Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100610	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR BEACH NURSING AND REHABILITATION CE	1615 MIAMI RD FORT LAUDERDALE, FL 33316

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N 000	INITIAL COMMENTS An unannounced Relicensure with complaints #2021010743, #2021014655, #2021015218, #2021015351, was conducted from to at Harbor Beach Nursing and Rehabilitation Center. The allegations were substantiated for complaint #2021014655 due to the facility failing to provide supervision to prevent an elopement, and failure to assess a resident at an elopement risk. On at 4:25 AM, a determination was made that the findings of the survey posed Imminent Danger to the health and safety of the residents admitted to the facility. Imminent Danger is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, , , or to the resident. The deficient practice allowed Resident #1 to exit the facility undetected on between 7:00 AM and 7:05 AM. The facility's system failure, lack of adequate supervision, inaccurate risk of elopement assessment, and a failure to thoroughly investigate the surrounding area of the door known to be the door from which the resident eloped. Class I violations which presented an imminent danger to residents were identified at N201 and N204, Class I, right to adequate and appropriate healthcare. The Nursing Home Administrator was notified of the identified Imminent Danger on at 10:25 AM.	N 000		
N 201 SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care	N 201		

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N 201	Continued From page 1 (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on interviews, observations, record reviews and policy review, the facility failed to prevent a resident with memory and from exiting the facility unsupervised. The facility did not provide supervision to prevent an elopement of 1 of 5 sampled residents reviewed for elopement risk (Resident #1). The deficient practice allowed Resident #1 to elope from the facility undetected on between 7:00 AM and 7:05 AM; the facility failed to 1) ensure that it obtained the attending physician's current orders for and indication for use, for a resident receiving for 1 of 2 residents (Resident #10). 2) failed to ensure that it dated and properly labeled the tubing for 2 of 2 residents receiving (Resident #10 and Resident #49); and the facility failed to ensure a timely nutritional assessment, was unable to assist with ordered nutritious treats and failed to prevent further loss for 2 of 11 residents reviewed for nutrition (Resident #21 and Resident #200). The findings included: 1). The facility's Policies and Procedures titled "Missing Patient/Resident" effective date	N 201	N201 1.Resident #1, #6, and #39 risk for elopement evaluation and Elopement books were updated, and other necessary interventions were placed to address exit seeking behaviors. The Regional Director of Clinical Services and/or designee conducted an elopement drill for staff to include Staff E and educated on Elopement Plan, /Neglect Policy and Procedure. 2.DCS and/or designee conducted an audit of residents record and facility s elopement drills to ensure that elopement risk evaluation and measures to address residents with high risk for elopement are in place, to include but not limited to, medications administration and elopement plan. Corrective actions were done as necessary. 3.DCS and/or designee educated staff to include new hired staff with return	

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N 201	Continued From page 2 and revised on has an Overview "Staff will investigate cases of missing patient/resident and possible elopement. An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury. Procedure: Check Leave of Absence (LOA) book and Medical Record to ensure patient/resident is not on an authorized leave or medical . Announce "resident name) please return to your room", over PA system. Repeat three times to alert staff of a missing patient/resident. Assigned staff to search the grounds. If the patient/resident is not located after the initial search the point person will notify the Executive Director and Director of Nurses, Resident Representative, and Physician. The Executive Director and/or Director of Nursing or designee to notify local Law Enforcement. Upon return to the Center a physical evaluation will be completed to determine if further treatment is needed. Document in the Medical Record. Notify Physician, Resident Representative, Executive Director, Director of Nurses and Law Enforcement (if applicable) of patient/resident's return. Review and revise the interventions as indicated related to elopement and risk and update the Care Plan and Kardex." Record review revealed Resident #1 was admitted to the facility from an acute care hospital on with diagnoses that include , , and . The Resident's Minimum Data Set (MDS) Comprehensive assessment dated revealed Resident #1 had a ( ) score of 11, which indicates moderate loss in ability and can be associated with poor	N 201	demonstration on new elopement plan, timely conduction of elopement drills, and educated on and Neglect Policy and Procedure. Licensed nurses were educated on following Physician orders Policy and Procedure as they relate to the , medication administration and guard use, and timely Elopement Risk Evaluation. 4.Executive Director and/or designee will conduct an audit of elopement drills, residents elopement risk assessment evaluation, and measures for residents who were identified with high risk for exit seeking behavior to include but not limited to , medication administration and guard use, to ensure of timely implementation, adequate supervision and residents are free from and neglect, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance. N201 1.The Registered Dietician reassessed Resident #21 and #200s nutritional status to provide the necessary interventions for their losses. Staff was educated on assisting residents during meals and to their nutritional supplements as necessary. 2.The Director of Clinical Services and/or	

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N 201	Continued From page 3 decision-making skills. In Section E of the MDS, Resident #1 was assessed not to have behaviors. In Section G of the MDS under Functional Status, Resident #1 needs supervision with walking in her room, corridor, and locomotion on and off the unit. Under Section N-medications, Resident #1 was assessed to take medication for the past 7 days, medications for the past 7 days, and medication for the past 7 days. Under Section P- and alarms, the /elopement alarm was coded as not used. Another test was conducted on , which showed a new score of 13 out of 15, indicating intact cognition. Record review revealed a skilled nursing note dated showed that Resident #1 was identified as an elopement risk. An elopement risk evaluation was conducted on , the day of the elopement incident, which was not done prior to that. The assessment showed a score of 4, which indicates that Resident #1 is at risk for elopement. Resident #1's care plan reveals a focus of Resident "has potential for drug-seeking type behaviors. Hx. [History] of drug and drug-seeking since admission." Date initiated . Interventions include " and meet" resident's "needs" (dated), "Educate" resident "on successful coping and interaction strategies" (dated), and resident "will not out of facility" (dated). An additional focus of the care plan includes the resident "is an elopement risk/ related to safety awareness" (date initiated) with interventions that include "actual elopement on " (dated), "assess for	N 201	designee conducted an audit of residents during meals and residents receiving nutritional supplements to ensure that they are receiving the assistance needed as necessary. The Registered Dietician conducted an audit of residents Nutritional Assessment record to ensure that losses are timely addressed as necessary. Corrective actions were made as necessary. 3.The Regional Dietician educated the Registered Dietician on the Nutrition/Hydration Status regulatory requirement. 4.The Registered Dietician and/or designee will conduct an audit of the residents during meals and residents with nutritional supplements to ensure that assistance are provided as necessary and nutritional assessments are in place for residents with losses for timely intervention, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance. N201 1.Resident #10 and #49s were checked for label and physician orders and were updated as needed during the survey. 2.The Director of Clinical Services and/or designee conducted an audit of residents	

