the 2nd floor had been conducted and that a search was in progress for the 1st and 3rd floor. RN, C, stated that she called the Director of Nursing (DON), who instructed her to call the Administrator, which she did. RN, C, stated that staff started to look outside and meanwhile she called Resident #210 ' s emergency contact (EC) to check to seek if the EC had visited and taken Resident #210 out. Per the RN, C, the EC informed her that he had not taken the resident out of the building. RN, C, stated that meantime, she estimated that approximately 15 minutes had elapsed and that a staff member had found Resident #210 down the road. RN, C, stated that she could not remember who the staff member was that found the resident, but that the staff member came back and gave the resident something to drink and offered the resident

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something to eat. RN, C, stated that Resident #210 told her he wanted to walk home. RN, C, stated that she informed the resident about signing out when he left the building; RN, C, stated that Resident #210 said he understood. RN, C, stated that she asked Resident #210 a series of questions and that he answered all the questions properly. RN, C, stated that she assessed him and asked the resident if she could supply him with a wander guard. RN, C, stated that Resident #210 said " ok " to the wander guard. RN, C, stated that she did not call the doctor about the event. " Honestly, I do not remember if I did or not, I would have to look at the chart. " RN, C, stated that once we located him, we stopped the phone calls. RN, C, stated " I was not working on Friday " , 06/20/14, when Resident #210 was admitted. I do not know what the set of circumstances were before that (at admission.) " Thinking it was that he left the 2nd floor, I do not know " how he was able to leave. " I do not know if he eats on the 2nd floor. " " No training since this happened in regards to a resident at risk for wandering and precautions to take. "

RN, C was asked: " How did he get off the 2nd floor? " She replied: " I do not know how he got off the 2nd floor unit. " " That would have to be investigated. "

RN, C was asked: " Were you aware he was exit seeking at admission? " She replied: " No " , I was not directly assigned to the resident. She further stated that " not every patient on the 2nd floor needs supervision. "

RN, C was asked: " How does staff know which residents are wanderers or exit seeking? " She replied: " it comes with staff knowing the resident. " " The 2nd floor is an Alzheimer ' s unit; I am not too familiar with the residents on

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that floor. " " I do not know what the process is to understand which residents are wanderers or exit seeking. "
RN, C was asked: " The facility uses Agency staff members, how do these staff members know which residents are at risk for wandering? "
RN, C, replied: " I do not know. "
RN, C, confirmed that Resident #210 was " missing " during 06/21/14 and that the Elopement Protocol was initiated.
RN, C, was asked why the event was not documented in Resident #210 ' s clinical chart, the nursing notes or anywhere else. RN, C, replied: " I do not know why a person did not enter the information into the clinical chart.
RN, C, stated that " If I have a resident that I am giving medication to and he is missing, I have a concern. "
Did you know at admission he was a wander risk or exit seeking? RN, C, replied: " I did not know he was identified as a wander risk. " She further stated that she did not know the location of the resident when he was found. She stated he was " hot " when he came back. Not sure of the staff member that found him.
RN, C was asked " Why was a Wander tool completed on the resident on 06/23/14? " RN, C, replied: " I do not know why the Wander tool was done. I believe that is done on admission, I would have to be instructed as to what the process is. Do not know why the Wander tool was not done at admission. "

No nurses notes were present or located documenting information about the resident on 06/20/14 thru the first entry of 06/21/14 at 4:10 p.m.

A review of Resident #210 ' s clinical chart

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revealed Narrative nurses notes, entered 06/21/14 at 4:40 p.m.: " No acute distress. Alert with some confusion noted. Head to toe skin check done this shift without areas of mention noted. Ambulating ad lib frequently in corridor, re-directed when observed entering into others rooms. Appetite good consumed 75% of meals served this shift, meals served in room. VS 138/64-98.4-20-82."
Further review of Resident #210 ' s clinical chart revealed no nurses notes for 06/20/14, no additional notes on 06/21/14 that would document the unauthorized exit from the 2nd floor, building, or facility grounds.
No documentation on 06/21/14 was present regarding any communication with Resident #210 ' s physician.
No documentation was present on 06/21/14 regarding any additional measures or monitoring that the facility was taking to ensure the safety of the resident who had just eloped from the facility.

06/22/14 at 6:47 a.m. , nurses notes: " Resident #210 alert with periods of confusion, no s/s of pain or discomfort, rested in bed most of the shift, up out of bed at 4 am walking in the hallways, stopping for short periods of times , standing at the back elevator, exit seeking; encouraged to return to his room by staff, resident returned to room, wander guard in place to LLE on q 15 min, resident in bed, eyes closed, resting quietly, no distress noted. "

An interview conducted on 07/11/14 at 9:45 a.m. with Staff Member D, a Certified Nursing Assistant (CNA), she confirmed that she had been working for the facility approximately 2 years. She confirmed that she was working on

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F 225	Continued From page 42 06/21/14 on the 2nd floor during the 7am-3pm shift and that on that day; she was supposed to clock out at 1:00 p.m. for the end of her shift. Staff Member D stated that a Restorative Aid came to the floor and asked for Resident #210, she stated that this was some time after lunch, possibly around 12 or 12:30 p.m. Staff Member D stated that it was at this time that she could not locate Resident #210 and that a room to room search on the 2nd floor was initiated. She stated that the search for the resident was expanded to include the other 2 floors and then the facility grounds. She stated that when Resident #210 was not located in the facility or on the facility grounds, the search was expanded to areas close by the facility. Staff Member D stated that she found Resident #210 at a bus stop. She stated that Resident #210 stated that he was trying to go home. She stated that Resident #210 looked tired and that she was able to encourage him to walk back to the facility, she stated that he was sweaty, that she helped him to change his clothes, gave him water and offered him food to eat. Staff member D stated that she clocked out of the facility after finding the resident at 1:29 p.m. Staff member D stated that she did not know that Resident #210 was a wander risk. A review of the facility Wandering, Unsafe Resident policy and procedure, revised 11/2010, documented the policy Statement : " The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. " The Policy Interpretation and Implementation: 1. " The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement).	F 225		

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2. The staff will assess at -risk individuals for potentially correctible risk factors related to unsafe wandering.
3. The resident ' s care plan will indicate the resident is at risk for elopement or other safety issues.
4. Interventions to try to maintain safety will be included in the resident ' s care plan.
5. Nursing staff will document circumstances related to unsafe actions, including wandering by a resident.
6. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior.
7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility. "

A review of the facility Elopement policy and procedure, revised 04/2010, documented the policy statement: " Staff shall investigate and report all cases of missing residents. "
The Policy Interpretation and Implementation:
1. " Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.
2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises.
3. When a departing individual returns to the

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facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Notify the Attending Physician.
4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on a leave or pass; b. If the resident was not on leave/pass, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services; d. If the resident is incapacitated notify the resident ' s representative and law enforcement; e. Provide search teams with resident identification information; and f. Initiate an extensive search of the surrounding area.
5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. notify the resident ' s legal representative (sponsor); d. Notify search teams that the resident has been located. "

An interview was completed on 07/10/14 at 11:03 a.m. with the Director of Nurses (D.O.N.). She stated that, sometimes, she will place a resident on the 2nd floor; if the bed situation warrants it. For example if they have no male beds on the 3rd floor. She stated that the 1st floor is for Medicare. Resident # 210 was placed on the 2nd floor due to the lack of beds on the other floors. If he started showing the behaviors of exit seeking; they will call me and alert me; they will call the doctor and let them; immediately means within the hour; I would expect that they would call the doctor within the hour; they would have to get permission from me to put a wander guard on the resident; they would complete a wander

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assessment to determine if he is high risk. Incapacitated means that they cannot make safe decisions for their everyday living; medical needs. I believed that he (Resident #210) could make safe decisions in regards to his medical needs and his everyday living; Today, I do not believe that he can make safe decisions; there has been a change, from my observations of him. I was here on Friday , date of admission; he was walking, talking and continent of bowel and bladder. Now he does not walk around as much; he is in therapy; he just does not do as much as he did when he came in. I do not think he can make decisions; when I ask him a question, he can answer. The DON confirmed that no event report was conducted in regards to the event that transpired on 06/21/14 with Resident #210 when he went missing from the facility. She stated that he did not sign out. " The resident left the facility; he was missing; they did not know where he went. " But, it was not an elopement. " No we did not call the police " . I did not complete an investigation for the event. We did not consider him an elopement. He was a couple of blocks down sitting on the bench.

In an interview conducted with a physician from Resident #210 ' s primary physician group, on 07/10/14 at 12:41 p.m., he stated he had been seeing the residents at the facility for approximately 1-2 weeks. He stated that he was familiar with Resident #210, that he had visited him 2 times since he had started at the building. He stated that the other doctor, (primary) had seen him earlier. He stated that he was not aware of the resident leaving the facility unsupervised. He stated that he would make some phone calls to other members in the group to find out if they were aware of the concern. He

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stated that the resident, when he talks to him, stays grumpy and irritable. The resident does not seem aware; he has met him 2 times; he stated that he would suggest that the resident does not have capacity. We should document when the facility calls and notifies us of an event like this. (Follow up call was received from this doctor the following day. He confirmed that the resident ' s physician practice had no knowledge of the resident unauthorized exit from the facility on 06/21/14).

An interview was conducted on 07/11/14 at 4:20 p.m. with the Medical Director for the building. He stated that he had been the Medical Director for approximately 2 years. The Medical Director was asked if facility staff were responsible to call and inform him of an unauthorized exit from the building by a resident, a resident that was found approximately 3 blocks from the facility. He stated that usually they would call; he stated that that he was not aware of a phone call regarding Resident #210 leaving the facility (unauthorized) on 06/21/14. But, he said he would check with his answering service, they may have knowledge of the phone call. (The Medical Director followed up with this conversation on 07/11/14 at 6:55 p.m. to confirm that no phone call had been placed to him or his answering service regarding Resident #210 ' s event on 06/21//14.) The Medical Director stated that he would want to know about an event like this. The Medical Director stated that the 2nd floor of the facility was a secure unit, that it typically meant the residents needed extra supervision.
The Medical Director stated that if someone is not deemed incompetent by paperwork that does not mean competency.
" I would expect that an event of an unauthorized

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F 225	Continued From page 47 departure from the facility would be investigated. " The Medical Director was given an example of a resident coming to the facility with a transfer form that states the resident is " exit seeking " , the resident is placed on the 2nd floor of this facility; the resident goes missing the day after admission; staff implement the elopement protocol and the resident is found approximately 3 blocks away from the facility. Is that an elopement? Medical Director stated: " yes, it is. " A review of the Agency system on 07/18/14, to review for submission of allegations of abuse or neglect by the facility and discuss with the central office unit which receives such reports, revealed that since 06/19/14 no events had been reported to the State or Federal Agency regarding the events surrounding Resident #210 ' s elopement from facility, lack of supervision, or lack of provision of care and services for Resident #210.	F 225		
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident record review, observations, interviews and review of facility policies and procedures, it was determined that the facility failed to implement its policy and procedure related to Abuse Protection and Response Policy	F 226		

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for failure to provide the goods and services for oversight of residents identified as elopement risks for 3 (#210, 211, and 212) 46 Stage II sampled residents of 142 residents.
The facility failed to follow its policy and procedure related to the facility definition of neglect.
The facility failed to prevent neglect by not identifying and communicating to direct care staff the " exit seeking behavior " of Resident #210 that made him a risk for unsafe wandering.
The facility failed to ensure supervision to prevent unsafe wandering for Resident #210.
The facility failed to identify a " missing " resident, #210, as an Elopement.
Additionally, the facility failed to implement its policy and procedure for investigating and reporting all allegations of abuse immediately to the abuse hotline and the state agency related to Resident #210 ' s elopement.
In addition, the facility failed to ensure that services were provided in accordance with the physician written plan of care for 2 (#211 and 212) of 46 Stage II sampled residents. For Resident #211 and 212, the facility failed to implement a wander guard order for placement and to check functioning of the wander guards every shift which potentiates neglect.
Failure to follow and implement policies and procedures put in place to ensure the safety and protection of residents, resulted in findings of Immediate Jeopardy, which is on-going.

Findings include:

1. A review of the facility Abuse Protection and Response Policy, revised 05/12/14, documented the policy of the facility to be: " Abuse, as hereafter defined, will not be tolerated by anyone,

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including staff, residents, volunteers, family members or legal guardians, friends or any other individuals. The health center Administrator is responsible for assuring that resident safety, including freedom from risk of abuse, holds the highest priority. "
The document defined Neglect: " The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the resident. "
Section VII. Reporting and Response: Policy: " All allegations of possible abuse will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation. Procedure: Any investigation that substantiates abuse, neglect, or exploitation will be reported immediately to the Administrator and/or the Abuse Prevention Coordinator. It will also be reported to other officials, in accordance with State and Federal Law. "
Section A. The immediate Report: " All allegations of abuse, neglect, exploitation ...must be reported immediately or practicable. This allegation must be reported to the Abuse Hotline (Adult protective Services) within immediately or practicable whenever an allegation is made.
The Abuse Prevention Coordinator will also submit the Agency for Health Care Administration AHCA Federal Immediate/ 5 day report ... "
Section B. " The Report of Investigation (Five Day Report): The facility Abuse Prevention Coordinator will send the result of the facility investigations to the State Survey Agency within five working days of the incident. "

Policy: " Trends of investigative findings will be

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analyzed and addressed by the QA and Risk Management committee process. "
Procedure: " An accurate summary reporting of all investigations conducted by the center will be maintained as a working document of the Quality Assessment and Risk Management Committees. "
" QA and RM will review and analyze investigations to track and determine presence of any trends. "

2. An attempt to interview Resident #210 was conducted on 07/09/14 at 10:33 a.m. The Resident was not able to answer the questions. Resident #210 was dressed for the day; laying on a bed that was made up; watching TV. Resident #210 stated that he had no concerns; but, he appeared to search for answers when asked specific questions. Resident #210 was observed to be currently residing on the 2nd floor of the facility, the secure unit.

A review of Resident #210 ' s MDS. Section C-Cognitive Patterns, 5 day Admission information, documented Brief Interview for Mental Status, (BIMS) which was electronically signed as completed on 06/28/14; Resident #210 ' s score was " 9 " , which falls in the range of moderate impairment.
An interview was conducted on 07/08/14 at 12:52 p.m. with LPN, F. She confirmed that she was working during 06/21/14 on the 2nd floor. " He left the facility, he did not sign out " . " One of the care aids located him, sitting at the bus stop a couple of blocks up " , Staff member D, C.N.A., that found the resident. "

A review was completed of the nurse ' s notes, with LPN, F. She confirmed that the

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progress notes did not document the resident leaving the facility un-supervised on 6/21/2014 within 24 hours of admission. Review of the note for 06/21/14 which documented her assessment of the resident found she did not call the doctor; " he has a friend; he is his own person-would be no family to call. " She further stated that right before lunch time he was noticed missing. He was found during the lunch period. She estimated the time resident #210 was missing to be 30 minutes. " We did a room to room search; immediate grounds search; if the resident is not located, then the search is extended to the area surrounding the facility; that is when he was located at the bus stop. It was warm out that day. (The resident said, I will never do that again, it was hot out there). His skin looked fine.
We have several people that live on the floor that just live here. He is own person; he can make decision on whether he wants to go or not. Any new admission they do an elopement risk screening. "

A review of Resident #210 ' s clinical chart revealed no nurses notes were present documenting information about the resident ' s admission on 06/20/14 thru the first entry of 06/21/14 at 4:10 p.m.

A review of Resident #210 ' s clinical chart revealed Narrative nurses notes, entered 06/21/14 at 4:40 p.m.: " No acute distress. Alert with some confusion noted. Head to toe skin check done this shift without areas of mention noted. Ambulating ad lib frequently in corridor, re-directed when observed entering into others rooms. Appetite good consumed 75% of meals served this shift, meals served in room. VS 138/64-98.4-20-82. "

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Further review of Resident #210 ' s clinical chart revealed no additional notes on 06/21/14 that would document the unauthorized exit from the 2nd floor, building, or facility grounds, i.e. unsafe wandering.

Further, there was no documentation on 06/21/14 was present regarding any communication with Resident #210 ' s physician.

No documentation was present on 06/21/14 regarding any additional measures or monitoring that the facility was taking to ensure the safety of the resident who had just eloped from the facility.