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N 201	Continued From page 4 elopement risk" (date initiated) "electronic monitoring to place on the resident" (dated). Record review revealed Resident #1 Physician's orders for , (prior to the elopement that occurred on) included the following: , 81milligrams (mg) one tablet daily for ; 20mg one tablet daily for ; 20mg one tablet daily for ( ); 325mg one tablet daily for a supplement; 100mg one tablet daily for ; Extended-release 24 hour 60mg one tablet daily for ; 20mg one tablet daily for ; 20mg one tablet daily for ; 75mg in the morning for ; D3 tablet 5000 units 1 tablet daily for D deficiency; tablet 1 mg every 12 hours for symptoms; tablet 0.25mg one tablet two times a day for ; tablet 15mg one tablet three times a day for . During the Medication Administration Record (MAR) review, there were blank sections where the nurses would put their initials indicating if the medication was given or why it was not given. The medication had blanks for the dates of , , , , , , at bedtime. The medication 0.25mg had blanks for the dates of , , , , at 5:00 PM. 100mg had blanks for , , , , for the bedtime doses. The medication had blanks for , , , , , , and for the 5:00 PM doses.	N 201	with to ensure that a physician order is in place and is appropriately labeled. 3.The Director of the Clinical Services and/or designee educated licensed nurses on the regulatory requirement for as related to order. 4.The Director of Clinical Services and/or designee will conduct an audit of residents with to ensure that a physician order is on place and is appropriately labeled, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	

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N 201	Continued From page 5 An interview was conducted on at 2:00 PM with the facility's Director of Nursing, who was asked why there were blank spaces when the nurse's initials should be there, and she was unable to provide a reason why. In an interview conducted on at 11:00 AM with the facility's the Director of Rehab, he stated that they use the BCAT (Brief Cognition Assessment Tool) to assess the level. Residents must be able to meet a specific criterion to be able to perform the test. The social worker will do her , and the SLP (Speech Language Pathologist) will conduct the BCAT to assess status. The is used as a baseline test when residents are admitted. The BCAT is more intensive with specific based questions that have 1 step command and 2 step commands. The test is very standardized and needs to be done by the book. He further stated that the BCAT could show specific goals for needs assessment and 1 to 2 steps goals. It is an excellent tool recognized by the American Speech-Language-Hearing Association (ASHA). A nursing referral must be sent to have the SLP conduct the BCAT test. The lower the score on the BCAT, the more dependent the residents may be on all their Activities of Daily Living (ADL's). Someone with a low BCAT score will need , supervision, and everything must be structured for them. Someone with a score of 20 and below will have a high risk of getting hurt if they walk outside the facility and start walking, and they will need constant monitoring to avoid any accidents. A resident with a score higher than the BCAT will have to be reassessed with a new score. The Director of Rehab stated that levels could change and fluctuate from one day to	N 201		

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N 201	Continued From page 6 another. The BCAT is more standardized, and it is a more accurate test. Resident #1 had a BCAT (Brief Assessment Tool) conducted after the incident on . The assessment was completed by the facility's Speech-Language Pathologist on , 3 days after the incident. The BCAT assessment showed a score of 18 out of 50, indicating severe -linguistic . The Resident presents with severe in sustained attention, comprehension for following basic directions, short-term memory recall, and problem-solving skills. Resident required max verbal cues for redirection to structured tasks throughout the examination. An elopement risk evaluation was conducted on , the day of the incident, which was not done prior to that. The assessment showed a score of 4, which indicates that Resident #1 is at risk for elopement. In an interview conducted on at 11:10 AM with Resident #1, she could not have a conversation with the surveyor and did not provide appropriate responses when answering the surveyor's questions. In an interview conducted with Staff H, CNA, via telephone on at 11:59 AM, she was asked about the incident on . Staff H stated that she was leaving the facility when Staff G, a Licensed Practical Nurse (LPN) asked her to look for Resident #1 on her drive home. At approximately 7:15 AM, Staff H located Resident #1 by a Speedway gas station located on US-1 and 16th street. Staff H stated that Resident #1 was about to turn right onto Highway	N 201		

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N 201	Continued From page 7 US-1 going North. The Resident was observed wearing sweatpants, a shirt, and sneakers and carrying her purse. Staff H pulled into the gas station and approached the Resident on . Resident #1 stated, "I do not want to go to the hospital." Staff H reported that Resident #1 did not recall her name but knew her by . Resident #1 agreed to get in the car, and Staff H then brought her to the facility at approximately 7:20 AM. Staff H further stated that Resident #1 was very restless the night before. During the night, she kept coming out of the room and asked to leave, and she had her shoes and purse. She asked to leave multiple times during the night shift and was monitored by staff. According to Staff H, Resident #1 was more than usual. When asked about her status before leaving the facility, she reported that Resident #1 was . She also said that Resident #1 exhibited exit behaviors before her leaving on but nothing to the extent of her leaving the facility. An interview with Staff E, Certified , Assistant (COTA), was conducted on at 12:15 PM. Staff E stated that on , between 7:00 AM and 7:05 AM, she was in the gym working on her notes when she heard an alarm. She walked in the direction of the door that the alarm sounded from and poked her out of the door but did not step out. The exit door was located between . On her way to the exit door, she stated that the Resident in told her that the skinny lady in was walking in the hallway toward the exit door earlier, but he did not see her leave. Staff E further stated that she returned to the nurse's station and alerted additional staff to what the Resident in told her. She then asked Staff F, Certified Nursing Assistant	N 201		

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N 201	Continued From page 8 (CNA), to check Resident #1's room to see if she was there. She did not call the police and is unsure if anyone called the police. The Director of Nurses and the Administrator had not arrived at the facility yet. Resident #1 was not located in her room or inside the facility. Staff immediately initiated a search of the grounds, including the parking lot. Staff G, a Licensed Practical Nurse (LPN) who worked the night shift, went outside looking for Resident #1. In a tour conducted on at 12:10 PM, surveyors walked the path that Resident #1 walked when she left the facility on . Resident #1 walked out from Harbor Beach Nursing and Rehabilitation Center through the exit door on the North-West side. She walked down the ramp and turned left onto 16th Street, going West towards US-1. The side street (16th Street) did not have any sidewalk on one side of the road and had cracked uneven pavement. Highway US-1 had 6 lane highway, with 3 lanes on each side. Further, observation showed no crossing light/or traffic light at the intersection of US-1 and 16th street. It is unknown what side of the road the Resident walked on or if she walked in the street. The resident could have gotten lost, , or been hit by a car. While Resident #1 was out of the facility unsupervised there was a high likelihood that she could have been seriously injured, seriously harmed, or . (Photographic evidence obtained). In an interview conducted on at 12:33 PM with Staff I, Social Services Director, she reported that scores could vary from one day to the other. If a resident has a , , ( ), or other , their	N 201		