An interview conducted on 07/11/14 at 9:45 a.m. with Staff Member D, a Certified Nursing Assistant (CNA), she confirmed that she had been working for the facility approximately 2 years. She confirmed that she was working on 06/21/14 on the 2nd floor during the 7am-3pm shift and that on that day; she was supposed to clock out at 1:00 p.m. for the end of her shift. Staff Member D stated that a Restorative Aid came to the floor and asked for Resident #210, she stated that this was some time after lunch, possibly around 12 or 12:30 p.m.. Staff Member D stated that it was at this time that she could not locate Resident #210 and that a room to room search on the 2nd floor was initiated. She stated that the search for the resident was expanded to include the other 2 floors and then the facility grounds. She stated that when Resident #210 was not located in the facility or on the facility grounds, the search was expanded to areas close by the facility. Staff Member D stated that she found Resident #210 at a bus stop. She stated

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that Resident #210 stated that he was trying to go home. She stated that Resident #210 looked tired and that she was able to encourage him to walk back to the facility, she stated that he was sweaty, that she helped him to change his clothes, gave him water and offered him food to eat. Staff member D stated that she clocked out of the facility after finding the resident at 1:29 p.m. Staff member D stated that she did not know that Resident #210 was a wander risk.

An observation was conducted on 07/11/14 at approximately 9:45 a.m., which included walking west approximately 3 blocks from the facility grounds along 42nd Avenue South, turning and walking approximately 1 more block to a bus stop located next to 4th Street South, a 4 lane road with a middle turning lane. Traffic on the road was observed to be moderate with a posted speed limit of 35 mph. The bench located next to the road, approximately 20 feet from the road, was observed not to have trees or shade present, but open to the full sun.
A review of the internet, (print date of 07/21/14), weather history for the St. Petersburg area for the date of 06/21/14 revealed an average maximum temperature of 89 degrees Fahrenheit, maximum humidity rate of 79, wind speed of 7 m.p.h. and sunny.

A review of the internet, Nordevald Software & information services, print date of 07/21/2014, and documented information about the Heat Index: The Heat Index is the " feels like, or apparent, temperature. As relative humidity increases, the air seems warmer than it actually is because the body is less able to cool itself via evaporation of perspiration. As the heat index

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rises, so do health risks. When the heat index is 90-105 degrees F., heat exhaustion is possible. When it is above 105 degrees F., it is probable. Heatstroke is possible when the heat index is above 105 degrees F., and very likely when it is 130 degrees F., and above. Physical activity and prolonged exposure to the heat increases the risks. "

A review of the Heat Index chart documented if the air temperature is approximately 85-90 degrees F., and the humidity is between 75 and 80, the heat index=between 109 and 113, thus it " feels like " 109-113 degrees F.

A review of the internet, About.com Florida travel and print date of 07/21/2014: " In Florida, more people die from excessive heat than from lightening. The human body temperature rises dangerously when hot days combine with high relative humidity, because perspiration cannot evaporate and cool the body. Elderly persons and small children, or persons on certain medications ...are particularly vulnerable to heat stress. "

Further, an observation, conducted on 7/10/2014 at approximately 12:00 p.m. of the facility location, at 435 42nd Avenue South, St. Petersburg, FL 33705, revealed that east of the facility, approximately 2 blocks, was a body of water, a channel between Big Bayou and Little Bayou. If a person were to walk East on the 42nd Avenue sidewalk, they could walk directly into the channel without having to enter any residential yard. The channel, when observed, looked to be approximately 600 yards across to the opposite side. The depth of the channel is unknown, but, observations of boats docked at the sides of the

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channel revealed various sized boats of average size of approximately 20-30 feet in length.

A review of a Rehabilitation Center of St. Petersburg, brochure, non-dated, tri-fold, advertised that the facility provides a " Secure Floor and divisions. " Despite this, the C.M.S. Form 671, " Long Term Care Application for Medicare and Medicaid, " dated 7/8/14, indicated that the facility had no dedicated special care units.

A review of the facility license documented that the facility is licensed to provide services for 159 beds.

The facility is a three story facility. An observation conducted on 07/08/14, 07/09/14 and 07/10/14 of the 2nd floor, between the approximate hours of 9am to 4 p.m. revealed that the 2nd floor was accessed by staff utilizing a key for the elevator and to leave the 2nd floor staff were observed to escort residents and or families off the floor by utilizing a key to allow the elevator to be retrieved and so persons could exit the floor.

A review of the facility census for the 2nd floor, for the date of 07/11/14, revealed a total of 61 beds located on the 2nd floor (secured division of the facility.) A further review of the census document revealed that 56 residents were residing on the 2nd floor on 07/11/14; 3 of the residents were identified by facility staff as not needing the secured unit; thus 53 of the remaining residents were identified to need the secure unit.

During an interview conducted on 07/10/14 at

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approximately 11:00 a.m., the Administrator stated that he had investigated the 06/21/14 event regarding #210, but, had not documented the investigation. A letter was provided to the surveyor on 07/10/14 at approximately 4:00 p.m. which stated the following:

" On 06/21/14 I received a call from the weekend supervisor that Resident #210 was brought back after leaving the facility for a brief time. I was informed that the patient was noted not to be in his room and the unit was searched. It was determined that a church group had left the unit and it was suspected that the resident may have left with the group. An immediate search of the facility was conducted and a call placed to the patients contact to determine if he/she took the patient out on a leave. The CNA, G initiated a search of immediate area and found the resident up the street. It was estimated the resident was out of the facility for 15 minutes.
When contacted by the supervisor I asked her to ask the patient several questions to determine if he is oriented. The supervisor asked the patient numerous questions, all of which he answered correctly. I asked the supervisor if she felt the patient was oriented and she felt that he was. I then asked her to check at the record to determine if incapacity was present. There was not incapacity on the chart. The resident ' s prior living arrangement was an ALF. I instructed the supervisor to notify the patient not to leave the facility without signing himself out and explain that we need to know his whereabouts. I also instructed the supervisor to monitor the patient closely and the resident gave permission to place a wander guard on him. I asked the supervisor to notify me if he made any attempts to leave the facility again without signing out. Based on the

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patient answering several questions correctly, the lack of a physician incapacity, and the supervisor indicating he appeared to be oriented, I felt the patient left the facility without signing out as opposed to eloping.
In discussion with the supervisor and DON post incident it was suspected that the resident exited the unit with a church group who were visiting patients on the unit. The group had access to getting on and off the unit with an elevator key that was issued by the receptionist. The group had exited the unit at approximately the same time that the resident was known to have left the unit. "

Observations were conducted on 07/08, 07/09 and 07/10/14 of the facility during the survey process at which time camera apparatuses were observed in place on the 1st, 2nd, and 3rd, floor hallways of the facility.

An interview was conducted on 07/11/14 at 2:30 p.m. with the Administrator; he was asked if he or anyone had reviewed the facility cameras to try to determine how the resident had gotten off of the 2nd floor and how he was able to leave the building unauthorized. The Administrator stated: " I did not think to look at the camera " footage.

An interview conducted on 07/10/14 at 11:03 a.m. with the DON. She stated that, sometimes, she will place a resident on the 2nd floor; if the bed situation warrants it. For example if they have no male beds on the 3rd floor. She stated that the 1st floor is for Medicare. Resident # 210 was placed on the 2nd floor due to the lack of beds on the other floors.
If he started showing the behaviors of exit seeking; they will call me and alert me; they will

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call the doctor and let them; immediately means within the hour; I would expect that they would call the doctor within the hour; they would have to get permission from me to put a wander guard on the resident; they would complete a wander assessment to determine if he is high risk. Incapacitated means that they cannot make safe decisions for their everyday living; medical needs. I believe that he (Resident #210) can make safe decisions in regards to his medical needs and his everyday living; Today, I do not believe that he can make safe decisions; there has been a change, from my observations of him (I was here on Friday , date of admission; he was walking, talking and continent of bowel and bladder.) Now he does not walk around as much; he is in therapy; he just does not do as much as he did when he came in. I do not think he can make decisions; when I ask him a question, he can answer. The DON confirmed that no event report was conducted in regards to the event that transpired on 06/21/14 with Resident #210 when he went missing from the facility. She stated that he did not sign out. " The resident left the facility he was missing; they did not know where he went. " But, it was not an elopement. " No we did not call the police " . I did not complete an investigation for the event. We did not consider him an elopement. He was a couple of blocks down sitting on the bench.

An interview conducted on 07/11/14 at 7:10 a.m. via phone with Staff Member C (RN C), a Registered Nurse (RN), confirmed that she was working as the " House Supervisor " for the facility on 06/21/14. She stated that she was called over the intercom by a nurse on the 2nd floor. She believed that the nurse that called her was Staff Member F, a Licensed Practical Nurse

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(LPN) that was working on the 2nd floor. Staff member C, RN stated that LPN, F, called to tell her that she could not find Resident # 210. RN, C, further stated that a room to room search of the 2nd floor had been conducted and that a search was in progress for the 1st and 3rd floor. RN, C, stated that she called the Director of Nursing (DON), who instructed her to call the Administrator, which she did. RN, C, stated that staff started to look outside and meanwhile she called Resident #210 ' s emergency contact (EC) to check to seek if the EC had visited and taken Resident #210 out. Per the RN, C, the emergency contact informed her that he had not taken the resident out of the building. RN, C, stated that, meantime, she estimated that approximately 15 minutes had elapsed and that a staff member had found Resident #210 down the road. RN, C, stated that she could not remember who the staff member was that found the resident, but that the staff member came back and gave the resident something to drink and offered the resident something to eat. RN, C, stated that Resident #210 told her he wanted to walk home. RN, C, stated that she informed the resident about signing out when he left the building; RN, C, stated that Resident #210 said he understood. RN, C, stated that she asked Resident #210 a series of questions and that he answered all the questions properly. RN, C, stated that she assessed him and asked the resident if she could supply him with a wander guard. RN, C, stated that Resident #210 said " ok " to the wander guard. RN, C, stated that she did not call the doctor about the event. " Honestly, I do not remember if I did or not, I would have to look at the chart. " RN, C, stated that once we located him, we stopped the phone calls. RN, C, stated " I was not working on

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Friday " , 06/20/14, when Resident #210 was admitted. I do not know what the set of circumstances were before that (at admission.) " Thinking it was that he left the 2nd floor, I do not know " how he was able to leave. " I do not know if he eats on the 2nd floor. " " No training since this happened in regards to a resident at risk for wandering and precautions to take. "
RN, C was asked: " How did he get off the 2nd floor? " She replied: " I do not know how he got off the 2nd floor unit. " " That would have to be investigated. "
RN, C was asked: " Were you aware he was exit seeking at admission? " She replied: " No " , I was not directly assigned to the resident. She further stated that " not every patient on the 2nd floor needs supervision. "
RN, C was asked: " How does staff know which residents are wanderers or exit seeking? " She replied: " it comes with staff knowing the resident. " " The 2nd floor is an Alzheimer ' s unit; I am not too familiar with the residents on that floor. " " I do not know what the process is to understand which residents are wanderers or exit seeking. "
RN, C was asked: " The facility uses Agency staff members, how do these staff members know which residents are at risk for wandering? "
RN, C, replied: " I do not know. "
RN, C, confirmed that Resident #210 was " missing " during 06/21/14 and that the Elopement Protocol was initiated.
RN, C, was asked why the event was not documented in Resident #210 ' s clinical chart, the nursing notes or anywhere else. RN, C, replied: " I do not know why a person did not enter the information into the clinical chart.
RN, C, stated that " If I have a resident that I am giving medication to and he is missing, I have a

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concern. "
Did you know at admission he was a wander risk or exit seeking? RN, C, replied: " I did not know he was identified as a wander risk. " She further stated that she did not know the location of the resident when he was found. She stated he was " hot " when he came back. Not sure of the staff member that found him.
RN, C was asked " Why was a Wander tool completed on the resident on 06/23/14? " RN, C, replied: " I do not know why the Wander tool was done. I believe that is done on admission, I would have to be instructed as to what the process is. Do not know why the Wander tool was not done at admission. "

An interview conducted with a physician on 07/10/14 at 12:41 p.m., who had been seeing the residents at the facility for approximately 1-2 weeks. He stated that he is familiar with Resident #210, that he had visited him two times since he had started at the building. He stated that the other doctor, (primary) might have seen him earlier. He stated that he was not aware of the resident leaving the facility unsupervised. He stated that he would make some phone calls to other members in the group to find out if they were aware of the concern. He stated that the resident, when he talks to him, stays grumpy and irritable. The resident does not seem aware; he has met him 2 x; he stated that he would suggest that the resident does not have capacity. (This doctor called back on 07/11/14 and informed the surveyor that the physician group office was unaware of the event that occurred on 06/21/14 for Resident #210.)

A review of the facility Wandering, Unsafe Resident policy and procedure, revised 11/2010,

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documented the policy Statement : The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.

The Policy Interpretation and Implementation:
1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement).
2. The staff will assess at -risk individuals for potentially correctible risk factors related to unsafe wandering.
3. The resident ' s care plan will indicate the resident is at risk for elopement or other safety issues.
4. Interventions to try to maintain safety will be included in the resident ' s care plan.
5. Nursing staff will document circumstances related to unsafe actions, including wandering by a resident.
6. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior.
7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility.

A review of Resident #210 ' s clinical chart was completed. A local hospital History and physical, dated 06/02/14, indicated, " This is a 64 year old male with PM Hx of HTN, chronic alcoholic encephalopathy, alcohol abuse hx, who was brought by EMS from ALF (name) for disorderly behavior and agitation. Per records, last alcohol about 2 days ago, pt was not suicidal on admission in ER. In ED, ... A couple of

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months ago he was admitted to (local hospital), where he was diagnosed with CVA, his dementia/Aims was worked up and he was noted to have chronic alcoholic encephalopathy. Currently, pt denies c/o palpitations/ dyspnea/ abd paid/ ...Pt admits to R ankle pain and R shoulder pain which are new, he cannot remember how he got the trauma.

A review of the admission record for Resident #210 documented that the original admission date for the present facility was 06/20/14; diagnoses included: other specified rehabilitation procedure; late effects of cerebrovascular disease; alcohol-induced persisting dementia; other persistent mental d/o due conds clase elsw; unspecified essential hypertension; altered mental status. Further review of the admission record documented that the resident was admitted from a nursing home.

A review of the Resident Transfer form located in Resident #210 ' s clinical chart on 07/10/14 and reviewed, documenting a date of transfer of 06/20/14, signed by an LPN on 06/20/14, documenting the receiving facility to be St. Pete Rehab, documented additional pertinent information: " Ambulates ad lib, Exit seeking can be redirected-Resident very confused to time, place. Resident does use toilet, but has occasional incontinence of bladder; Resident has good appetite and takes fluids well. "
Further review of the form, documented that the resident was transferred from a " sister " facility, i.e. a facility that was owned by the same corporation.
The form documented that the resident had a hospital stay within the last 60 days.
The diagnoses at the time of transfer-AMS

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(Altered Mental Status); secondary: Late effects CVA.
The form documented the potential for rehabilitation was " poor " .
The form documented that Resident #210 had " Mental " impairments.
The form documented the following medications at the time of discharge:
Xanax, 0.5 mg bid.
Norvasc, 5 mg hs.
ASA, 325 mg daily
Lisinopril, 10mg daily
Multi-vitamin with minerals, 1 tab daily.
Flomax, 0.4mg hs
Namenda xR, 14mg, hs x 5 days then; Namenda xR, 21 mg hs x 7 days until July 1st; Namenda XR, 28 mg hs , starts July 2nd, B/P weekly on Friday, 7am-3pm.
The form documented that the mental status of the resident was " alert " and " confused " .

Entrance to the Sister facility was conducted on 07/10/14 at 7:15 p.m. for the purpose of reviewing Resident #210 ' s record.

An interview was conducted on 07/10/14 at 7:23 p.m. with the sister facility Administrator. He confirmed that he initiated the transfer for Resident #210. He confirmed that Resident #210 was exit seeking during his stay. He stated that the resident would appear to be of the ability to make decisions and then at other times he did not. He stated that he was not sure if the receiving facility knew that the resident was exit seeking; he talked to a woman in Admissions at the facility, though he was not sure of her name. He stated that he sent the paperwork over, the H & P, the psych notes and the medication list for the resident. He stated that he was unaware if

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the receiving facility nurse called for any further details about the resident.

A review of the " Recapitulation of Resident stay " form from the originating facility for Resident #210 was conducted. The Nursing recapitulation included the following information: " ambulates ad lib-exit seeking-can be redirected-co-op with staff. Makes some needs known-good appetite, takes fluids well/ skin w/d to touch intact " , signed by an LPN, with date of discharge documented to be 06/20/14.