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N 201	Continued From page 9 score might be affected. She may repeat the test for the depending on the discrepancies after a resident is all better. When asked if she is aware of the BCAT test, she said that SLP does it, but she is not very familiar with it. The BCAT may be done on residents with or because it is more detailed. Staff said that the BCAT is more accurate than the because they are going into more details with the questions, and it takes longer to do the test. Staff I, further stated that Resident #1's level and speech have improved since her admission to the facility. On , Resident #1's repeated score was at 13, which is On at 1:00 PM, Staff I indicated a new test would be completed for Resident #1 . In this test, Resident #1 was only able to answer the present year and scored 3 out of 15, indicating severely In a phone interview conducted on at 1:48 PM with Resident #1's father, he stated that Resident's #1 communication and status have worsened since she was admitted to the facility. He further reported that Resident #1 is not able to verbalize her needs to him. A review of the Elopement drills that were provided by the facility showed no indication that and Elopement in-services were given in as listed on the Education Calendar for 2021. This surveyor was provided education in-service attendance reports for /mistreatment dated and Missing Resident/Elopement/ dated . The facility also conducted elopement drills on and after the incident on . A closer review of the Elopement drills	N 201		

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N 201	Continued From page 10 after . . . . did not show an education that included: an outside search that needs to be done outside the facility as far as the . , . distance from the alarming exit door as a point of reference. In an interview conducted on . . . . at 10:20 AM, with Staff J, Certified Nursing Assistant, she arrived at the facility at 7:00 AM, on the morning of . On her way to the nursing station, she heard from another staff that Resident #1 had escaped and that they listened to the alarm. According to Staff J, Resident #1 always says that she wants to go out and wants to leave and is known to be a little . . . . . On the morning of the incident, staff started looking for her outside and inside the facility. She was told to look for Resident #1 outside in the front parking lot of the facility. When asked if Resident #1 had a guard before she attempted to leave the facility, she said no. She further stated that because she had never left the facility before, she did not need one. According to Staff J, on , they did not have a supervisor in charge because it was too early. She further said that when she was educated on elopement, she was told to first check each room before searching outside the premises. Then you go out to look for the resident. When an elopement happens, they are supposed to tell someone in charge and follow the directions of the supervisor. Staff J stated that she did not participate in any elopement drills after . . . . . When asked as to how many exit doors does the facility has, she did not know. In a second interview conducted on . . . . . at 11:07 AM with Staff E, she stated that she was educated on elopement twice a year. The drills consisted of a code called "BODYBEAR" as an	N 201		

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N 201	Continued From page 11 indication that a resident was missing. They needed to get to the nurse's station and receive the individual assignment from the supervisor. Once you have your instructions, you follow them and report your findings. On the morning of , she heard the alarm and told the nurses what the Resident in told her. She tried getting the staff around the facility to search for Resident #1, and she even looked outside the front of the facility. After the incident, the facility conducted an in-service on elopement which she did not participate. When she returned, she completed a test on elopement. According to Staff E, nothing new was part of the education, and that they re-educated staff on the same instruction you would follow if an elopement happened again. She did not know if the facility completed another drill after the incident on . When asked by the surveyor if she could see Resident #1 walking away when she peeked outside the door on , she said: "I can see a partial view of the street, on both sides but more to the left." She then said Resident #1 must-have walked very fast. In an interview conducted on at 11:57 AM, Staff K, Housekeeping, stated that on the day of the incident, she passed by to go to the nurses' stations. She is familiar with Resident #1, who usually comes out of her room at around 8:00 AM and goes outside the patio across from her room. On the morning of , she saw Resident #1 walking out of her room and did not think much of it. The next thing she heard was the alarm on the door. She walked in the direction of the sound and was told by Staff E, who was by the exit door, that Resident #1 had already gone and could not see her. She then started looking for Resident #1 around the	N 201		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR BEACH NURSING AND REHABILITATION CE	1615 MIAMI RD FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 12 building. She also reported that by the time she was ready to go into her car and drive around to look for Resident #1, another staff brought Resident #1 to the facility. She could not remember when the last time she participated in elopement drills. When asked if this happened again: she said, "they would not have to tell me anything; I would go looking for [Resident #1] right away". In an interview conducted on at 12:15 PM with the Maintenance Director, he stated he helps with the elopement drills. He noted that elopement drills are conducted once a month for every shift. Before this year, they used to have a dressed-up teddy bear called BODYBEAR, which the facility would hide either inside or outside. Once announced, staff would have to come to the nurse's station to receive their assignments. Now they have changed the drills, they will call the name of the missing resident, and staff will follow the supervisor's instructions. In a tour conducted on at 6:00 PM, with the Regional Director of Clinical Services, she was asked to accompany the surveyor to the exit door that Resident #1 escaped from. Surveyor opened the exit door and peeked outside. Surveyor could not see a full view of the street from right to left, and only the ramp to the street was visible from the door (Photographic evidence obtained). The Regional Director of Clinical Services agreed that Staff E, should have stepped outside the door, and walked down the ramp, to have a full view of the street. 2). Review of facility policy and procedure on at 5 PM for provided by the (DON) effective indicated that ....Procedure: Physician's order for	N 201		

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N 201	Continued From page 13 , , shall include: Administration modality, FiO2 or liter flow, continuous or PRN. PRN orders must include specific guidelines as to when the resident is to use , . Documentation shall include: Date and time of setup, Type of administration devices used, liter flow or FiO2 ...Instructions given to the resident for no smoking or flammable substances, while , is in the room, " , " sign placed on the resident's door ...Signature and credentials. Review physician's order ....Assess the resident ...Post " , " signs on the resident's door, label tubing and humidifier with date and time ....Document initiation of , in the resident's chart. Review of facility policy and procedure on at 5:15 PM for Administering Medications (,) provided by the (DON) revised , indicated for Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation ....Medications are administered in accordance with prescriber orders, including any required time frame. 2a).During an observation conducted on at 11:24 AM, Resident #10 was observed receiving continuous , infusing at two to three ( ) liters per minute via , concentrator. There was no date/label noted on his , tubing to indicate when it was last changed and there was no signage outside of the resident's doorway indicating , in use. Resident #10 was initially admitted to the facility on and re-admitted to the facility on with diagnoses which included: , ( ), , Failure, and Dependence on Supplemental , . Record review revealed	N 201		

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N 201	Continued From page 14 Resident #10 had a Brief Interview Mental Status ( ) score of 15 ( ). Photographic evidence obtained of the absent label on Resident #10's tubing and lack of signage outside Resident #10's door. On at 11:26 AM, a computerized record review was conducted of Resident #10's current physician's orders. However, there was no current order noted for the with parameters, for this resident. Neither were there any orders or other documentation written on Resident #10's Medication Administration Record (MAR) nor on the Treatment Administration Record (TAR), to indicate any routine changing of the resident's tubing. On at 11:33 AM further computerized record review of the physician's order dated revealed that Resident #10's was discontinued when he was transferred out of the facility to the hospital for distress and not re-ordered upon re-admission to the facility on . Again, the resident was transferred out to the hospital on , per resident request for difficulty breathing and again his was not re-ordered/re-newed upon re-admission to the facility on . However, on at 11:44 AM, a computerized record review was conducted of the Resident #10's Minimum Data Set (MDS) section O for assessment reference dates of and , in both of these instances it was indicated that the resident was receiving for dates-of-service (DOS). On at 12:15 PM, a computerized record review of Resident #10's nursing care plan dated	N 201		

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N 201	Continued From page 15 . . . . . also reflected the following: Monitor sat per order and report to Medical Director (MD) if . ,, . (. . .) sat is less than (<) 90%, provide ,, per MD orders, ,, Settings: ( ) via . . prongs/mask per order, history of (. . . .) and ,, use related to (. .). On . at 12:28 PM, an interview was conducted with Resident #10 in which he was asked about his ,, usage, and he replied that his . ,, . should be infusing at three (3) liters per minute. The resident was not noted to be in any acute distress or exhibiting any ( ), at the time. The resident also stated that he routinely uses his ,, everyday (24/7) and has done so for over two (2) years. He added that the facility staff should be changing his tubing at least every three (3) days. However, he said that sometimes they don't change the tubing for about two to three (. . .) weeks. On . . . . . at 4:32 PM there was still no date/label noted on Resident #10's ,, tubing to indicate when it was last changed and there wass still no signage outside Resident #10's doorway, indicating . ,, . in use. On . . . . . at 2:35 PM there was still no date/label noted on Resident #10's ,, tubing to indicate when it was last changed and there is still no signage outside resident #10's doorway indicating . ,, . in use. On . . . . . at 10:41 AM there was still no date/label noted on Resident #10's ,, tubing to indicate when it was last changed and there is still no signage outside resident #10's doorway indicating . ,, . in use.	N 201		

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N 201	Continued From page 16 There was no "active" order noted/obtained for [redacted] for Resident #10. On [redacted] at 10:51 AM, an interview was conducted with Staff D, a Licensed Practical Nurse (LPN), in which she was asked the following three (3) questions regarding the resident's [redacted]: 1) Is this resident on [redacted] ? She replied, "Yes, on two (2) liters." 2) Did you have or get an order to administer this resident's [redacted] ? She stated, "no." 3) If no, why not? Staff D, acknowledged that she did not take the time to verify whether or not the resident actually had an order for the [redacted], and she also acknowledged that the resident's [redacted] tubing should have been labeled and dated as to when it was last changed by staff. 2b) On [redacted] at 10:59 AM Resident #49 was observed receiving his ordered [redacted] at four to five ( ) liters via [redacted] via ox concentrator. However, there was no date/label noted on his [redacted] tubing to indicate when it was last changed. Record review revealed Resident #49 was originally admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses which included: [redacted] ( ) and history of [redacted] and [redacted] in [redacted]. He had a Brief Interview Mental Status (BIM) score of 12 (moderately [redacted]). Photographic evidence obtained of absent label on Resident #49's [redacted] tubing. On [redacted] at 4:03 PM there was no date/label noted on [redacted] tubing to indicate when it was last changed. On [redacted] at 10:30 AM there was still no date/label noted on [redacted] tubing to indicate	N 201		

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N 201	Continued From page 17 when it was last changed. On at 11:05 AM, a computerized record review conducted of the resident's current physician's orders indicated - Continuous at 2 liters (L)/minute (M) via to increase resident's to five (5) (L) via continuously, change tubing, mask and /or weekly, may change sooner as needed and ox. Computerized record review of Resident #49's Treatment Administration Record (TAR), further indicates for changing of this resident's tubing, mask and/or weekly, may change sooner as needed every night shift with the presence of at two (2) liters per minute, to increase to five (5) liters via continuously every shift for . On at 11:21 AM record review of Resident #49's nursing care plan dated also indicated for Settings: ( ) via (prongs) at two (2) (L) as needed (PRN) and a potential for ( ) related to prior history of ( ) episodes. On at 10:51 AM, an interview was conducted with Staff D, an (LPN), in which she acknowledged that the resident's tubing should have been labeled and dated as to when it was last changed by staff. In fact, the order, tubing label and signage were not obtained/put into place for Resident #10, until after surveyor intervention. During an interview conducted on at 11:20 AM, the Director of Nursing (DON) further acknowledged that Resident #10 should have	N 201		

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N 201	Continued From page 18 had an order and signage in place, and she also acknowledged that both Resident #10 and Resident #49's tubing should have been labeled and dated; this was not done. 3) A review of the facility's policy titled "Weighing the Resident," revised on , showed that residents will be unless ordered otherwise by the Physical on admission, weekly for 4 weeks and once a month after that. A record review of Resident #21 revealed his readmission to the facility on with diagnoses of Adult and (difficulty swallowing) following a . The annual Minimum Data Set (MDS) dated showed that Resident #21 had a Brief Interview of Mental Status ( ) score of 06, which is moderate to the severe . Review of the Care plan dated showed that Resident #1 has the potential for imbalanced nutrition, related to the process and . A review of the above MDS section G showed that for eating, Resident #21 was coded as requiring supervision and 1 person assist. In an observation conducted on at 11:00 AM, a container of a house shake (nutritional supplements) was noted unopened at the side table of Resident #21. Another observation conducted on at 1:00 PM noted the same unopened house shake at the side table in Resident #21's room. In an observation conducted on at 3:30 PM, Resident #21 was observed in his room. Closer observation showed a Vanilla house shake	N 201		