A review of the Resident Transfer form, documenting a date of transfer of 06/20/14, signed by an LPN on 06/20/14, documenting the receiving facility to be St. Pete Rehab, documented additional pertinent information: " Ambulates ad lib, Exit seeking can be redirected-Resident very confused to time, place. Resident does use toilet, but has occasional incontinence of bladder; Resident has good appetite and takes fluids well. "

A review of a physician ' s telephone order, (p.t.o.), dated 06/20/14, signed by the physician, documented: " order received transfer resident to St. Petersburg Rehabilitation; needs secure unit. "

A review of a p.t.o., dated 06/06/14, signed by the physician, documented: " wander guard for safety, check placement every shift; check wander guard function weekly on Wednesday 7-3 shift. "

A review of nursing notes:
Dated 06/12/14: Resident requires frequent monitoring and use of wander guard for safety has been observed testing all doors and

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wandering others rooms.
Dated 06/18/14: Resident has been alert with confusion. He ambulates the unit independently and ...
He does test the doors most of the evening and is easily redirected.
Dated 06/19/14: Resident has been exit seeking and returned to unit after going thru doors to parking lot and continues to look for ways to leave.
Dated 06/20/14: Resident discharged to SNF. Care ride driver pick up resident. All paperwork with resident and driver.
A review of Social Service Progress notes, dated 06/20/14: " Resident transferred to St. Pete Rehab. Locked unit due to wandering. "

An interview was conducted on 07/11/14 at 1:33 p.m. via phone with Staff member E, Licensed Practical Nurse, LPN. LPN, E confirmed that she was the nurse that was present and completed the admission paperwork for Resident #210 on 06/21/14.
LPN, E, was asked: " Do you know why Resident #210 was transferred? (From another nursing facility). " No, I do not know. " " He needed a secure unit; I do not know why he needed the secure unit. " She further stated that she called and confirmed the resident ' s medication orders and treatment orders. She stated that usually, his orders would state if he was to have a wander guard or not. She stated that she did not see any orders for a wander guard.

An interview was conducted on 07/11/14 at 4:20 p.m. with the Medical Director for the facility. He stated that he had been the Medical Director for approximately 2 years. The Medical Director was

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asked if facility staff were responsible to call and inform him of an unauthorized exit from the building by a resident, a resident that was found approximately 3 blocks from the facility. He stated that usually they would call; he stated that that he was not aware of a phone call regarding Resident #210 leaving the facility (unauthorized) on 06/21/14. But, he said he would check with his answering service, they may have knowledge of the phone call. (The Medical Director followed up with this conversation on 07/11/14 at 6:55 p.m. to confirm that no phone call had been placed to him or his answering service regarding Resident #210 ' s event on 06/21/14.) The Medical Director stated that he would want to know about an event like this. The Medical Director stated that the 2nd floor of the facility was a secure unit, that it typically meant the residents needed extra supervision.
The Medical Director stated that if someone is not deemed incompetent by paperwork that does not mean competency.
" I would expect that an event of an unauthorized departure from the facility would be investigated. "
The Medical Director was given an example of a resident coming to the facility with a transfer form that states the resident is " exit seeking " , the resident is placed on the 2nd floor of this facility; the resident goes missing the day after admission; staff implement the elopement protocol and the resident is found approximately 3 blocks away from the facility. Is that an elopement? Medical Director stated: " yes, it is. "

3. A review of the record for resident # 211 revealed that she was admitted to the facility on 6/27/14 from another nursing facility. An Admission/Readmission Nursing Evaluation form, with an effective date of 6/27/14 and signature

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dates by the LPN of 6/28/14 and an RN on 6/30/14 was found in the resident ' s electronic health record. Review of this Admission Nursing Evaluation form revealed that the resident had an admitting diagnosis of " Deconditioning Dementia Psychosis " . The form indicated the resident was independent with bed mobility, transfer, ambulation and locomotion and was alert to person with periods of confusion.

An observation was conducted on 7/11/14 at 1: 45 p.m., Resident # 211 was observed seated in her room in her wheelchair. A Wander guard was observed on the resident ' s wrist.

A review of progress notes in the resident ' s record revealed:
6/27/14 20: 27 Narrative Nurses note: " New admission arrived to facility at 5: 30 p.m. Resident alert and orient to self, periods of confusion noted, admitting diagnosis Dementia and Psychosis, denies pain or discomfort. " Continent of B& B, ambulating with a slow steady gait. "
6/30/14 09: 30 Narrative Nurses note: " Late entry for 6/29/14, Resident alert with confusion. Refused all meds x 3 stating ' I ' m not taking any more medicine it ' s just going to poison me ' . Minimal assist with ADL care provided x 1 staff. Mobilizes via w/c able to propel self. Wanders aimless in corridors and into other rooms, redirected at these times. Refused meals stating, ' I ' m not hungry and you ' re not going to shove any of that food in me. '
6/30/14 14: 32 Social Services: " Met with residents this afternoon to introduce self, review rights, abuse, grievance policy, advances directives, and current status. Resident is an 84 year old female admitted to us from (another

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nursing facility) as she needs a secured unit. Is alert, responds to verbal stimuli with forgetfulness and delayed reactions noted. Is able to communicate her needs. Was cooperative and answered all questions as best she can recall. Has poor recall and insight. Has Dx of Dementia, Psychosis, and Delusions. "
6/30/14 13: 32 Narrative Nurses Note: "
Resident alert with some confusion noted. All meds accepted except iron this shift. Minimal assist with ADL care x 1 staff. Mobilizes via w/c, able to propel self. Aimless wanders in corridors and into others room, redirected at these times. "
A review of the electronic health record revealed a " Wandering/ Elopement Assessment Tool " with an effective date of 6/30/14 (three days after admission). Review of this tool indicated the resident was determined to be:
" Disoriented (x 2 spheres)
Combative/ severely agitated
Recent experiences of Change of roommate, room change, admission within the last month, caregiver or staff change,
Mobility - independent
Diagnosis: Dementia with Psychosis
Medications: Taking antipsychotics

History of Wandering: Know wanderer/hx of wandering
Care plan/recommendations:
By this assessment is the resident at risk for wandering? " Yes "
If yes, have appropriate interventions been initiated " Secure "
Has the care plan been updated and communicated to the staff? " Yes "
Has the physician and family been consulted? " No "
This form was signed by the Unit Manager on

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F 226	Continued From page 70 6/30/14. Review of the interim care plan for resident # 211, dated 6/ 27/14, revealed under the section for " Falls/Safety Risk/Elopement Risk " the following areas were checked : " Keep call bell in reach/ encourage use of call light, Therapy to screen and evaluate as needed, Apply bed/ wheelchair alarm, wander guard if needed, Resident to wear proper footwear and non - skid soles. " An interview was completed with the Minimum Data Set Staff member, on 7/11/14 at 2: 07. p.m. revealed that the comprehensive care plans were not completed yet for the resident as " she hasn ' t been here 21 days yet so no comprehensive care plans but she has the interim care plan. " A review of verbal admission orders from the physician, dated 6/27/14, revealed " Wander guard, Check Q shift for function and placement " . A review of documentation in the resident ' s chart, paper and electronic records, revealed that there was no documentation for June 27, 2014, June 28, 2014, June 29, 2014 or June 30 2014 of the facility checking for placement of the wander guard every shift. An interview was conducted with the Unit Manager on the secured unit, on 7/11/14 at 7: 40 p.m. She stated that documentation for the wander guard checks would be on the Treatment Record in the resident ' s chart. She stated it is placed on the Treatment Record when the order is received. She reviewed the chart and confirmed there was no entry on the Treatment Record for the wander guard and no documentation that the wander guard was checked for placement each shift from June 27, 2014 through June 30, 2014. Per interview with the Assistant Director of	F 226		

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Nursing and the 3 p.m. to 11 p.m. Nurse Supervisor, on 7/11/14, at approximately 8: 00 p.m. revealed that all residents with wander guards are in the wander guard books. There are two books, one kept at the front lobby desk and one kept at the 1st floor nurse ' s station. Each book contains a list of all residents with wander guards and a picture of each resident with a wander guard. Review of both books with the Nurse Supervisor and the Assistant Director of Nursing revealed no picture of Resident # 211 in either book.

4. A review of the record for Resident # 212 revealed that he was admitted to the facility on 6/23/14 from another nursing facility. Review of documentation from the other nursing facility, found in resident # 212 ' s record, revealed that the resident, on 6/22/14 and 6/23/14 (prior to admission at current facility), exited and/or attempted to exit the other facility multiple times and removed his wander guard at least twice, the last time by biting it off.

An observation was conducted on 7/11/14 at 7: 50 p.m., Resident # 212 was observed ambulating independently down the hall of the secured unit. The resident was noted to have a Wander guard on his right wrist. Resident # 212 stated that he was " doing well " .
A review of the Admission/Readmission Nursing Evaluation , with an effective date of 6/23/14 an signature dates from the LPN and the Unit Manager on 6/25/14 and 6/27/14, revealed that the resident had admitting diagnoses of " fall, hematoma, brain bleed. " The evaluation indicated that the resident was independent in bed mobility, transfer, ambulation and locomotion and alert to person, time and situation with a note

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indicating " resident is confused at times. "
Further diagnoses found in the resident ' s record indicated that the resident also had diagnoses of Bipolar disorder and Schizophrenia.
A review of the Admission/ Readmission Nursing Evaluation and the nursing narrative notes in the resident ' s record revealed no indication that the resident was considered to be exit seeking, a wanderer, or at risk for elopement. An Activity/ Recreation progress note, dated 6/24/14 at 11: 59 stated, " Welcomed him to our facility and took his picture for our wander guard book, wander guard in place per unit manager. "
A " Wandering/ Elopement Assessment tool " was found in the resident ' s record with an effective date of 6/24/14. The assessment tool indicated:
" Orientation - Disoriented (x 2 spheres)
Recent Experiences - Change of roommate, admission within the last month, caregiver or staff change,
Mobility - Independent (no assist)
Diagnosis- Early Dementia.
Medications- Taking antipsychotics
History of wandering - known wanderer / history of wandering
Care plan/ Recommendations:
By this assessment, is the resident at risk for wandering? - Yes
If yes, have appropriate interventions been initiated? - Yes
Has the care plan been updated and communicated to the staff? - Yes
Has the physician and family been consulted? - Physician /self
A review of the interim care plan, dated 6/23/14, did not indicate that the resident was a wanderer, exit seeking or an elopement risk. Review of the section for " Falls/Safety Risk/Elopement

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Risk indicates check marks only in the areas of " keep call bell in reach/ encourage use of call list, Therapy to screen and evaluate as needed Apply bed alarm if needed, and Resident to wear proper footwear and non - skid soles. "
A comprehensive care plan for " Elopement " indicating that the resident " was at risk for elopement due to: is exit seeking, verbalizes desire to leave and has the means to do so, is ambulatory, impaired cognition " was not completed until 7/7/14.
A review of admission physician orders, dated 6/23/14, revealed an order for " Wander guard check placement and function Q shift. "

A review of the resident ' s record, including the Treatment Record, revealed no documentation from June 23- June 30, 2014 that the placement of the wander guard had been checked each shift as ordered. " An interview was conducted with the Unit Manager, on 7/11/14 at 7: 28 p.m. She stated that the documentation for checking placement of the wander guard each shift was written on the Treatment Record when the order was received. She reviewed the resident ' s record and confirmed that there was no documentation that placement was checked from June 23, 2014- June 30, 2014.

5. On 7/11/14 at 9: 25 p.m., the Director of Nursing provided two sheets of paper, one entitled " 2014 June Wander guard check list " and the other entitled " 2014 July Wander guard checklist. " She stated that these sheets were kept " right next to the wander guard book at the 1st floor nurses station " and the central supply person, Michael, checked the functionality of each wander guard daily and documented it on these sheets. She provided documentation that

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F 226	Continued From page 74 the function of the wander guards were checked daily for resident ' s # 211 and # 212 in June 2014. She stated that the nurses checked for placement. She stated that the order for " wander guard check Q shift for function and placement " for both resident # 211 and # 212 was written incorrectly and that it should only be once a day.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews, the facility failed to ensure that physician care orders for a wander guard and staff monitoring of the wander guard were implemented for 2 (#211 and 212) of 46 stage II sampled. The facility census was 142 residents. Findings include: 1.A review of the record for resident # 211 revealed that she was admitted to the facility on 6/27/14 from another nursing facility. An Admission/Readmission Nursing Evaluation form, with an effective date of 6/27/14 and signature dates by the LPN of 6/28/14 and an RN on 6/30/14 were found in the resident's electronic health record. Review of this Admission Nursing Evaluation form revealed that the resident had an admitting diagnosis of "Deconditioning Dementia	F 282		

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Psychosis." The form indicated the resident was independent with bed mobility, transfer, ambulation and locomotion and was alert to person with periods of confusion.

An observation was conducted on 7/11/14 at 1: 45 p.m. Resident # 211 was observed seated in her room in her wheelchair. A Wander guard was observed on the resident's wrist.

A review of verbal admission orders from the physician, dated 6/27/14, revealed "Wander guard, Check Q shift for function and placement." A review of documentation in the resident's chart, paper and electronic records, revealed that there was no documentation for June 27, 2014, June 28, 2014, June 29, 2014 or June 30 2014 of the facility checking for placement of the wander guard every shift. An interview was conducted with the Unit Manager on the secured unit, on 7/11/14 at 7: 40 p.m. She stated that documentation for the wander guard checks would be on the Treatment Record in the resident's chart. She stated it is placed on the Treatment Record when the order is received. She reviewed the chart and confirmed there was no entry on the Treatment Record for the wander guard and no documentation that the wander guard was checked for placement each shift from June 27, 2014 through June 30, 2014.

2.A review of the record for Resident # 212 revealed that he was admitted to the facility on 6/23/14 from another nursing facility. Review of documentation from the other nursing facility, found in Resident # 212's record, revealed that the resident, on 6/22/14 and 6/23/14 (prior to admission at current facility), exited and/or attempted to exit the other facility multiple times

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F 282	Continued From page 76 and removed his wander guard at least twice, the last time by biting it off. An observation was conducted on 7/11/14 at 7: 50 p.m. Resident # 212 was observed ambulating independently down the hall of the secured unit. The resident was noted to have a Wander guard on his right wrist. Resident # 212 stated that he was "doing well." A review of admission physician orders, dated 6/23/14, revealed an order for "Wander guard check placement and function Q shift." A review of the resident's record, including the Treatment Record, revealed no documentation from June 23- June 30, 2014 that the placement of the wander guard had been checked each shift as ordered. An interview was conducted with the Unit Manager, on 7/11/14 at 7: 28 p.m. She stated that the documentation for checking placement of the wander guard each shift was written on the Treatment Record when the order was received. She reviewed the resident's record and confirmed that there was no documentation that placement was checked from June 23, 2014- June 30, 2014.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on record review, interviews and observations, the facility failed to ensure that 3 (#210, 211, and 212) of 46 Stage II sampled residents, of 142 total residents, received supervision to prevent elopement and the accurate assessment of wandering potential & the application of monitoring devices, as needed, to prevent unsafe wandering or exit. Resident #210, a 64 year old, was admitted to the facility as a documented " exit seeking " resident that ambulated " ad lib " ; the resident had a primary diagnosis of " AMS " , (Altered Mental Status) with a secondary diagnoses of Late effects CVA (Cerebral Vascular Accident); Resident #210 was admitted to a " Secure floor " (the 2nd floor) . After a period of approximately 11-12 hours after admission, Resident #210 exited the " secure floor " unseen by direct care staff; exited the building unseen by facility staff members and exited the facility grounds to reportedly " try to go home " . Resident #210 was found sitting at an unsheltered bus stop next to a 4 lane road that was approximately 4 blocks away from the facility grounds. Direct Care Facility staff, D and C stated that they were unaware that Resident #210 had " exit seeking ' ' behavior upon admission. A Wander Assessment tool was completed (untimely) 2 days after Resident #210 went " missing " from the facility. Facility staff did not comprehensively investigate Resident # 210 ' s " missing " event as an elopement, in order to attempt to prevent unsafe wandering of other residents.
In addition, for Resident #211, the facility failed to ensure that a timely " Wandering/Elopement Assessment Tool " was completed; that physician orders for a " wander guard " and for

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staff to check for placement and function every shift was followed; and that the facility process for ensuring a " wander risk " resident ' s photo was placed timely in the " wander guard " book at the nurse ' s station. In addition, for Resident #212, the facility failed to ensure that an interim care plan accurately reflected the " wander risk " status for a resident admitted with documentation of known exit seeking behaviors and removal of wander guard behaviors; that a timely " Wandering/Elopement Assessment Tool " was completed; and that physician orders for a " wander guard " and for staff to check for placement and function every shift was followed. The facility ' s failure to provide oversight of persons with known exit seeking behaviors resulted in findings of Immediate Jeopardy, which is on-going.