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N 201	Continued From page 19 that was opened but completed at the bedside. A container of another house shake provided at 2:00 PM was also at the side table unopened. An observation was conducted on at 6:00 PM. The meal cart arrived on the unit and was placed in the hallway. The meals were delivered to all residents while Resident #21 was waiting on his dinner tray. At 6:30 PM, the meal tray was brought into the room by staff, and at 6:40 PM, the team started assisting Resident #21 with his dinner meal (40 minutes later). An observation conducted on at 8:10 AM showed the meal cart that arrived on the unit between to 117. At 8:40 AM, the staff brought the breakfast meal to Resident #21 in his bed (30 minutes later). A review of the Order Summary Report showed an order for Health shake two times a day for a supplement with lunch and dinner and record amount dated . A review of the 's summary showed the following recorded for Resident #21: on at , on at , on at at . In an observation conducted on at 2:30 PM, Staff B, Restorative Certified Nursing Assistants, was asked to take the on Resident #21. Staff B used a bed scale to obtain the for Resident #21. Continued observation showed a new recorded at . In this observation, Staff B stated that weekly are conducted on all residents on Mondays and Wednesdays. The new recorded for Resident #21 showed an additional 3-, loss from .	N 201		

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N 201	Continued From page 20 A record review of the progress note dated by the facility's Dietitian revealed trending gradually for Resident #21 in the past 6 months. In this note, recommendations were made for Medpass (nutritional supplement) twice a day for management. An interview conducted on at 1:44 PM, with the facility's clinical Dietitian, revealed that she only comes to the facility in person once a week, but can review medical charts remotely. She said that are given to her by Staff B when she comes into the facility on Fridays. The initial assessment is done up to 14 days from admission, but high-risk residents will be seen sooner. The facility's Dietitian reported that supplements can be provided to residents before her initial assessment if they have a history of loss or are at high nutritional risk. She further stated that she will speak to nursing staff regarding the intake of meals on all residents. According to her, the house supplement shakes are always given between meals to aid with gain. In this interview, she said that Resident #21 is not able to eat on his own and that he needs with his meals. In an interview conducted on at 2:20 PM, Staff C, Patient Care Assistance ( ), stated that Resident #21 needs full assistance with all his meals. She further stated that someone needs to sit with him for the duration of the meals. When asked if he can drinkhis House Shakes (nutritional supplements) on his own, she said no. Staff C reported that she needs to hold the Shake and the straw to his for him to drink the shake. In an interview conducted on at 12:39	N 201		

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N 201	Continued From page 21 PM, the facility's clinical Dietitian reported that she did not know that a new was obtained for Resident #21 and that he lost 3 more pounds. She also was not aware that Resident #21 is not assisted with his nutritional supplements between meals. 2. A review of the chart showed Resident #200 was admitted to the facility on and discharged to the hospital on . Diagnoses of severe protein-calorie , , and . A review of the 5 days MDS dated showed that Resident #200 had a score of 15 which is . Section G for eating showed limited assistance with one person's physical assist. The care plan initiated on revealed Resident #200 has a nutritional problem due to her protein and calorie . It further showed that Resident #200 will maintain adequate nutritional status and will consume over 50% of her meals. A review of the summary showed the following recorded for Resident #200: on recorded at , on at , at , at , and on at . The Nutrition Evaluation Initial that was completed on which was 7 days after Resident #200 admission, revealed no history recorded, the usual , and that Resident #200 is at risk for due to poor intake of meals. A review of the Order Summary Report showed an order for nutritional supplements dated which was 8 days after admission. A review of the hospital records showed that Resident #200 had a , in	N 201		

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N 201	Continued From page 22 5 weeks. It further showed that her , , and it was noted that she appeared to be somewhat . In an interview conducted on at 12:39 PM, the facility's clinical Dietitian stated that Resident #200 is considered at high nutritional risk because of her poor intake of meals and low body . When asked by the surveyor, if she reviewed the hospital records of Resident #200, she said yes, and that not much was said about her nutrition from the hospital records. When asked as to the missing admission for Resident #200 she did not know but said that a , was recorded on . The Dietitian did not review Resident #200 chart prior to completing her initial assessment 7 days later . She agreed with the surveyor that Resident #200 is at nutritional risk and that she needed nutritional supplements upon admission. In an interview conducted on at 2:00 PM, with the facility's Administrator, she was informed of the findings. Class I	N 201		
N 204 SS=J	400.022(1)(o), FS Right to be Free from , , etc (o) The right to be free from mental and , , , corporal punishment, extended involuntary , and from physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified	N 204		

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N 204	Continued From page 23 licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety. This Statute or Rule is not met as evidenced by: Based on interviews, observations, record reviews and policy review, the facility failed to prevent neglect by failing to appropriately assess a resident as an elopement risk for 3 of 5 sampled residents reviewed for elopements (Residents #1, Resident #39, and Resident #6). Additionally the facility failed to implement facility Elopement Risk Evaluation/Assessment at the time of admission, facility failed to provide staff with instructions/policy procedure to communicate increase exit seeking behavior to identify need to increase supervision, failed to administer , medications as ordered, failed to instruct staff on what to do if a resident exits the 8 doors in the facility, and failed to do elopement drills. These failures allowed Resident #1 to elope from the facility undetected on between 7:00 AM and 7:05 AM. The findings included: The facility's Policies and Procedures titled "Elopement/ Risk Guideline" effective date and revised on has an Overview "To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions. Process: Patient/Residents to be evaluated on admission, re-admission, 7 days post-admission, quarterly, with a significant change in condition, and	N 204	N204 1.Resident #1 s Risk Assessment Evaluation and score was updated. Resident #1 s guard remains in place with no other episodes of elopement and is scheduled to be discharged from the facility. The Licensed nurses were educated on the Policy and Procedure of Following Physician Orders as they relate to , medication administration and guard placement. Staff E was educated on the Elopement Plan Policy and Procedure and participated in the elopement drill conducted by the facility. 2.The Director of Clinical Services and/or designee conducted an audit of elopement drills completion, residents elopement risk assessment evaluation for elopement, Physician orders related to , medication administration, and measures to include but not limited to guard use for residents identified with high risk	