Findings include:

1. An interview was conducted on 07/11/14 at 9:45 a.m. with Staff Member D, a Certified Nursing Assistant (CNA). She confirmed that she had been working for the facility approximately 2 years. She confirmed that she was working on 06/21/14 on the 2nd floor during the 7am-3pm shift and that on that day; she was supposed to clock out at 1:00 p.m. for the end of her shift. Staff Member D stated that a Restorative Aid came to the floor and asked for Resident #210. She stated that this was some time after lunch, possibly around 12 or 12:30 p.m. Staff Member D stated that it was at this time that she could not locate Resident #210 and that a room to room search on the 2nd floor was initiated. She stated that the search for the resident was expanded to include the other 2 floors and then the facility

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grounds. She stated that when Resident #210 was not located in the facility or on the facility grounds, the search was expanded to areas close by the facility. Staff Member D stated that she found Resident #210 at a bus stop. She stated that Resident #210 stated that he was trying to go home. She stated that Resident #210 looked tired and that she was able to encourage him to walk back to the facility, she stated that he was sweaty, that she helped him to change his clothes, gave him water and offered him food to eat. Staff member D stated that she clocked out of the facility after finding the resident at 1:29 p.m. Staff member D stated that she did not know that Resident #210 was a wander risk.

An observation was conducted on 07/11/14 at approximately 9:45 a.m., which included walking west approximately 3 blocks from the facility grounds along 42nd Avenue South, turning and walking approximately 1 more block to a bus stop located next to 4th Street South, a 4 lane road with a middle turning lane. Traffic on the road was observed to be moderate with a posted speed limit of 35 mph. The bench located next to the road, approximately 20 feet from the road, was observed not to have trees or shade present, but was open to the full sun.
A review of the internet, (print date of 07/21/14), weather history for the St. Petersburg area for the date of 06/21/14 revealed an average maximum temperature of 89 degrees Fahrenheit, maximum humidity rate of 79, wind speed of 7 m.p.h. and sunny.

A review of the internet, Nordevald Software & information services, print date of 07/21/2014, documented information about the Heat Index: The Heat Index is the " feels like, or apparent,

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temperature. As relative humidity increases, the air seems warmer than it actually is because the body is less able to cool itself via evaporation of perspiration. As the heat index rises, so do health risks. When the heat index is 90-105 degrees F., heat exhaustion is possible. When it is above 105 degrees F., it is probable. Heatstroke is possible when the heat index is above 105 degrees F., and very likely when it is 130 degrees F., and above. Physical activity and prolonged exposure to the heat increases the risks. "

A review of the Heat Index chart documented, if the air temperature was approximately 85-90 degrees F., and the humidity was between 75 and 80, the heat index=between 109 and 113, thus it " feels like " 109-113 degrees F.

A review of the internet, About.com Florida travel and print date of 07/21/2014: " In Florida, more people die from excessive heat than from lightening. The human body temperature rises dangerously when hot days combine with high relative humidity, because perspiration cannot evaporate and cool the body. Elderly persons and small children, or persons on certain medications ...are particularly vulnerable to heat stress. "

Further, an observation, conducted on 7/10/2014 at approximately 12:00 p.m. of the facility location, at 435 42nd Avenue South, St. Petersburg, FL 33705, revealed that east of the facility, approximately 2 blocks, was a body of water, a channel between Big Bayou and Little Bayou. If a person were to walk East on the 42nd Avenue sidewalk, they could walk directly into the channel without having to enter any residential

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yard. The channel, when observed, looked to be approximately 600 yards across to the opposite side. The depth of the channel is unknown, but, observations of boats docked at the sides of the channel revealed various sized boats of average size of approximately 20-30 feet in length.

A review of Resident #210 ' s electronic notes revealed no nurse ' s notes entered into the record for 06/20/14 and the first nurse ' s note was on 06/21/14 at 4:40 p.m., which stated: " No acute distress. Alert with some confusion noted. Head to toe skin check done this shift without areas of mention noted. Ambulating ad lib frequently in corridor, re-directed when observed entering into others rooms. Appetite good consumed 75% of meals served this shift, meals served in room. VS 138/64-98.4-20-82. "

Further review of the 06/21/14 nurse ' s notes entry revealed no documentation of the event where Resident #210 had made an unauthorized exit from the secure 2nd floor, left the building and facility grounds unnoticed by staff and found at a bus stop approximately 4 blocks away. No documentation was present that would indicate that Resident #201 ' s physician had been notified on the date of 06/21/14 or up to the present date of 07/10/14 regarding the event.

A review of a Rehabilitation Center of St. Petersburg, brochure, non-dated, tri-fold, advertised that the facility provides a " Secure Floor and divisions. " Despite this, the C.M.S. Form 671, " Long Term Care Application for Medicare and Medicaid, " dated 7/8/14, indicated that the facility had no dedicated special care units. A review of the facility census for the 2nd

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floor, for the date of 07/11/14, revealed a total of 61 beds located on the 2nd floor (secured division of the facility.) A further review of the census document revealed that 56 residents were residing on the 2nd floor on 07/11/14; 3 of the residents were identified by facility staff as not needing the secured unit; thus 53 of the remaining residents were identified to need the secure unit.

A review of the facility license documented that the facility was licensed to provide services for 159 beds.

The facility is a three story facility. An observation conducted on 07/08/14, 07/09/14 and 07/10/14 of the 2nd floor, between the approximate hours of 9am to 4 p.m. revealed that the 2nd floor was accessed by staff utilizing a key for the elevator and to leave the 2nd floor staff were observed to escort residents and or families off the floor by utilizing a key to allow the elevator to be retrieved and so persons could exit the floor.

A review of Resident #210 ' s clinical chart was completed. A local hospital History and physical, dated 06/02/14, indicated, " This is a 64 year old male with PM Hx of HTN, chronic alcoholic encephalopathy, alcohol abuse hx, who was brought by EMS from ALF (name) for disorderly behavior and agitation. Per records, last alcohol about 2 days ago, pt was not suicidal on admission in ER. In ED, ... A couple of months ago he was admitted to (local hospital), where he was diagnosed with CVA, his dementia/Aims was worked up and he was noted to have chronic alcoholic encephalopathy. Currently, pt denies c/o palpitations/ dyspnea/ abd paid/ ...Pt admits

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to R ankle pain and R shoulder pain which are new, he cannot remember how he got the trauma.

A review of the admission record for Resident #210 documented that the original admission date for the present facility was 06/20/14; diagnoses included: "other specified rehabilitation procedure; late effects of cerebrovascular disease; alcohol-induced persisting dementia; other persistent mental d/o due conds clase elsw; unspecified essential hypertension; altered mental status." Further review of the admission record documented that the resident was admitted from a nursing home.

A review of the Resident Transfer form located in Resident #210 ' s clinical chart on 07/10/14 and reviewed, documented a date of transfer of 06/20/14, signed by an LPN on 06/20/14, documenting the receiving facility to be Rehabilitation of St. Petersburg. The form documented additional pertinent information: " Ambulates ad lib, Exit seeking can be redirected-Resident very confused to time, place. Resident does use toilet, but has occasional incontinence of bladder; Resident has good appetite and takes fluids well. "
Further review of the form, documented that the resident was transferred from a " sister " facility, i.e. a facility that was owned by the same corporation.
The form documented that the resident had a hospital stay within the last 60 days.
The diagnoses at the time of transfer-AMS (Altered Mental Status); secondary: Late effects CVA.
The form documented the potential for rehabilitation was " poor " .

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The form documented that Resident #210 had " Mental " impairments.
The form documented the following medications at the time of discharge:
Xanax, 0.5 mg bid.
Norvasc, 5 mg hs.
ASA, 325 mg daily
Lisinopril, 10mg daily
Multi-vitamin with minerals, 1 tab daily.
Flomax, 0.4mg hs
Namenda xR, 14mg, hs x 5 days then; Namenda xR, 21 mg hs x 7 days unti July 1st; Namenda XR, 28 mg hs , starts July 2nd, B/P weekly on Friday, 7am-3pm.
The form documented that the mental status of the resident was " alert " and " confused " .

A review of Resident #210 ' s interim care plan, dated 06/20/14 documented a concern area of Behavioral Symptoms, the goal: Resident will have fewer episodes of : a " slash mark " was present in the " Re-direct resident as needed " and a hand written note of " exit seeking " .
Further review of the interim care plan documented a concern area of Falls/Safety Risk/ Elopement Risk, the goal: Resident will remain free of injuries and falls; a " slash mark " was present in " apply bed/wheelchair arm, wander guard if needed. "

A review of Resident #210 ' s MDS. Section C-Cognitive Patterns, 5 day Admission information, documented Brief Interview for Mental Status, (BIMS) which was electronically signed as completed on 06/28/14; Resident #210 ' s score was " 9, " which reflected moderate impairment.
An attempt to interview Resident #210 was conducted on 07/09/14 at 10:33 a.m. The

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Resident was not able to answer the questions. Resident #210 was dressed for the day; laying on a bed that was made up; watching TV. Resident #210 stated that he had no concerns; but, he appeared to search for answers when asked specific questions. Resident #210 was observed to be currently residing on the 2nd floor of the facility, the secure unit.

In an interview conducted on 07/10/14 at 11:03 a.m. with the DON, she stated that sometimes she will place a resident on the 2nd floor; if the bed situation warrants it. For example if they have no male beds on the 3rd floor. She stated that the 1st floor is for Medicare. Resident # 210 was placed on the 2nd floor due to the lack of beds on the other floors.

It was also stated that, if he started showing the behaviors of exit seeking; they would call me and alert me; they would call the doctor and let them know; immediately means within the hour;; they have to get permission from me to put a wander guard on the resident; they would complete a wander assessment to determine if he is high risk. Incapacitated means that they cannot make safe decisions for their everyday living; medical needs. I believe that he can make safe decisions in regards to his medical needs and his everyday living. " No event report was conducted in regards to the event that transpired on 06/21/14 with Resident #210. He did not sign out. Supposed to sign out, but did not. He was a couple of blocks down sitting on the bench " . " The resident left the facility, he was missing; " they did not know where he went. " But, it was not an elopement. No we did not call the police. I did not complete an investigation for the event. "

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An interview was conducted on 07/11/14 at approximately 7:10 a.m. during which the Regional Nurse was asked: If there was information on the transfer form for a resident that stated the resident was exit seeking, you would expect your nurse, who is performing the assessment to communicate to the staff, the direct care staff-being the CNA on the floor? " This patient was exit seeking " ; that would be my expectation.

A visit to the named sister facility from which Resident #210 was transferred from on 06/20/14 to the current facility was conducted on 07/10/14 at 7:15 p.m. for the purpose of reviewing Resident #210 ' s record.

An interview was conducted on 07/10/14 at 7:23 p.m. with the facility Administrator. He confirmed that he initiated the transfer for Resident #210. He confirmed that Resident #210 was exit seeking during his stay. He stated that the resident would appear to be of the ability to make decisions and then at other times he did not. He stated that he was not sure if the receiving facility knew that the resident was exit seeking; he talked to a woman in Admissions at the facility, though he was not sure of her name. He stated that he sent the paperwork over, the H & P, the psych notes and the medication list for the resident. He stated that he was unaware if the receiving facility nurse called for any further details about the resident.

A review of a physician ' s telephone order, (p.t.o.), dated 06/20/14, signed by the physician, documented: " order received transfer resident to St. Petersburg Rehabilitation; needs secure unit "

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A review of a p.t.o., dated 06/06/14, signed by the physician, documented: " wander guard for safety, check placement every shift; check wander guard function weekly on Wednesday 7-3 shift. "

A review of nursing notes:
Dated 06/12/14: " Resident requires frequent monitoring and use of wander guard for safety has been observed testing all doors and wandering others rooms. "
Dated 06/18/14: " Resident has been alert with confusion. He ambulates the unit independently and ...
He does test the doors most of the evening and is easily redirected. "
Dated 06/19/14: " Resident has been exit seeking and returned to unit after going thru doors to parking lot and continues to look for ways to leave. "
Dated 06/20/14: " Resident discharged to SNF. Care ride driver pick up resident. All paperwork with resident and driver. "

An interview was conducted with a physician on 07/10/14 at 12:41 p.m., who had been seeing the residents at the facility for approximately 1-2 weeks. He stated that he is familiar with Resident #210, that he had visited him 2 times since he had started at the building. He stated that the other doctor, (primary) might have seen him earlier. He stated that he was not aware of the resident leaving the facility unsupervised. He stated that he would make some phone calls to other members in the group to find out if they were aware of the concern. He stated that the resident, when he talks to him, stays grumpy and

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irritable. The resident does not seem aware; he has met him 2 x; he stated that he would suggest that the resident does not have capacity. (This doctor called back on 07/11/14 and informed the surveyor that the physician group office was unaware of the event that occurred on 06/21/14 for Resident #210.)

An interview was conducted on 07/11/14 at 7:10 a.m. via phone with Staff Member C (RN C), a Registered Nurse (RN). She confirmed that she was working as the " House Supervisor " for the facility on 06/21/14. She stated that she was called over the intercom by a nurse on the 2nd floor. She believed that the nurse that called her was Staff Member F, a Licensed Practical Nurse (LPN) that was working on the 2nd floor. Staff member C, RN, stated that LPN, F, called to tell her that she could not find Resident # 210. RN, C, further stated that a room to room search of the 2nd floor had been conducted and that a search was in progress for the 1st and 3rd floor. RN, C, stated that she called the Director of Nursing (DON), who instructed her to call the Administrator, which she did. RN, C, stated that staff started to look outside and meanwhile she called Resident #210 ' s emergency contact to check to seek if the emergency had visited and taken Resident #210 out. Per the RN, C, the emergency contact informed her that he had not taken the resident out of the building. RN, C, stated that meantime, she estimated that approximately 15 minutes had elapsed and that a staff member had found Resident #210 down the road. RN, C, stated that she could not remember who the staff member was that found the resident, but that the staff member came back and gave the resident something to drink and

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offered the resident something to eat. RN, C, stated that Resident #210 told her he wanted to walk home. RN, C, stated that she informed the resident about signing out when he left the building; RN, C, stated that Resident #210 said he understood. RN, C, stated that she asked Resident #210 a series of questions and that he answered all the questions properly. RN, C, stated that she assessed him and asked the resident if she could supply him with a wander guard. RN, C, stated that Resident #210 said " ok " to the wander guard. RN, C, stated that she did not call the doctor about the event. " Honestly, I do not remember if I did or not, I would have to look at the chart. " RN, C, stated that once we located him, we stopped the phone calls. RN, C, stated " I was not working on Friday " , 06/20/14, when Resident #210 was admitted. I do not know what the set of circumstances were before that (at admission.) " Thinking it was that he left the 2nd floor, I do not know " how he was able to leave. " I do not know if he eats on the 2nd floor. " " No training since this happened in regards to a resident at risk for wandering and precautions to take. "
RN, C was asked: " How did he get off the 2nd floor? " She replied: " I do not know how he got off the 2nd floor unit. " " That would have to be investigated. "
RN, C was asked: " Were you aware he was exit seeking at admission? " She replied: " No " , I was not directly assigned to the resident. She further stated that " not every patient on the 2nd floor needs supervision. "
RN, C was asked: " How does staff know which residents are wanderers or exit seeking? " She replied: " it comes with staff knowing the resident. " " The 2nd floor is an Alzheimer ' s unit; I am not too familiar with the residents on

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that floor. " " I do not know what the process is to understand which residents are wanderers or exit seeking. "
RN, C was asked: " The facility uses Agency staff members, how do these staff members know which residents are at risk for wandering? "
RN, C, replied: " I do not know. "
RN, C, confirmed that Resident #210 was " missing " during 06/21/14 and that the Elopement Protocol was initiated.
RN, C, was asked why the event was not documented in Resident #210 ' s clinical chart, the nursing notes or anywhere else. RN, C, replied: " I do not know why a person did not enter the information into the clinical chart. "
RN, C, stated that " If I have a resident that I am giving medication to and he is missing, I have a concern. "
Did you know at admission he was a wander risk or exit seeking? RN, C, replied: " I did not know he was identified as a wander risk. " She further stated that she did not know the location of the resident when he was found. She stated he was " hot " when he came back. Not sure of the staff member that found him.
RN, C was asked " Why was a Wander tool completed on the resident on 06/23/14? " RN, C, replied: " I do not know why the Wander tool was done. I believe that is done on admission, I would have to be instructed as to what the process is. Do not know why the Wander tool was not done at admission. "

An interview was conducted on 07/11/14 at approximately 1:30 p.m. with the Administrator, regarding the event that transpired on 06/21/14 with Resident #210. He did not believe it was an elopement. He stated that they had investigated the event, but not written down the investigation

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or documented the scenario as an event.
A letter was provided to the surveyor on 07/10/14 at approximately 4:00 p.m. which stated the following:
" On 06/21/14 I received a call from the weekend supervisor that Resident #210 was brought back after leaving the facility for a brief time. I was informed that the patient was noted not to be in his room and the unit was searched. It was determined that a church group had left the unit and it was suspected that the resident may have left with the group. An immediate search of the facility was conducted and a call placed to the patients contact to determine if he/she took the patient out on a leave. The CNA, G initiated a search of immediate area and found the resident up the street. It was estimated the resident was out of the facility for 15 minutes.
When contacted by the supervisor I asked her to ask the patient several questions to determine if he is oriented. The supervisor asked the patient numerous questions, all of which he answered correctly. I asked the supervisor if she felt the patient was oriented and she felt that he was. I then asked her to check at the record to determine if incapacity was present. There was not incapacity on the chart. The resident ' s prior living arrangement was an ALF. I instructed the supervisor to notify the patient not to leave the facility without signing himself out and explain that we need to know his whereabouts. I also instructed the supervisor to monitor the patient closely and the resident gave permission to place a wander guard on him. I asked the supervisor to notify me if he made any attempts to leave the facility again without signing out. Based on the patient answering several questions correctly, the lack of a physician incapacity, and the supervisor indicating he appeared to be oriented, I felt the

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patient left the facility without signing out as opposed to eloping.
In discussion with the supervisor and DON post incident it was suspected that the resident exited the unit with a church group who were visiting patients on the unit. The group had access to getting on and off the unit with an elevator key that was issued by the receptionist. The group had exited the unit at approximately the same time that the resident was known to have left the unit. "

An interview was conducted on 07/11/14 at 2:30 p.m. with the Administrator; he was asked if he or anyone had reviewed the facility cameras to try to determine how the resident had gotten off of the 2nd floor and how he was able to leave the building unauthorized. The Administrator stated: " I did not think to look at the camera " footage. At approximately 4:00 p.m. on 07/11/14, the Administrator stated that he was unable to access the footage on the cameras that would potentially reveal the method of which Resident #210 was able to leave the secure area of the 2nd floor and complete an unauthorized exit from the nursing home facility.

An interview was conducted on 07/11/14 at 4:20 p.m. with the facility Medical Director for the building. He stated that he had been the Medical Director for approximately 2 years. The Medical Director was asked if facility staff were responsible to call and inform him of an unauthorized exit from the building by a resident, a resident that was found approximately 3 blocks from the facility. He stated that usually they would call; he stated that that he was not aware of a phone call regarding Resident #210 leaving

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the facility (unauthorized) on 06/21/14. But, he said he would check with his answering service, they may have knowledge of the phone call. (The Medical Director followed up with this conversation on 07/11/14 at 6:55 p.m. to confirm that no phone call had been placed to him or his answering service regarding Resident #210 ' s event on 06/21/14.) The Medical Director stated that he would want to know about an event like this. The Medical Director stated that the 2nd floor of the facility was a secure unit, that it typically meant the residents needed extra supervision.
The Medical Director stated that if someone is not deemed incompetent by paperwork that does not mean competency.
" I would expect that an event of an unauthorized departure from the facility would be investigated. "
The Medical Director was given an example of a resident coming to the facility with a transfer form that states the resident is " exit seeking " , the resident is placed on the 2nd floor of this facility; the resident goes missing the day after admission; staff implement the elopement protocol and the resident is found approximately 3 blocks away from the facility. Is that an elopement? Medical Director stated: " yes, it is. "

2. A review of the record for resident # 211 revealed that she was admitted to the facility on 6/27/14 from another nursing facility. An Admission/Readmission Nursing Evaluation form, with an effective date of 6/27/14 and signature dates by the LPN of 6/28/14 and an RN on 6/30/14 was found in the resident ' s electronic health record. Review of this Admission Nursing Evaluation form revealed that the resident had an admitting diagnosis of " Deconditioning Dementia

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Psychosis " . The form indicated the resident was independent with bed mobility, transfer, ambulation and locomotion and was alert to person with periods of confusion.

An observation was conducted on 7/11/14 at 1: 45 p.m., Resident # 211 was observed seated in her room in her wheelchair. A Wander guard was observed on the resident ' s wrist.

A review of progress notes in the resident ' s record revealed:
6/27/14 20: 27 Narrative Nurses note: " New admission arrived to facility at 5: 30 p.m. Resident alert and orient to self, periods of confusion noted, admitting diagnosis Dementia and Psychosis, denies pain or discomfort. " Continent of B& B, ambulating with a slow steady gait. "
6/30/14 09: 30 Narrative Nurses note: " Late entry for 6/29/14, Resident alert with confusion. Refused all meds x 3 stating ' I ' m not taking any more medicine it ' s just going to poison me ' . Minimal assist with ADL care provided x 1 staff. Mobilizes via w/c able to propel self. Wanders aimless in corridors and into other rooms, redirected at these times. Refused meals stating, ' I ' m not hungry and you ' re not going to shove any of that food in me. '
6/30/14 14: 32 Social Services: " Met with residents this afternoon to introduce self, review rights, abuse, grievance policy, advances directives, and current status. Resident is an 84 year old female admitted to us from (another nursing facility) as she needs a secured unit. Is alert, responds to verbal stimuli with forgetfulness and delayed reactions noted. Is able to communicate her needs. Was cooperative and answered all questions as best she can recall.

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Has poor recall and insight. Has Dx of Dementia, Psychosis, and Delusions. "
6/30/14 13: 32 Narrative Nurses Note:
Resident alert with some confusion noted. All meds accepted except iron this shift. Minimal assist with ADL care x 1 staff. Mobilizes via w/c, able to propel self. Aimless wanders in corridors and into others room, redirected at these times. "
A review of the electronic health record revealed a " Wandering/ Elopement Assessment Tool " with an effective date of 6/30/14 (three days after admission). Review of this tool indicated the resident was determined to be:
" Disoriented (x 2 spheres)
Combative/ severely agitated
Recent experiences of Change of roommate, room change, admission within the last month, caregiver or staff change,
Mobility - independent
Diagnosis: Dementia with Psychosis
Medications: Taking antipsychotics

History of Wandering: Known wanderer/hx of wandering
Care plan/recommendations:
By this assessment is the resident at risk for wandering? " Yes "
If yes, have appropriate interventions been initiated " Secure "
Has the care plan been updated and communicated to the staff? " Yes "
Has the physician and family been consulted? " No "
This form was signed by the Unit Manager on 6/30/14.
Review of the interim care plan for resident # 211, dated 6/ 27/14, revealed under the section for " Falls/Safety Risk/Elopement Risk " the following areas were checked :

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" Keep call bell in reach/ encourage use of call light, Therapy to screen and evaluate as needed, Apply bed/ wheelchair alarm, wander guard if needed, Resident to wear proper footwear and non - skid soles. "

An interview with the MDS person, on 7/11/14 at 2: 07. p.m. revealed that the comprehensive care plans were not completed yet for the resident as " she hasn ' t been here 21 days yet so no comprehensive care plans but she has the interim care plan. "

A review of verbal admission orders from the physician, dated 6/27/14, revealed " Wander guard, Check Q shift for function and placement " .

A review of documentation in the resident ' s chart, paper and electronic records, revealed that there was no documentation for June 27, 2014, June 28, 2014, June 29, 2014 or June 30 2014 of the facility checking for placement of the wander guard every shift. An interview was conducted with the Unit Manager on the secured unit, on 7/11/14 at 7: 40 p.m. She stated that documentation for the wander guard checks would be on the Treatment Record in the resident ' s chart. She stated it is placed on the Treatment Record when the order is received. She reviewed the chart and confirmed there was no entry on the Treatment Record for the wander guard and no documentation that the wander guard was checked for placement each shift from June 27, 2014 through June 30, 2014.

Per interview with the Assistant Director of Nursing and the 3 p.m. to 11 p.m. Nurse Supervisor, on 7/11/14, at approximately 8: 00 p.m. revealed that all residents with wander guards are in the wander guard books. There are two books, one kept at the front lobby desk and one kept at the 1st floor nurse ' s station.

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Each book contains a list of all residents with wander guards and a picture of each resident with a wander guard. Review of both books with the Nurse Supervisor and the Assistant Director of Nursing revealed no picture of Resident # 211 in either book.

3. A review of the record for resident # 212 revealed that he was admitted to the facility on 6/23/14 from another nursing facility. Review of documentation from the other nursing facility, found in resident # 212 ' s record, revealed that the resident, on 6/22/14 and 6/23/14 (prior to admission at current facility), exited and/or attempted to exit the other facility multiple times and removed his wander guard at least twice, the last time by biting it off.

An observation was conducted on 7/11/14 at 7: 50 p.m., Resident # 212 was observed ambulating independently down the hall of the secured unit. The resident was noted to have a Wander guard on his right wrist. Resident # 212 stated that he is happy at the facility and " doing well " .
A review of the Admission/Readmission Nursing Evaluation, with an effective date of 6/23/14 and signature dates from the LPN and the Unit Manager on 6/25/14 and 6/27/14, revealed that the resident had admitting diagnoses of " fall, hematoma, brain bleed. " The evaluation indicated that the resident was independent in bed mobility, transfer, ambulation and locomotion and alert to person, time and situation with a note indicating " resident is confused at times. "
Further diagnoses found in the resident ' s record indicated that the resident also had diagnoses of Bipolar disorder and Schizophrenia.
A review of the Admission/ Readmission Nursing

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Evaluation and the nursing narrative notes in the resident ' s record revealed no indication that the resident was considered to be exit seeking, a wanderer, or at risk for elopement. An Activity/ Recreation progress note, dated 6/24/14 at 11: 59 stated, " Welcomed him to our facility and took his picture for our wander guard book, wander guard in place per unit manager. "
A " Wandering/ Elopement Assessment tool " was found in the resident ' s record with an effective date of 6/24/14. The assessment tool indicated:
" Orientation - Disoriented (x 2 spheres)
Recent Experiences - Change of roommate, admission within the last month, caregiver or staff change,
Mobility - Independent (no assist)
Diagnosis- Early Dementia.
Medications- Taking antipsychotics
History of wandering - known wanderer / history of wandering
Care plan/ Recommendations:
By this assessment, is the resident at risk for wandering? - Yes
If yes, have appropriate interventions been initiated? - Yes
Has the care plan been updated and communicated to the staff? - Yes
Has the physician and family been consulted? - Physician /self
A review of the interim care plan, dated 6/23/14, did not indicate that the resident was a wanderer, exit seeking or an elopement risk. Review of the section for " Falls/Safety Risk/Elopement Risk indicates check marks only in the areas of " keep call bell in reach/ encourage use of call list, Therapy to screen and evaluate as needed Apply bed alarm if needed, and Resident to wear proper footwear and non - skid soles. "

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A comprehensive care plan for " Elopement " indicating that the resident " was at risk for elopement due to: is exit seeking, verbalizes desire to leave and has the means to do so, is ambulatory, impaired cognition " was not completed until 7/7/14.
A review of admission physician orders, dated 6/23/14, revealed an order for " Wander guard check placement and function Q shift. "

A review of the resident ' s record, including the Treatment Record, revealed no documentation from June 23- June 30, 2014 that the placement of the wander guard had been checked each shift as ordered. " An interview was conducted with the Unit Manager, on 7/11/14 at 7: 28 p.m. She stated that the documentation for checking placement of the wander guard each shift was written on the Treatment Record when the order was received. She reviewed the resident ' s record and confirmed that there was no documentation that placement was checked from June 23, 2014- June 30, 2014.
On 7/11/14 at 9: 25 p.m., the Director of Nursing provided two sheets of paper, one entitled " 2014 June Wander guard check list " and the other entitled " 2014 July Wander guard checklist. " She stated that these sheets were kept " right next to the wander guard book at the 1st floor nurses station " and the central supply person checked the functionality of each wander guard daily and documented it on these sheets. She provided documentation that the function of the wander guards were checked daily for resident ' s # 211 and # 212 in June 2014. She stated that the nurses checked for placement. She stated that the order for " wander guard check Q shift for function and placement " for both resident # 211 and # 212 was written incorrectly and that it

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should only be once a day.

4. A review of the facility " Wandering, Unsafe Resident " policy and procedure, revised 11/2010, documented the policy Statement : " The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. "
The Policy Interpretation and Implementation:
1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement).
2. The staff will assess at -risk individuals for potentially correctible risk factors related to unsafe wandering.
3. The resident ' s care plan will indicate the resident is at risk for elopement or other safety issues.
4. Interventions to try to maintain safety will be included in the resident ' s care plan.
5. Nursing staff will document circumstances related to unsafe actions, including wandering by a resident.
6. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior.
7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility.

5. A review of the facility Elopement policy and procedure, revised 04/2010, documented the policy statement: " Staff shall investigate and report all cases of missing residents. "

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REHABILITATION CENTER OF ST PETE	435 42ND AVE S SAINT PETERSBURG, FL 33705

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F 323	Continued From page 101 The Policy Interpretation and Implementation: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. 2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Notify the Attending Physician. 4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on a leave or pass; b. If the resident was not on leave/pass, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services; d. If the resident is incapacitated notify the resident ' s representative and law enforcement; e. Provide search teams with resident identification information; and f. Initiate an extensive search of the surrounding area. 5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. notify the resident ' s legal representative (sponsor); d. Notify search teams that the resident has been located.	F 323		
F 490	483.75 EFFECTIVE	F 490		

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F 490 SS=J	Continued From page 102 ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident medical record review, facility policy reviews, staff interviews and staff personnel file reviews, the facility failed to ensure that Administration, the Director of Nursing Services and the Administrator, utilized it ' s resources effectively and efficiently to maintain the highest practicable physical and mental well-being of 3 (#210, 211, 212) of 46 sampled Stage II residents, of a total census of 142. For Resident #210, the resident had documentation presented upon admission, from a facility under the same corporate ownership, that identified him as a " wander risk, " however, the facility failed to timely assess and implement services to prevent unsafe wandering which resulted in the resident leaving the facility less than 24 hours after admission and being found by staff members at a bus stop, down the road. This, despite information that Resident #210 was transferred to the facility as it provided a " secure " unit. The Administration failed to identify Resident #211 ' s " missing " from the facility as an elopement. The Administration failed to completely investigate the events surrounding how a resident was able to leave a secure unit of the building, a potential lack of supervision and lack of provision of services; and the Administration failed to report an occurrence	F 490		

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which met the facility ' s definition of neglect.

In addition, for Resident #211, the facility failed to ensure that a timely " Wandering/Elopement Assessment Tool " was completed; that physician orders for a " wander guard " and for staff to check for placement and function every shift was followed; and that the facility process for ensuring " wander risk " resident ' s photo was placed timely in the " wander guard " book at the nurse ' s station.
In addition, for Resident #212, the facility failed to ensure that an interim care plan accurately reflected the " wander risk " status for a resident admitted with documentation of known exit seeking behaviors and removal of wander guard behaviors; that a timely " Wandering/Elopement Assessment Tool " was completed; that physician orders for a " wander guard " and for staff to check for placement and function every shift was followed.

These system failures resulted in the facility failing to ensure the safety and protection of residents, resulting in findings of ongoing Immediate Jeopardy.

Findings include:

1. A review of the Administrator ' s job description was conducted, which was obtained on 07/11/14 at approximately 10 p.m. from the Administrator. The description was undated and unsigned.