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N 204	Continued From page 24 elopement event using the risk tool. It further showed that if a patient/resident is identified as being at risk for elopement, the following steps are needed: complete an Elopement risk Alert and obtain a photograph, initiate individualized interventions based on Patient/Residents' risk, and document individualized interventions in the patient/resident Care plan and Kardex. If a [redacted] monitoring system device is utilized, check the placement of the device every shift and functionality every day. The staff will need to maintain the Elopement Risk Alerts in an easily accessible location and complete routine elopement drills monthly and review in QAPI meetings." Record review revealed Resident #1 was admitted to the facility from an acute care hospital on [redacted] with diagnoses that include [redacted], and [redacted]. The Resident's Minimum Data Set (MDS) Comprehensive assessment dated [redacted] revealed Resident #1 had a [redacted] of 11, which indicates moderate loss in [redacted] ability and can be associated with poor decision-making skills. In Section E of the MDS, Resident #1 was assessed not to have [redacted] behaviors. In Section G of the MDS under Functional Status, Resident #1 needs supervision with walking in her room, corridor, and locomotion on and off the unit. Under Section N- medications, Resident #1 was assessed to take [redacted] medication for the past 7 days, [redacted] medications for the past 7 days, and [redacted] medication for the past 7 days. Under Section P- [redacted] and alarms, the [redacted] /elopement alarm was coded as not used. Another [redacted] test was conducted on [redacted], which showed a new score of 13 out of 15, indicating intact cognition.	N 204	for exit seeking, to ensure that the Elopement Plan and Procedure is followed. Corrective actions were addressed as necessary. 3.The Director of Clinical Services and/or designee educated staff with return demonstration on Elopement Plan and Procedure, Risk Evaluation for elopement, timely conduction of elopement drills, and Following Physician orders Policy and Procedure as they relate to [redacted] medications and [redacted] guard use. 4.The Executive Director and/or designee will conduct an audit of the Elopement drills, Elopement Plan and Procedure, residents' Elopement risk assessment, Following Physicians orders as they relate to [redacted] medication and [redacted] guards, to ensure of timely implementation, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	

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	100610	A. BUILDING: _____ B. WING _____	C 11/05/2021

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N 204	Continued From page 25 Record review revealed a skilled nursing note dated showed that Resident #1 was identified as an elopement risk. An elopement risk evaluation was conducted on , the day of the elopement incident, which was not done prior to that. The assessment showed a score of 4, which indicates that Resident #1 is at risk for elopement. Record review revealed Resident #1 Physician's orders for medications in , (prior to the elopement that occurred on) included the following: 81 milligrams (mg) one tablet daily for ; 20mg one tablet daily for ; 20mg one tablet daily for ( ); 325mg one tablet daily for a supplement; 100mg one tablet daily for ; Extended-release 24 hour 60mg one tablet daily for ; 20mg one tablet daily for ; 20mg one tablet daily for ; 75mg in the morning for ; D3 tablet 5000 units 1 tablet daily for D deficiency; tablet 1 mg every 12 hours for symptoms; tablet 0.25mg one tablet two times a day for ; tablet 15mg one tablet three times a day for . During the Medication Administration Record (MAR) review, there were blank sections where the nurses would put their initials indicating if the medication was given or why it was not given. The medication had blanks for the dates of	N 204		

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N 204	Continued From page 26 at bedtime. The medication , 0.25mg had blanks for the dates of , , , , , , at 5:00 PM. 100mg had blanks for , , , for the bedtime doses. The medication , had blanks for , , , , , and for the 5:00 PM doses. A review of the Elopement drills that were provided by the facility showed no indication that and Elopement in-services were given in as listed on the Education Calendar for 2021. This surveyor was provided education in-service attendance reports for /mistreatment dated and Missing Resident/Elopement/ dated . The facility also conducted elopement drills on and after the incident on . A closer review of the Elopement drills after did not show an education that included: an outside search that needs to be done outside the facility as far as the distance from the alarming exit door as a point of reference. An interview was conducted on at 2:00 PM with the facility's Director of Nursing, who was asked why there were blank spaces when the nurse's initials should be there, and she was unable to provide a reason why. Resident #1's care plan reveals a focus of Resident "has potential for drug-seeking type behaviors. History of drug and drug-seeking since admission." Date initiated . Interventions include " , and meet" resident's "needs" (dated), "Educate" resident "on successful coping and	N 204		

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N 204	Continued From page 27 interaction strategies" (dated), and resident "will not out of facility" (dated). An additional focus of the care plan includes a focus of the resident "is an elopement risk/ related to , safety awareness" (date initiated) with interventions that include "actual elopement on " (dated), "assess for elopement risk" (date initiated) "electronic monitoring to place on the resident" (dated). In an interview conducted with Staff H, CNA, via telephone on at 11:59 AM, she was asked about the incident on . Staff H stated that she was leaving the facility when Staff G, a Licensed Practical Nurse (LPN) asked her to look for Resident #1 on her drive home. At approximately 7:15 AM, Staff H located Resident #1 by a Speedway gas station located on US-1 and 16th street. Staff H stated that Resident #1 was about to turn right onto Highway US-1 going North. The Resident was observed wearing sweatpants, a shirt, and sneakers and carrying her purse. Staff H pulled into the gas station and approached the Resident on . Resident #1 stated, "I do not want to go to the hospital." Staff H reported that Resident #1 did not recall her name but knew her by . Resident #1 agreed to get in the car, and Staff H then brought her to the facility at approximately 7:20 AM. Staff H further stated that Resident #1 was very restless the night before. During the night, she kept coming out of the room and asked to leave, and she had her shoes and purse. She asked to leave multiple times during the night shift and was monitored by staff. According to Staff H, Resident #1 was more than usual. When asked about her status before leaving the facility, she	N 204		

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N 204	Continued From page 28 reported that Resident #1 was . She also said that Resident #1 exhibited exit behaviors before her leaving on but nothing to the extent of her leaving the facility. An interview with Staff E, Certified , Assistant (COTA), was conducted on at 12:15 PM. Staff E stated that on , between 7:00 AM and 7:05 AM, she was in the gym working on her notes when she heard an alarm. She walked in the direction of the door that the alarm sounded from and poked her out of the door but did not step out. The exit door was located between . On her way to the exit door, she stated that the Resident in told her that the skinny lady in was walking in the hallway toward the exit door earlier, but he did not see her leave. Staff E further stated that she returned to the nurse's station and alerted additional staff to what the Resident in told her. She then asked Staff F, Certified Nursing Assistant (CNA), to check Resident #1's room to see if she was there. She did not call the police and is unsure if anyone called the police. The Director of Nurses and the Administrator had not arrived at the facility yet. Resident #1 was not located in her room or inside the facility. Staff immediately initiated a search of the grounds, including the parking lot. Staff G, who worked the night shift, went outside looking for Resident #1. In an interview with the Director of Maintenance on at 4:25 PM it was revealed that the will only lock the front door. Last Friday ( ) they changed the whole system but the keypads at the 7 other exit doors are not wired yet for the	N 204		