Specific Requirements included: " Must possess the ability to plan, organize, develop, implement, and interpret the programs, goals, objectives,

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policies and procedures, etc., that are necessary for providing quality care and maintaining a sound operation. "

Duties and Responsibilities regarding Resident Rights included: " Ensure that the resident ' s rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints, are well established and maintained at all times. "

" Report all allegations of resident abuse and/or misappropriation of resident property. "

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behavior.
7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility. "

A review of the facility Elopement policy and procedure, revised 04/2010, documented the policy statement: " Staff shall investigate and report all cases of missing residents. "
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4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on a leave or pass; b. If the resident was not on leave/pass, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services; d. If the resident is incapacitated notify the resident ' s representative and law enforcement; e. Provide search teams with resident identification information; and f. Initiate

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an extensive search of the surrounding area.
5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries; b. Contact the Attending Physician and report findings and conditions of the resident; c. notify the resident ' s legal representative (sponsor); d. Notify search teams that the resident has been located. "

A review was completed of the facility ' s Adverse protocol, provided to the survey team on 07/10/14 at approximately 4:00 p.m. by the Administrator who he stated that the facility utilizes the State requirements for Adverse incidents. The paperwork that was provided was " Assisted Living Facility-How to Determine if an Incident is " Adverse " (400.423, F.S.), the document was not dated.
Review of the presented document, page 2, stated: " Automatically defined as Adverse: Any one of the following is automatically defined as an " adverse incident " and must be reported on the 1-Day Adverse Incident Report to the Agency within one business day of the occurrence of the incident:
· Abuse, neglect or exploitation as defined in s.415.102, F.S., (Vulnerable Adult).
· Resident elopement (based on the facility ' s definition of elopement.)
· An event that is reported to law enforcement.
Continue the internal investigation and within 15 days of the occurrence of the incident and submit the completed 15 -day Adverse Incident Report. "

A review of the facility Abuse Protection and Response Policy, revised 05/12/14, documented the policy of the facility to be: " Abuse, as hereafter defined, will not be tolerated by anyone,

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including staff, residents, volunteers, family members or legal guardians, friends or any other individuals. The health center Administrator is responsible for assuring that resident safety, including freedom from risk of abuse, holds the highest priority. "
The document defined Neglect: " The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the resident. "
Section VII. Reporting and Response: Policy: " All allegations of possible abuse will be immediately reported to the Abuse Hotline and will be assessed to determine the direction of the investigation. Procedure: Any investigation that substantiates abuse, neglect, or exploitation will be reported immediately to the Administrator and/or the Abuse Prevention Coordinator. It will also be reported to other officials, in accordance with State and Federal Law. "
Section A. The immediate Report: " All allegations of abuse, neglect, exploitation ...must be reported immediately or practicable. This allegation must be reported to the Abuse Hotline (Adult protective Services) within immediately or practicable whenever an allegation is made.
The Abuse Prevention Coordinator will also submit the Agency for Health Care Administration AHCA Federal Immediate/ 5 day report ... "
Section B. The Report of Investigation (Five Day Report): " The facility Abuse Prevention Coordinator will send the result of the facility investigations to the State Survey Agency within five working days of the incident. "

Policy: Trends of investigative findings will be

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analyzed and addressed by the QA and Risk Management committee process.
Procedure: " An accurate summary reporting of al investigations conducted by the center will be maintained as a working document of the Quality Assessment and Risk Management Committees. "

" QA and RM will review and analyze investigations to track and determine presence of any trends. "

An interview conducted on 07/11/14 at 9:45 a.m. with Staff Member D, a Certified Nursing Assistant (CNA) during which she confirmed that she had been working for the facility approximately 2 years. She confirmed that she was working on 06/21/14 on the 2nd floor during the 7am-3pm shift and that on that day; she was supposed to clock out at 1:00 p.m. for the end of her shift. Staff Member D stated that a Restorative Aid came to the floor and asked for Resident #210. She stated that this was some time after lunch, possibly around 12 or 12:30 p.m. Staff Member D stated that it was at this time that she could not locate Resident #210 and that a room to room search on the 2nd floor was initiated. She stated that the search for the resident was expanded to include the other 2 floors and then the facility grounds. She stated that when Resident #210 was not located in the facility or on the facility grounds, the search was expanded to areas close by the facility. Staff Member D stated that she found Resident #210 at a bus stop. She stated that Resident #210 stated that he was trying to go home. She stated that Resident #210 looked tired and that she was able to encourage him to walk back to the facility. She stated that he was sweaty, that she helped him to change his clothes, gave him water and

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offered him food to eat. Staff member D stated that she clocked out of the facility after finding the resident at 1:29 p.m. Staff member D stated that she did not know that Resident #210 was a wander risk.

An observation was conducted on 07/11/14 at approximately 9:45 a.m., which included walking west approximately 3 blocks from the facility grounds along 42nd Avenue South, turning and walking approximately 1 more block to a bus stop located next to 4th Street South, a 4 lane road with a middle turning lane. Traffic on the road was observed to be moderate with a posted speed limit of 35 mph. The bench located next to the road, approximately 20 feet from the road, was observed not to have trees or shade present, but open to the full sun.

A review of the internet, (print date of 07/21/14), weather history for the St. Petersburg area for the date of 06/21/14 revealed an average maximum temperature of 89 degrees Fahrenheit, maximum humidity rate of 79, wind speed of 7 m.p.h. and sunny.

A review of the internet, Nordevald Software & information services, print date of 07/21/2014, documented information about the Heat Index: The Heat Index is the " feels like, or apparent, temperature. As relative humidity increases, the air seems warmer than it actually is because the body is less able to cool itself via evaporation of perspiration. As the heat index rises, so do health risks. When the heat index is 90-105 degrees F., heat exhaustion is possible. When it is above 105 degrees F., it is probable. Heatstroke is possible when the heat index is

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above 105 degrees F., and very likely when it is 130 degrees F., and above. Physical activity and prolonged exposure to the heat increases the risks. "

A review of the Heat Index chart documented if the air temperature is approximately 85-90 degrees F., and the humidity is between 75 and 80, the heat index=between 109 and 113, thus it " feels like " 109-113 degrees F.

A review of the internet, About.com Florida travel and print date of 07/21/2014: " In Florida, more people die from excessive heat than from lightening. The human body temperature rises dangerously when hot days combine with high relative humidity, because perspiration cannot evaporate and cool the body. Elderly persons and small children, or persons on certain medications ...are particularly vulnerable to heat stress. "

An observation had also been conducted on 7/10/2014 at approximately 12:00 p.m. of the facility location, at 435 42nd Avenue South, St. Petersburg, FL 33705, which revealed that east of the facility, approximately 2 blocks, was a body of water, a channel between Big Bayou and Little Bayou. If a person were to walk East on the 42nd Avenue sidewalk, they could walk directly into the channel without having to enter any residential yard. The channel, when observed, looked to be approximately 600 yards across to the opposite side. The depth of the channel is unknown, but, observations of boats docked at the sides of the channel revealed various sized boats of average size of approximately 20-30 feet in length.

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A review of a Rehabilitation Center of St. Petersburg, brochure, non-dated, tri-fold, advertised that the facility provided a " Secure Floor and divisions. " Despite this, the C.M.S. Form 671, " Long Term Care Application for Medicare and Medicaid, " dated 7/8/14, indicated that the facility had no dedicated special care units.
The facility is a three story facility. An observation conducted on 07/08/14, 07/09/14 and 07/10/14 of the 2nd floor, between the approximate hours of 9am to 4 p.m., revealed that the 2nd floor was accessed by staff utilizing a key for the elevator and to leave the 2nd floor staff were observed to escort residents and or families off the floor by utilizing a key to allow the elevator to be retrieved and so persons could exit the floor.

A review of the facility license documented that the facility is licensed to provide services for 159 beds. A review of the facility census for the 2nd floor, for the date of 07/11/14, revealed a total of 61 beds located on the 2nd floor (secured division of the facility.) A further review of the census document revealed that 56 residents were residing on the 2nd floor on 07/11/14; three of the residents were identified by facility staff as not needing the secured unit; thus, 53 of the remaining residents were identified to need the secure unit.

A review of Resident #210 ' s electronic notes revealed no nurses ' notes entered into the record for 06/20/14 and the first nurse ' s note was on 06/21/14 at 4:40 p.m., which stated: " No acute distress. Alert with some confusion noted. Head to toe skin check done this shift

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without areas of mention noted. Ambulating ad lib frequently in corridor, re-directed when observed entering into others rooms. Appetite good consumed 75% of meals served this shift, meals served in room. VS 138/64-98.4-20-82. "

Further review of the 06/21/14 nurses ' notes entry revealed no documentation of the event where Resident #210 had made an unauthorized exit from the secure 2nd floor, left the building and facility grounds unnoticed by staff and was found at a bus stop approximately 4 blocks away. No documentation was present that would indicate that Resident #210 ' s physician had been notified on the date of 06/21/14 or up to the present date of 07/10/14 regarding the event.

A review of Resident #210 ' s clinical chart was completed. A local hospital History and physical, dated 06/02/14, indicated, " This is a 64 year old male with PM Hx of HTN, chronic alcoholic encephalopathy, alcohol abuse hx, who was brought by EMS from ALF (name) for disorderly behavior and agitation. Per records, last alcohol about 2 days ago, pt was not suicidal on admission in ER. In ED, ... A couple of months ago he was admitted to (local hospital), where he was diagnosed with CVA, his dementia/Aims was worked up and he was noted to have chronic alcoholic encephalopathy. Currently, pt denies c/o palpitations/ dyspnea/ abd paid/ ...Pt admits to R ankle pain and R shoulder pain which are new, he cannot remember how he got the trauma. "

A review of the admission record for Resident #210 documented that the original admission date for the present facility was 06/20/14;

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diagnoses included: " other specified rehabilitation procedure; late effects of cerebrovascular disease; alcohol-induced persisting dementia; other persistent mental d/o due conds clase elsw; unspecified essential hypertension; altered mental status. Further review of the admission record documented that the resident was admitted from a nursing home. "

A review of the Resident Transfer form, located in Resident #210 ' s clinical chart on 07/10/14 and reviewed, documented a date of transfer of 06/20/14, signed by a LPN on 06/20/14, documenting the receiving facility to be Rehabilitation of St. Petersburg. The form documented additional pertinent information: " Ambulates ad lib, Exit seeking can be redirected-Resident very confused to time, place. Resident does use toilet, but has occasional incontinence of bladder; Resident has good appetite and takes fluids well. "
Further review of the form, documented that the resident was transferred from a " sister " facility, i.e. a facility that was owned by the same corporation.
The form documented that the resident had a hospital stay within the last 60 days.
The diagnoses at the time of transfer- " AMS (Altered Mental Status); secondary: Late effects CVA. "
The form documented the potential for rehabilitation was " poor " .
The form documented that Resident #210 had " Mental " impairments.
The form documented the following medications at the time of discharge:
Xanax, 0.5 mg bid.
Norvasc, 5 mg hs.
ASA, 325 mg daily

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Lisinopril, 10mg daily
Multi-vitamin with minerals, 1 tab daily.
Flomax, 0.4mg hs
Namenda xR, 14mg, hs x 5 days then; Namenda xR, 21 mg hs x 7 days unti July 1st; Namenda XR, 28 mg hs , starts July 2nd, B/P weekly on Friday, 7am-3pm.
The form documented that the mental status of the resident was " alert " and " confused " .

A review of Resident #210 ' s interim care plan, dated 06/20/14 documented a concern area of Behavioral Symptoms, the goal: Resident will have fewer episodes of : a " slash mark " was present in the " Re-direct resident as needed " and a hand written note of " exit seeking " .
Further review of the interim care plan documented a concern area of Falls/Safety Risk/ Elopement Risk, the goal: " Resident will remain free of injuries and falls " ; a " slash mark " was present in " apply bed/wheelchair arm, wander guard if needed. "

A review of Resident #210 ' s MDS. Section C-Cognitive Patterns, 5 day Admission information, documented Brief Interview for Mental Status, (BIMS) which was electronically signed as completed on 06/28/14; Resident #210 ' s score was " 9 " which is moderately impaired.
An attempt to interview Resident #210 was conducted on 07/09/14 at 10:33 a.m. The resident was not able to answer the questions. Resident #210 was dressed for the day; laying on a bed that was made up; watching TV. Resident #210 stated that he had no concerns; but, he appeared to search for answers when asked specific questions. Resident #210 was observed to be currently residing on the 2nd floor of the facility, the secure unit.

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An interview was conducted on 07/11/14 at approximately 7:10 a.m. during which the Regional Nurse was asked: If there was information on the transfer form for a resident that stated the resident was exit seeking, you would expect your nurse, who is performing the assessment to communicate to the staff, the direct care staff-being the CNA on the floor? " This patient was exit seeking " ; that would be my expectation. "

A visit to the named sister facility, from which Resident #210 was transferred on 06/20/14 to the current facility, was conducted on 07/10/14 at 7:15 p.m. for the purpose of reviewing Resident #210 ' s record.

An interview was conducted on 07/10/14 at 7:23 p.m. with that facility ' s Administrator. He confirmed that he initiated the transfer for Resident #210. He confirmed that Resident #210 was exit seeking during his stay. He stated that the resident would appear to be of the ability to make decisions and then, at other times, he did not. He stated that he was not sure if the receiving facility knew that the resident was exit seeking; he talked to a woman in Admissions at the facility, though he was not sure of her name. He stated that he sent the paperwork over, the H & P, the psych notes and the medication list for the resident. He stated that he was unaware if the receiving facility nurse called for any further details about the resident.

A review of a physician ' s telephone order, (p.t.o.), dated 06/20/14, signed by the physician, documented: " order received transfer resident to St. Petersburg Rehabilitation; needs secure unit "

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F 490	Continued From page 116 . A review of a p.t.o., dated 06/06/14, signed by the physician, documented: " wander guard for safety, check placement every shift; check wander guard function weekly on Wednesday 7-3 shift. " A review of nursing notes: Dated 06/12/14: " Resident requires frequent monitoring and use of wander guard for safety has been observed testing all doors and wandering others rooms. " Dated 06/18/14: " Resident has been alert with confusion. He ambulates the unit independently and ... He does test the doors most of the evening and is easily redirected. " Dated 06/19/14: " Resident has been exit seeking and returned to unit after going thru doors to parking lot and continues to look for ways to leave. " Dated 06/20/14: " Resident discharged to SNF. Care ride driver pick up resident. All paperwork with resident and driver. " An interview was conducted on 07/11/14 at 7:10 a.m. via phone with Staff Member C (RN C), a Registered Nurse (RN). She confirmed that she was working as the " House Supervisor " for the facility on 06/21/14. She stated that she was called over the intercom by a nurse on the 2nd floor. She believed that the nurse that called her was Staff Member F, a Licensed Practical Nurse (LPN) that was working on the 2nd floor. Staff member C, RN stated that LPN, F, called to tell her that she could not find Resident # 210. RN, C,	F 490		

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further stated that a room to room search of the 2nd floor had been conducted and that a search was in progress for the 1st and 3rd floor. RN, C, stated that she called the Director of Nursing (DON), who instructed her to call the Administrator, which she did. RN, C, stated that staff started to look outside and meanwhile she called Resident #210 ' s emergency contact to check to seek if the emergency had visited and taken Resident #210 out. Per the RN, C, the emergency contact informed her that he had not taken the resident out of the building. RN, C, stated that meantime, she estimated that approximately 15 minutes had elapsed and that a staff member had found Resident #210 down the road. RN, C, stated that she could not remember who the staff member was that found the resident, but that the staff member came back and gave the resident something to drink and offered the resident something to eat. RN, C, stated that Resident #210 told her he wanted to walk home. RN, C, stated that she informed the resident about signing out when he left the building; RN, C, stated that Resident #210 said he understood. RN, C, stated that she asked Resident #210 a series of questions and that he answered all the questions properly. RN, C, stated that she assessed him and asked the resident if she could supply him with a wander guard. RN, C, stated that Resident #210 said " ok " to the wander guard. RN, C, stated that she did not call the doctor about the event. " Honestly, I do not remember if I did or not, I would have to look at the chart. " RN, C, stated that once we located him, we stopped the phone calls. RN, C, stated " I was not working on Friday " , 06/20/14, when Resident #210 was admitted. I do not know what the set of circumstances were before that (at admission.) "

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Thinking it was that he left the 2nd floor, I do not know " how he was able to leave. " I do not know if he eats on the 2nd floor. " " No training since this happened in regards to a resident at risk for wandering and precautions to take. "
RN, C was asked: " How did he get off the 2nd floor? " She replied: " I do not know how he got off the 2nd floor unit. " " That would have to be investigated. "
RN, C was asked: " Were you aware he was exit seeking at admission? " She replied: " No " , I was not directly assigned to the resident. She further stated that " not every patient on the 2nd floor needs supervision. "
RN, C was asked: " How does staff know which residents are wanders or exit seeking? " She replied: " it comes with staff knowing the resident. " " The 2nd floor is an Alzheimer ' s unit; I am not too familiar with the residents on that floor. " " I do not know what the process is to understand which residents are wanders or exit seeking. "
RN, C was asked: " The facility uses Agency staff members, how do these staff members know which residents are at risk for wandering? "
RN, C, replied: " I do not know. "
RN, C, confirmed that Resident #210 was " missing " during 06/21/14 and that the Elopement Protocol was initiated.
RN, C, was asked why the event was not documented in Resident #210 ' s clinical chart, the nursing notes or anywhere else. RN, C, replied: " I do not know why a person did not enter the information into the clinical chart. "
RN, C, stated that " If I have a resident that I am giving medication to and he is missing, I have a concern. "
Did you know at admission he was a wander risk or exit seeking? RN, C, replied: " I did not know

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he was identified as a wander risk. " She further stated that she did not know the location of the resident when he was found. She stated he was " hot " when he came back. Not sure of the staff member that found him.
RN, C was asked " Why was a Wander tool completed on the resident on 06/23/14? " RN, C, replied: " I do not know why the Wander tool was done. I believe that is done on admission, I would have to be instructed as to what the process is. Do not know why the Wander tool was not done at admission. "
In an interview conducted on 07/10/14 at 11:03 a.m. with the DON, she stated that, sometimes, she would place a resident on the 2nd floor; if the bed situation warrants it. For example if they have no male beds on the 3rd floor. She stated that the 1st floor is for Medicare. Resident # 210 was placed on the 2nd floor due to the lack of beds on the other floors.
It was also stated that, if he started showing the behaviors of exit seeking; they would call me and alert me; they would call the doctor and let them know; immediately means within the hour;; they have to get permission from me to put a wander guard on the resident; they would complete a wander assessment to determine if he is high risk. Incapacitated means that they cannot make safe decisions for their everyday living; medical needs. I believe that he can make safe decisions in regards to his medical needs and his everyday living. " No event report was conducted in regards to the event that transpired on 06/21/14 with Resident #210. He did not sign out. Supposed to sign out, but did not. He was a couple of blocks down sitting on the bench " . " The resident left the facility, he was missing; they did not know where he went. " But, it was not an elopement. " No we did not call the police. I did

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not complete an investigation for the event. "

An interview was conducted with a physician on 07/10/14 at 12:41 p.m., who had been seeing the residents at the facility for approximately 1-2 weeks. He stated that he was familiar with Resident #210, that he had visited him two times since he had started at the building. He stated that the other doctor, (primary) might have seen him earlier. He stated that he was not aware of the resident leaving the facility unsupervised. He stated that he would make some phone calls to other members in the group to find out if they were aware of the concern. He stated that the resident, when he talks to him, stays grumpy and irritable. The resident does not seem aware; he has met him 2 x; he stated that he would suggest that the resident does not have capacity. (This doctor called back on 07/11/14 and informed the surveyor that the physician group office was unaware of the event that occurred on 06/21/14 for Resident #210.)

An interview was conducted on 07/11/14 at approximately 1:30 p.m. with the Administrator. He stated the event that transpired on 06/21/14 with Resident #210, he did not believe it was an elopement. He stated that they had investigated the event, but not written down the investigation or documented the scenario as an event. Another interview was conducted on 07/11/14 at 2:30 p.m. with the Administrator. He was asked if he or anyone had reviewed the facility cameras to try to determine how the resident had gotten off of the 2nd floor and how he was able to leave the building unauthorized. The Administrator stated: " I did not think to look at the camera " footage. At approximately 4:00 p.m. on 07/11/14, the

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Administrator stated that he was unable to access the footage on the cameras that would potentially reveal the method of which Resident #210 was able to leave the secure area of the 2nd floor and complete an unauthorized exit from the nursing home facility.

An interview was conducted on 07/11/14 at 4:20 p.m. with the facility Medical Director for the building. He stated that he had been the Medical Director for approximately 2 years. The Medical Director was asked if facility staff were responsible to call and inform him of an unauthorized exit from the building by a resident, a resident that was found approximately 3 blocks from the facility. He stated that usually they would call; he stated that that he was not aware of a phone call regarding Resident #210 leaving the facility (unauthorized) on 06/21/14. But, he said he would check with his answering service, they may have knowledge of the phone call. (The Medical Director followed up with this conversation on 07/11/14 at 6:55 p.m. to confirm that no phone call had been placed to him or his answering service regarding Resident #210 ' s event on 06/21/14.) The Medical Director stated that he would want to know about an event like this. The Medical Director stated that the 2nd floor of the facility was a secure unit, that it typically meant the residents needed extra supervision.
The Medical Director stated that if some is not deemed incompetent by paperwork that does not mean competency.
" I would expect that an event of an unauthorized departure from the facility would be investigated. "
The Medical Director was given an example of a resident coming to the facility with a transfer form that states the resident is " exit seeking " , the

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resident is placed on the 2nd floor of this facility; the resident goes missing the day after admission; staff implement the elopement protocol and the resident is found approximately 3 blocks away from the facility. Is that an elopement? Medical Director stated: " yes, it is. "

2. A review of the record for resident # 211 revealed that she was admitted to the facility on 6/27/14 from another nursing facility. An Admission/Readmission Nursing Evaluation form, with an effective date of 6/27/14 and signature dates by the LPN of 6/28/14 and an RN on 6/30/14 was found in the resident ' s electronic health record. Review of this Admission Nursing Evaluation form revealed that the resident had an admitting diagnosis of " Deconditioning Dementia Psychosis " . The form indicated the resident was independent with bed mobility, transfer, ambulation and locomotion and was alert to person with periods of confusion.

An observation was conducted on 7/11/14 at 1: 45 p.m., Resident # 211 was observed seated in her room in her wheelchair. A Wander guard was observed on the resident ' s wrist.

A review of progress notes in the resident ' s record revealed:
6/27/14 20: 27 Narrative Nurses note: " New admission arrived to facility at 5: 30 p.m. Resident alert and orient to self, periods of confusion noted, admitting diagnosis Dementia and Psychosis, denies pain or discomfort. " Continent of B& B, ambulating with a slow steady gait. "
6/30/14 09: 30 Narrative Nurses note: " Late

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entry for 6/29/14, Resident alert with confusion. Refused all meds x 3 stating ' I ' m not taking any more medicine it ' s just going to poison me ' . Minimal assist with ADL care provided x 1 staff. Mobilizes via w/c able to propel self. Wanders aimless in corridors and into other rooms, redirected at these times. Refused meals stating, ' I ' m not hungry and you ' re not going to shove any of that food in me. '
6/30/14 14: 32 Social Services: " Met with residents this afternoon to introduce self, review rights, abuse, grievance policy, advances directives, and current status. Resident is an 84 year old female admitted to us from (another nursing facility) as she needs a secured unit. Is alert, responds to verbal stimuli with forgetfulness and delayed reactions noted. Is able to communicate her needs. Was cooperative and answered all questions as best she can recall. Has poor recall and insight. Has Dx of Dementia, Psychosis, and Delusions. "
6/30/14 13: 32 Narrative Nurses Note: Resident alert with some confusion noted. All meds accepted except iron this shift. Minimal assist with ADL care x 1 staff. Mobilizes via w/c, able to propel self. Aimless wanders in corridors and into others room, redirected at these times. "
A review of the electronic health record revealed a " Wandering/ Elopement Assessment Tool " with an effective date of 6/30/14 (three days after admission). Review of this tool indicated the resident was determined to be:
" Disoriented (x 2 spheres)
Combative/ severely agitated
Recent experiences of Change of roommate, room change, admission within the last month, caregiver or staff change,
Mobility - independent
Diagnosis: Dementia with Psychosis

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	105772	A. BUILDING _____ B. WING _____	C 07/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF ST PETE	435 42ND AVE S SAINT PETERSBURG, FL 33705

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Medications: Taking antipsychotics

History of Wandering: Know wanderer/hx of wandering
Care plan/recommendations:
By this assessment is the resident at risk for wandering? " Yes "
If yes, have appropriate interventions been initiated " Secure "
Has the care plan been updated and communicated to the staff? " Yes "
Has the physician and family been consulted? " No "
This form was signed by the Unit Manager on 6/30/14.
Review of the interim care plan for resident # 211, dated 6/ 27/14, revealed under the section for " Falls/Safety Risk/Elopement Risk " the following areas were checked :
" Keep call bell in reach/ encourage use of call light, Therapy to screen and evaluate as needed, Apply bed/ wheelchair alarm, wander guard if needed, Resident to wear proper footwear and non - skid soles. "
An interview with the MDS staff person, on 7/11/14 at 2: 07. p.m. revealed that the comprehensive care plans were not completed yet for the resident as " she hasn ' t been here 21 days yet so no comprehensive care plans but she has the interim care plan. "
A review of verbal admission orders from the physician, dated 6/27/14, revealed " Wander guard, Check Q shift for function and placement " .
A review of documentation in the resident ' s chart, paper and electronic records, revealed that there was no documentation for June 27, 2014, June 28, 2014, June 29, 2014 or June 30 2014 of the facility checking for placement of the wander

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guard every shift. An interview was conducted with the Unit Manager on the secured unit, on 7/11/14 at 7: 40 p.m. She stated that documentation for the wander guard checks would be on the Treatment Record in the resident ' s chart. She stated it is placed on the Treatment Record when the order is received. She reviewed the chart and confirmed there was no entry on the Treatment Record for the wander guard and no documentation that the wander guard was checked for placement each shift from June 27, 2014 through June 30, 2014.
Per interview with the Assistant Director of Nursing and the 3 p.m. to 11 p.m. Nurse Supervisor, on 7/11/14, at approximately 8: 00 p.m. revealed that all residents with wander guards were in the wander guard books. There are two books, one kept at the front lobby desk and one kept at the 1st floor nurse ' s station. Each book contains a list of all residents with wander guards and a picture of each resident with a wander guard. Review of both books with the Nurse Supervisor and the Assistant Director of Nursing revealed no picture of Resident # 211 in either book.

3. A review of the record for resident # 212 revealed that he was admitted to the facility on 6/23/14 from another nursing facility. Review of documentation from the other nursing facility, found in resident # 212 ' s record, revealed that the resident, on 6/22/14 and 6/23/14 (prior to admission at current facility), exited and/or attempted to exit the other facility multiple times and removed his wander guard at least twice, the last time by biting it off.

An observation was conducted on 7/11/14 at 7: 50 p.m., Resident # 212 was observed

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ambulating independently down the hall of the secured unit. The resident was noted to have a Wander guard on his right wrist. Resident # 212 stated that he was " doing well " .
A review of the Admission/Readmission Nursing Evaluation , with an effective date of 6/23/14 an signature dates from the LPN and the Unit Manager on 6/25/14 and 6/27/14, revealed that the resident had admitting diagnoses of " fall, hematoma, brain bleed. " The evaluation indicated that the resident was independent in bed mobility, transfer, ambulation and locomotion and alert to person, time and situation with a note indicating " resident is confused at times. "
Further diagnoses found in the resident ' s record indicated that the resident also had diagnoses of Bipolar disorder and Schizophrenia.
A review of the Admission/ Readmission Nursing Evaluation and the nursing narrative notes in the resident ' s record revealed no indication that the resident was considered to be exit seeking, a wanderer, or at risk for elopement. An Activity/ Recreation progress note, dated 6/24/14 at 11: 59 stated, " Welcomed him to our facility and took his picture for our wander guard book, wander guard in place per unit manager. "
A " Wandering/ Elopement Assessment tool " was found in the resident ' s record with an effective date of 6/24/14. The assessment tool indicated:
" Orientation - Disoriented (x 2 spheres)
Recent Experiences - Change of roommate, admission within the last month, caregiver or staff change,
Mobility - Independent (no assist)
Diagnosis- Early Dementia.
Medications- Taking antipsychotics
History of wandering - known wanderer / history of wandering

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Care plan/ Recommendations:
By this assessment, is the resident at risk for wandering? - Yes
If yes, have appropriate interventions been initiated? - Yes
Has the care plan been updated and communicated to the staff? - Yes
Has the physician and family been consulted? - Physician /self
A review of the interim care plan, dated 6/23/14, did not indicate that the resident was a wanderer, exit seeking or an elopement risk. Review of the section for " Falls/Safety Risk/Elopement Risk indicates check marks only in the areas of " keep call bell in reach/ encourage use of call list, Therapy to screen and evaluate as needed Apply bed alarm if needed, and Resident to wear proper footwear and non - skid soles. "
A comprehensive care plan for " Elopement " indicating that the resident " was at risk for elopement due to: is exit seeking, verbalizes desire to leave and has the means to do so, is ambulatory, impaired cognition " was not completed until 7/7/14.
A review of admission physician orders, dated 6/23/14, revealed an order for " Wander guard check placement and function Q shift. "

A review of the resident ' s record, including the Treatment Record, revealed no documentation from June 23- June 30, 2014 that the placement of the wander guard had been checked each shift as ordered. " An interview was conducted with the Unit Manager, on 7/11/14 at 7: 28 p.m. She stated that the documentation for checking placement of the wander guard each shift was written on the Treatment Record when the order was received. She reviewed the resident ' s record and confirmed that there was no

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F 490	Continued From page 128 documentation that placement was checked from June 23, 2014- June 30, 2014. 4. On 7/11/14 at 9: 25 p.m., the Director of Nursing provided two sheets of paper, one entitled " 2014 June Wander guard check list " and the other entitled " 2014 July Wander guard checklist. " She stated that these sheets were kept " right next to the wander guard book at the 1st floor nurses station " and the central supply person checked the functionality of each wander guard daily and documented it on these sheets. She provided documentation that the function of the wander guards were checked daily for resident ' s # 211 and # 212 in June 2014. She stated that the nurses checked for placement. She stated that the order for " wander guard check Q shift for function and placement " for both resident # 211and # 212 was written incorrectly and that it should only be once a day.	F 490		
F 493 SS=K	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on record review, and interviews, the Administrator, as appointed by the Governing Body, and the Governing Body failed to ensure	F 493		

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that the Administer performed his duties for implementing policies regarding the management and operation of the facility. The Administrator failed to ensure implementation of the abuse policy, adverse incident policy, wander assessment policy and the elopement policy. It was determined the facility was not administered in a manner to keep residents safe from unsafe wandering and lack of supervision for 3 (#210, 211, and 212) of 46 Stage II sampled resident; In addition, a review of the facility history revealed repeat deficient practice and four surveys with findings of Immediate Jeopardy. The Administrator and Governing Body demonstrated a lack of commitment to ensure that policies and procedures are implemented by knowledgeable staff. Immediate Jeopardy was identified on the current survey, which is on-going.

Findings include:

1. A review of the Administrator ' s job description was conducted, which was obtained on 07/11/14 at approximately 10 p.m. from the Administrator. The description was undated and unsigned.

Specific Requirements included: " Must possess the ability to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for providing quality care and maintaining a sound operation. "

Duties and Responsibilities regarding Resident Rights included: " Ensure that the resident ' s rights to fair and equitable treatment, self-determination, individuality, privacy, property and

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F 493	Continued From page 130 civil rights, including the right to wage complaints, are well established and maintained at all times. " " Report all allegations of resident abuse and/or misappropriation of resident property. " 2. An Annual QIS and Life Safety Survey was conducted on 01/28/14-02/03/14 and 02/10/14 in conjunction with a complaint investigation, Immediate Jeopardy was identified at F155 S/S=K; F156 S/S=K; F250 S/S=K; F490 S/S=K; F514 S/S=K. (other deficient areas cited at level D, F159, F250, F253, F272, F279, F312, F313, F313, F431, F441). Reviewing the deficient practice of F155, the facility failed to promote the rights of residents to have their advance directives honored as were formulated. The facility failed to include " Do Not Resuscitate (DNR) orders and accurate advance directive information on the clinical record for sampled residents, which placed residents at risk for not having their rights protected and wishes honored. Reviewing the deficient practice of F156, the facility failed to ensure that facility staff were knowledgeable of facility policy and procedures for advance directives and could identify end-of life wishes regarding resuscitation or non-resuscitation of resident in the event of a cardiac arrest. F250, the facility failed to maintain current, accurate and accessible information regarding end of life choices placed the residents at risk for failure to honor their advance directives. F490, the facility failed to follow policy and procedure and provide resource management to incorporate, maintain and re-assess " do Not	F 493		

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Resuscitate orders for sampled residents.
F514, the facility failed to ensure staff were knowledgeable of their roles and responsible for maintaining accurate information in the record.