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N 204	Continued From page 29 system. The will lock the door within 3 of the door and , of pressure will open the door in case of fire. The Director of Maintenance is not sure when all doors will be fully wired for a to be working on all 8 doors. In an interview conducted on at 10:20 AM, with Staff J, Certified Nursing Assistant, she arrived at the facility at 7:00 AM, on the morning of . On her way to the nursing station, she heard from another staff that Resident #1 had escaped and that they listened to the alarm. According to Staff J, Resident #1 always says that she wants to go out and wants to leave and is known to be a little . On the morning of the incident, staff started looking for her outside and inside the facility. She was told to look for Resident #1 outside in the front parking lot of the facility. When asked if Resident #1 had a guard before she attempted to leave the facility, she said no. She further stated that because she had never left the facility before, she did not need one. According to Staff J, on , they did not have a supervisor in charge because it was too early. She further said that when she was educated on elopement, she was told to first check each room before searching outside the premises. Then you go out to look for the resident. When an elopement happens, they are supposed to tell someone in charge and follow the directions of the supervisor. Staff J stated that she did not participate in any elopement drills after . When asked as to how many exit doors does the facility have, she did not know. In a second interview conducted on at 11:07 AM with Staff E, she stated that she was educated on elopement twice a year. The drills	N 204		

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N 204	Continued From page 30 consisted of a code called "BODYBEAR" as an indication that a resident was missing. They needed to get to the nurse's station and receive the individual assignment from the supervisor. Once you have your instructions, you follow them and report your findings. On the morning of [redacted], she heard the alarm and told the nurses what the Resident in [redacted] told her. She tried getting the staff around the facility to search for Resident #1, and she even looked outside the front of the facility. After the incident, the facility conducted an in-service on elopement which she did not participate. When she returned, she completed a test on elopement. According to Staff E, nothing new was part of the education, and that they re-educated staff on the same instruction you would follow if an elopement happened again. She did not know if the facility completed another drill after the incident on [redacted]. When asked by the surveyor if she could see Resident #1 walking away when she peeked outside the door on [redacted], she said: "I can see a partial view of the street, on both sides but more to the left." She then said Resident #1 must-have walked very fast. In an interview conducted on [redacted] at 11:57 AM, Staff K, Housekeeping, stated that on the day of the incident, she passed by [redacted] to go to the nurses' stations. She is familiar with Resident #1, who usually comes out of her room at around 8:00 AM and goes outside the patio across from her room. On the morning of [redacted], she saw Resident #1 walking out of her room and did not think much of it. The next thing she heard was the alarm on the door. She walked in the direction of the sound and was told by Staff E, who was by the exit door, that Resident #1 had	N 204		

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N 204	Continued From page 31 already gone and could not see her. She then started looking for Resident #1 around the building. She also reported that by the time she was ready to go into her car and drive around to look for Resident #1, another staff brought Resident #1 to the facility. She could not remember when the last time was, she participated in elopement drills. When asked if this happened again: she said, "they would not have to tell me anything; I would go looking for [Resident #1] right away". In an interview conducted on at 12:15 PM with the Maintenance Director, he stated he helps with the elopement drills. He noted that elopement drills are conducted once a month for every shift. Before this year, they used to have a dressed-up teddy bear called BODYBEAR, which the facility would hide either inside or outside. Once announced, staff would have to come to the nurse's station to receive their assignments. Now they have changed the drills, they will call the name of the missing resident, and staff will follow the supervisor's instructions. In an interview conducted on at 2:10 PM, during the Resident Council meeting, Resident #33 stated that when an alarm goes off in one of the 8 exit doors, there is no sense of urgency by staff. He further said that staff would take a long time before , the loud noise of the alarm. Resident #9 stated that the last time one of the alarm doors went off, it took staff 15 minutes to come to the door to check as to why the alarm sounded off. Record review of Resident #33 showed that he was initially admitted to the facility on . A review of the Quarterly Minimum Data Set (MDS) dated showed that Resident #33 has a	N 204		

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N 204	Continued From page 32 Brief interview of Mental Status ( ) score of 15, which is . Record review of Resident #9 showed that he was initially admitted to the facility on . A review of the Quarterly MDS showed that Resident #9 is with score of 15, which is . 2. Resident #39 was admitted to the facility on with diagnoses that include 's , Major , , and Type 2 . A review of the Physician's orders for Resident #39 revealed an order for a guard dated . A review of a nursing progress note dated revealed: "patient attempted to go out the door re-oriented patient to facility patient appeared to be ." An elopement assessment was not completed on Resident #39 until , when it was determined that the resident was at risk for elopement. An interview with the Director of Nursing (DON) on at 10:30 AM revealed there are no additional elopement assessments for Resident #39. A review of the resident's care plan for elopement risk initiated and revised on revealed the following: a focus of resident is "an elopement risk/ ...history of attempts to leave the facility unattended ...secondary to ..." interventions dated and revised on include "identify a pattern of ", and "provide electronic monitoring device (guard)" date initiated and modified on .	N 204		

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N 204	Continued From page 33 An interview was conducted with the Minimum Data Set (MDS) coordinator on at 11:00 AM, which revealed the original order for the guard is uncertain due to medical records dating to his admission are not in the facility anymore. 3. Resident #6 was admitted to the facility on with diagnoses that include and following affecting the left non-dominant side, and of . The Quarterly minimum data set (MDS) dated revealed in section C a brief interview of mental status ( ) score of 13, indicating an intact response. A review of nursing progress noted date reveals Resident #6 was" up and about pacing in the hallway. The resident appeared to be very , screaming and yelling at staff, and very difficult to redirect. A call was placed to (Psychiatrist). New order received for 0.25mg q 12 hrs. as needed (PRN) for . Noted and carried out." An interview with the DON on at 10:15 AM reveals Resident #6 refused to have the guard put on his ankle, so they put it on the walker since he always uses his walker. Questioned the DON on why the guard was not put on when exit-seeking behaviors were identified on , and she stated that after he was seen by psych, he didn't have any more exit-seeking behaviors. The first elopement risk evaluation for Resident #6 was done on and he was identified as at risk for elopement so the guard was placed on his walker on .	N 204		