3. A Revisit to Annual QIS and Life Safety survey (that was conducted 01/28/14 thru 02/03/14 and 02/10/14) was conducted in conjunction with a complaint investigation on 03/17/14 -03/20/14, Findings of on-going Immediate Jeopardy were identified at F490 S/S=J; and F520 S/S=J; in addition deficiencies were identified during the survey at level D F278 and F441; F431 S/S=E.
For F490, the facility administration failed to operationalize facility policies related to abuse for sampled residents; failed to investigate and report an allegation of sexual abuse to the abuse hotline and state agency and failed to provide emotional support and psychosocial services to an alleged victim. The administration failed to provide staff with the necessary information to protect a resident from the sexual approaches of a resident. The administrator failed to ensure that systems were in place and staff trained to prevent a recurrence of sexual assault by a known sexual offender. Administration demonstrated a lack of action and commitment to protect residents.
For F520, the facility ' s Quality Assessment and Assurance Committee failed to identify errors and omissions in staff interpretation and implementation of facility policies for abuse and failed to ensure that an issue related to the admission of a known sexual offender was effectively addressed to ensure protection of residents. The facility administrator ' s lack of investigation and acknowledgement of an allegation of sexual abuse failed to ensure that all issues and concerns related to resident sexual abuse were identified and action plans developed

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to prevent further occurrences related to an allegation of sexual advances toward a resident from a known sex offender. The facility administrator failed to implement policies and procedures related to investigation of allegations of abuse, protection of residents and reporting of allegations to the abuse hotline and state agency. The facility failed to correct F490 from the Annual survey of 01/28/14 -02/03/14. Additionally the facility failed to ensure the quality assurance committee was actively involved in the effective creation, implementation and monitoring of the plan of correction for deficient practice related to medical storage .

4. In conjunction with this revisit, a complaint survey was conducted which identified findings of on-going Immediate Jeopardy at F 223 (J), F 225(J) & F 226 (J), & F 319 (J) related to the above findings.
For F 223, the facility failed to ensure measures were in place to prevent unwanted sexual advances and intimidation for one of nine sampled residents (#11) from a known sexual offender (Resident #1).
For F 225, the facility failed to have evidence that an alleged violation involving sexual abuse was thoroughly investigated and reported immediately to the abuse hotline and the state agency for three of nine sampled residents (#1, #11 and #225) related to an allegation of an unwanted sexual advance to Resident #11 from Resident #1, a known sexual offender. The facility failed to identify the unwanted sexual advance as an allegation of sexual abuse.

For F 226, the facility failed to implement its policy and procedure related to abuse prevention, identification, investigation, protection and

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reporting/response related to allegations of abuse for two of nine residents reviewed (#11 and # 225).
And for F 319, the facility failed to ensure that a resident (Resident # 11) who was a victim of an unwanted sexual advance from Resident # 1 and who expressed embarrassment and anger to facility staff regarding the sexual abuse, received treatment and services to address his psychosocial and emotional needs. Failure to provide treatment and services to address the psychosocial and emotional needs of a resident who was a victim of abuse caused emotional harm to this resident.
5. A Revisit, conducted on 04/10/14-04/11/14, to determine if Immediate Jeopardy identified during the complaint investigation conducted 03/17/14-03/20/14, was removed. The facility was cited during the survey for F225 S/S=D; F226 S/S=D; F282 S/S=D; F323 S/S=D; F371 S/S=E; F 278 S/S=D; F431 S/S=E; F441 S/S=D; F520 S/S=D, representing patterns of repeat deficient practice.

6. Findings of Immediate Jeopardy were identified during the current and most recent survey 07/8-7/11/2014, which is on-going.
Refer to F 224-Failure to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
Refer to F 225--Failure to ensure that allegations of neglect were thoroughly investigated and reported to the appropriate state agencies.
Refer to F 226--Failure to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

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F 493	Continued From page 134 Refer to F 323--Failure to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Refer to F 490--Failure to ensure the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Refer to F 520--Failure to ensure that the Quality Assessment and Assurance Committee develops and implements appropriate plans of action to correct identified quality deficiencies.	F 493		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		

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Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on resident record review, policy and procedure review and staff and resident interviews, it was determined that the facility Quality Assessment and Assurance Committee failed to put systemic measures in place to ensure that residents, admitted with needs that required immediate oversight of staff, were communicated to staff to ensure the safety and protection of residents. During the surveys of 07/08/-07/11/14, the facility administration failed to identify errors and omissions in Administration ' s implementation of facility policies for wander assessment, elopements, abuse, and adverse incidents for 3 (#210, 211 and 212) of 46 stage II sampled residents. The facility Administrator failed to inform the Quality Assurance Committee that a known " exit seeking " resident was admitted to the facility, Resident #210, the resident proceeded to elope from the facility, the event was not reported as adverse, the event was not reported to the state and federal agencies which resulted in no action plan being developed to address untimely assessment, lack of supervision, lack of investigation, lack of mandated reporting to provide protection to elderly and vulnerable adults.
The facility ' s failure to failure to assess, failure to provide supervision, failure to fully investigate an event of lack of supervision, failure to recognize neglect and failure to report to state and federal agencies an allegation of neglect placed residents at risk for unsafe wandering and

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REHABILITATION CENTER OF ST PETE	435 42ND AVE S SAINT PETERSBURG, FL 33705

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neglect.
The facility Administration failed to implement policies and procedures related to quality assurance, assessment, elopement, prevention, identification, protection, investigation, and reporting.

In addition, the facility has shown a history of egregious noncompliance and failure of the Quality Assessment and Assurance Committee. Findings of Immediate Jeopardy were identified during the Annual survey of 1/28-2/3/14 and extended survey of 2/10/2014. Findings of Immediate Jeopardy were identified during the 3/17-3/20/14 revisit and complaint surveys during which on-going Immediate Jeopardy was identified in Administration (F 490) and Quality Assessment and Assurance (F 520), which were not corrected from the original survey. During the same visit, a complaint survey (conducted in conjunction with the Revisit) there were new findings of Immediate Jeopardy identified at Abuse (F 223), Investigation & Reporting of Allegations of Abuse/Neglect/Exploitation (F 225), the Development and Implementation of Procedures to Prevent Abuse/Neglect/Exploitation (F 226), and the Treatment for Mental and Psychosocial disorders (F319). A revisit to a complaint survey was conducted on 04/10/14-04/11/14, 9 deficiencies were identified of which included: F225, F226 and F520 (Note, the facility is exhibiting a continuous pattern). A 2nd Revisit to the Annual Survey was conducted on 04/10/14-04/11/14, 4 deficiencies were identified of which included F278 (Lack of accurate assessment) and F520 (repeat).
Between February 10, 2014 to July 11, 2014, findings of Immediate Jeopardy (I J) were identified to exist on three separate surveys in

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addition to the survey conducted on 07/08/14-07/11/14; meaning 4 IJ surveys out of 6 that were conducted in a 6 month period. This pattern of non-compliance demonstrates a lack of commitment of the facility to ensure the well-being of their residents and has resulted in findings of Immediate Jeopardy, which is on-going.

Findings include:

1. During an interview conducted on 07/11/14 at approximately 9:30 p.m., the Director of Nursing (DON) stated that the Quality Assurance committee ' s members were: The Administrator, Director of Nursing, and Assistant Director of Nursing, the Unit Managers, Social Service Director, Medical Records, Certified Dietary Manager, Activities Director, Maintenance Director, Housekeeping director, the wound care nurse and the Medical Director. She further stated that the committee meets monthly for QA, the last meeting was held on 06/27/14.
The QA interview was offered to the Administrator and the DON. The DON stated that she could conduct the meeting solo. The Quality Assurance interview was conducted with the Director of Nursing, on 7/11/14 at 9: 30 p.m. The Director of Nursing reported that the last meeting of the Quality Assurance Committee was 6/27/14, six days after the critical event with resident # 210, who left the building without staff knowledge within 24 hours after admission. The Director of Nursing stated, at 9: 45 p.m., that the critical event with resident # 210 was not discussed at the Quality Assurance meeting of 6/27/14 because it was not an elopement and not an adverse incident so it would not have been discussed.

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The Director of Nursing provided a document entitled " Quality Assurance Monthly Meeting " , on 7/11/14 at 10: 08 p.m. She indicated that the agenda items on this document are the items discussed at each quality assurance meeting. Review of the document revealed that Adverse Incidents and Elopements were both listed on the agenda.

2. The current survey, conducted 07/08/14 thru 07/11/14, revealed deficient practices:

F323, the facility failed to ensure that 1 (#210) of 46 Stage II sampled residents received adequate supervision and application of adequate monitoring devices to prevent unsafe wandering. Resident #210 was admitted to the facility as a documented " exit seeking " resident that ambulated " ad lib " ; the resident had a primary diagnosis of " AMS " , (Altered Mental Status) with a secondary diagnoses of Late effects CVA (Cerebral Vascular Accident); Resident #210 was admitted to a " Secure floor " (the 2nd floor) " because of lack of Medicare beds on the 1st floor " per the Director of Nursing, not because he needed monitoring..
Subsequently, after a period of approximately 11-12 hours after admission, Resident #210 exited the " secure floor " unseen by direct care staff; exited the building unseen by facility staff members and exited the facility grounds to reportedly " try to go home " . Resident #210 was found sitting at an unsheltered bus stop next to a 4 lane road that was approximately 4 blocks away from the facility grounds.
Direct Care Facility staff, D and C stated that they were unaware that Resident #210 had " exit seeking ' ' behavior upon admission and the Director of Nursing placed Resident #210 on the

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F 520	Continued From page 139 2nd floor Secure area due to the lack of beds on the 1st floor, not because he was " exit seeking " . A Wander Assessment tool was completed (untimely) 2 days after Resident #210 went " missing " from the facility. Facility staff did not comprehensively investigate Resident ' s " missing " event as an Elopement, in order to attempt to prevent unsafe wandering of residents. F224, the facility failed to provide goods and care services for 3 (#210, 211 and 212) of 46 Stage II sampled residents. F225, the facility failed to have evidence of a comprehensive investigation of an event involving the lack of appropriate monitoring devices and lack of supervision which resulted in an elopement event where Resident #210 was able to leave a secure floor, unwitnessed; able to leave the facility and facility grounds, unwitnessed. The facility definition for Neglect: the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the resident. The facility failed to have evidence of reporting immediately to the abuse hotline and the state agency the potential findings (allegation) of neglect for 1 (#210) of 46 Stage II residents. F226, the facility failed to implement its policy and procedure related to Abuse Protection and Response Policy related to an allegation of neglect for 1 (#210) 46 Stage II sampled residents and ultimately affecting all 142 elderly and or disabled residents in the facility.	F 520		

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F 520	Continued From page 140 The facility failed to follow its policy and procedure related to the facility definition of neglect. The facility failed to prevent neglect by not identifying and communicating to direct care staff the " exit seeking behavior " of Resident #210 that made him a risk for unsafe wandering. The facility failed to ensure supervision to prevent unsafe wandering for Resident #210. The facility failed to identify a " missing " resident, #210, as an Elopement. Additionally, the facility failed to implement its policy and procedure for investigating and reporting all allegations of abuse immediately to the abuse hotline and the state agency related to Resident #210 ' s elopement. In addition, the facility failed to ensure that services were provided in accordance with the physician written plan of care for 2 (#211 and 212) of 46 Stage II sampled residents. For Resident #211 and 212, the failure to implement a wander guard order for placement and to check functioning of the wander guards every shift which potentiates neglect. 3. Surveys conducted prior to the current survey included: An Annual QIS and Life Safety Survey was conducted on 01/28/14-02/03/14 and 02/10/14 in conjunction with a complaint investigation, Immediate Jeopardy was identified at F155 S/S=K; F156 S/S=K; F250 S/S=K; F490 S/S=K; F514 S/S=K. Reviewing the deficient practice of F155, the facility failed to promote the rights of residents to have their advance directives honored as were formulated. The facility failed to include " Do Not Resuscitate (DNR) orders and accurate advance	F 520		

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directive information on the clinical record for sampled residents, which placed residents at risk for not having their rights protected and wishes honored.
Reviewing the deficient practice of F156, the facility failed to ensure that facility staff were knowledgeable of facility policy and procedures for advance directives and could identify end-of life wishes regarding resuscitation or non-resuscitation of resident in the event of a cardiac arrest. F250, the facility failed to maintain current, accurate and accessible information regarding end of life choices placed the residents at risk for failure to honor their advance directives.
F490, the facility failed to follow policy and procedure and provide resource management to incorporate, maintain and re-assess " do Not Resuscitate " orders for sampled residents.
F514, the facility failed to ensure staff were knowledgeable of their roles and responsible for maintaining accurate information in the record.

4. A Revisit to Annual QIS and Life Safety survey conducted in conjunction with complaint investigation on 03/17/14 -03/20/14, findings of on-going Immediate Jeopardy were identified at F490 S/S=J; and F520 S/S=J; in additional deficiencies were identified during the survey at level D F278 and F441; F431 S/S=E.
F490, the facility administration failed to operationalize facility policies related to abuse for sampled residents; failed to investigate and report an allegation of sexual abuse to the abuse hotline and state agency and failed to provide emotional support and psychosocial services to an alleged victim. The administration failed to provide staff with the necessary information to protect a resident from the sexual approaches of a

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resident. The administrator failed to ensure that systems were in place and staff trained to prevent a recurrence of sexual assault by a known sexual offender. Administration demonstrated a lack of action and commitment to protect residents.
F520, the facility ' s Quality Assessment and Assurance Committee failed to identify errors and omissions in staff interpretation and implementation of facility policies for abuse and failed to ensure that an issue related to the admission of a known sexual offender was effectively addressed to ensure protection of residents. The facility administrator ' s lack of investigation and acknowledgement of an allegation of sexual abuse failed to ensure that all issues and concerns related to resident sexual abuse were identified and action plans developed to prevent further occurrences related to an allegation of sexual advances toward a resident from a known sex offender. The facility administrator failed to implement policies and procedures related to investigation of allegations of abuse, protection of residents and reporting of allegations to the abuse hotline and state agency. The facility failed to correct F490 from the Annual survey of 01/28/14 -02/03/14. Additionally the facility failed to ensure the quality assurance committee was actively involved in the effective creation, implementation and monitoring of the plan of correction for deficient practice related to medical storage.

5. A complaint investigation was conducted on 03/17/14 -03/20/14, in conjunction with the Revisit to the Annual QIS. Findings of Immediate Jeopardy were identified for
F223 S/S=J; F225 S/S=J; F226 F319=J.

F223, the facility failed to ensure measures were

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F 520	Continued From page 143 in place to prevent unwanted sexual advances and intimidation for the residents. F225, the facility failed to have evidence that an alleged violation involving sexual abuse was thoroughly investigated and reported immediately to the abuse hotline and the state agency for residents. F226, the facility failed to implement its policy and procedure related to abuse prevention, identification, investigation, protection and reporting/response related to allegations of abuse. F391, the facility failed to ensure that a resident who was a victim of an unwanted sexual advance from another resident, the victim expressed embarrassment and anger to facility staff regarding the sexual abuse, failed to receive treatment and services to address his psychosocial and emotional needs. 6. A Revisit to a complaint survey, conducted on 04/10/14-04/11/14, the facility was cited during the survey for F225 S/S=D; F226 S/S=D; F282 S/S=D; F323 S/S=D; F371 S/S=E; F 278 S/S=D; F431 S/S=E; F441 S/S=D; F520 S/S=D. F225, the facility failed to show evidence that an allegation of physical abuse was investigated and reported to the abuse hotline and the State survey and certification agency F226, the facility failed to implement the identification, investigation and reporting components of their abuse policy and procedure. F323, the facility failed to ensure that it provided oversight during for a resident needing observation during the smoking activity. 7. A 2nd Revisit to the Annual QIS survey was conducted on 04/10/14-04/11/14. The facility was	F 520		

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F 520	Continued From page 144 cited during the survey for F278 S/S =D; F431 S/S=D; F441 S/S=D; F520 S/S=D. F278, the facility failed to ensure assessments for smoking were accurate. F520, the facility failed to an allegation of abuse; because the allegation was not identified, the facility failed to implement their policies and procedures for abuse to include identification investigation and reporting.	F 520		