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N 204	Continued From page 34 An interview with Resident #6 on . . . . at 10:45 AM revealed a guard on his walker. He further stated that he is not going anywhere because his are bad, and he would not get that far. Resident #6 also said that he wanted to leave when he was first admitted to the facility. He did not like the condition of the facility, but he knows now that he isn't going anywhere. Class I	N 204		

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F 000	INITIAL COMMENTS An unannounced Recertification survey, with complaints #2021010743, #2021014655, #2021015218, #2021015351, was conducted from to at Harbor Beach Nursing and Rehabilitation Center. The facility was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The allegation related to complaint #2021014655 was substantiated due to the facility failing to provide supervision to prevent an elopement, and failure to assess a resident at an elopement risk. On at 4:25 AM, a determination was made that the findings of the survey posed Immediate Jeopardy to the health and safety of the residents admitted to the facility. Substantiated Quality of Care was identified at F600, Scope and Severity (J)-Freedom from , Neglect, and , ; and F689, Scope and Severity (J)-Free of Accidents, Hazards/Supervision/Devices. The Immediate Jeopardy noncompliance started on . Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, , , or to the resident. The deficient practice allowed Resident #1 to exit the facility undetected on between 7:00 AM and 7:05 AM. The facility's system failure, lack of adequate supervision, inaccurate risk of elopement assessment, and a failure to thoroughly investigate the surrounding area of the door known to be the door from which the resident eloped.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2021

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 000	Continued From page 1 There were 51 residents residing in the facility at the time of the survey. The facility's Administrator and Director of Nursing were notified of the Immediate Jeopardy and given the IJ Templates on 11/04/21 at 10:25 AM. On . . . . . at 2:00 PM, the Administrator, Director of Nursing, Corporate Regional Registered Nurse Consultant, Interim Regional Nurse Consultant, Regional Control Preventionist Nurse, and the Vice President of Operations, were notified that the Immediate Jeopardy was removed. The date of . . . . . was when the facility removed the immediacy based upon the completion of elopement drills for alarm response, education provided to all staff on reporting exit seeking behaviors, implementing immediate interventions for exit seeking behaviors, higher level of supervision, and identifying the correct root cause analysis. The scope and severity of F600 and F689 were lowered to a (D) for No actual harm with a potential for more than minimal harm that is not immediate jeopardy as of . . . . . . The scope and severity were lowered because of the facility's corrective actions implemented. These corrective actions were verified by the survey team through observations, record reviews, and interviews which were conducted on .	F 000		
F 600 SS=J	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from . . . . . , Neglect, and . The resident has the right to be free from . . . . . ,	F 600		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , corporal punishment, or involuntary ; This REQUIREMENT is not met as evidenced by: Based on interviews, observations, record reviews and policy review, the facility failed to prevent neglect by failing to appropriately assess a resident as an elopement risk for 3 of 5 sampled residents reviewed for elopements (Residents #1, Resident #39, and Resident #6). Additionally the facility failed to implement facility Elopement Risk Evaluation/Assessment at the time of admission, facility failed to provide staff with instructions/policy procedure to communicate increase exit seeking behavior to identify need to increase supervision, failed to administer , medications as ordered, failed to instruct staff on what to do if a resident exits the 8 doors in the facility, and failed to do elopement drills. These failures allowed Resident #1 to elope from the facility undetected on between 7:00 AM and 7:05 AM. The findings included: The facility's Policies and Procedures titled "Elopement/ , Risk Guideline" effective date and revised on has an Overview "To evaluate and identify	F 600	F600 1.Resident #1, #6, and #39 risk for elopement evaluation and Elopement books were updated, and other necessary interventions were placed to address exit seeking behaviors. The Regional Director of Clinical Services and/or designee conducted an elopement drill for staff to include Staff E and educated on Elopement Plan, /Neglect Policy and Procedure. 2.DCS and/or designee conducted an audit of residents record and facility s elopement drills to ensure that elopement risk evaluation and measures to address residents with high risk for elopement are in place, to include but not limited to, , medications administration and elopement plan. Corrective actions were done as necessary.	

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F 600	Continued From page 3 patient/residents that are at risk for elopement and develop individualized interventions. Process: Patient/Residents to be evaluated on admission, re-admission, 7 days post-admission, quarterly, with a significant change in condition, and elopement event using the risk tool. It further showed that if a patient/resident is identified as being at risk for elopement, the following steps are needed: complete an Elopement risk Alert and obtain a photograph, initiate individualized interventions based on Patient/Residents' risk, and document individualized interventions in the patient/resident Care plan and Kardex. If a monitoring system device is utilized, check the placement of the device every shift and functionality every day. The staff will need to maintain the Elopement Risk Alerts in an easily accessible location and complete routine elopement drills monthly and review in QAPI meetings." Record review revealed Resident #1 was admitted to the facility from an acute care hospital on with diagnoses that include , and . The Resident's Minimum Data Set (MDS) Comprehensive assessment dated revealed Resident #1 had a of 11, which indicates moderate loss in ability and can be associated with poor decision-making skills. In Section E of the MDS, Resident #1 was assessed not to have behaviors. In Section G of the MDS under Functional Status, Resident #1 needs supervision with walking in her room, corridor, and locomotion on and off the unit. Under Section N- medications, Resident #1 was assessed to take medication for the past 7 days, medications for	F 600	3.DCS and/or designee educated staff to include new hired staff with return demonstration on new elopement plan, timely conduction of elopement drills, and educated on and Neglect Policy and Procedure. Licensed nurses were educated on following Physician orders Policy and Procedure as they relate to the medication administration and guard use, and timely Elopement Risk Evaluation. 4.Executive Director and/or designee will conduct an audit of elopement drills, residents elopement risk assessment evaluation, and measures for residents who were identified with high risk for exit seeking behavior to include but not limited to medication administration and guard use, to ensure of timely implementation, adequate supervision and residents are free from and neglect, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	

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the past 7 days, and [redacted] medication for the past 7 days. Under Section P- and alarms, the [redacted] /elopement alarm was coded as not used. Another [redacted] test was conducted on [redacted], which showed a new score of 13 out of 15, indicating intact cognition.

Record review revealed a skilled nursing note dated [redacted] showed that Resident #1 was identified as an elopement risk. An elopement risk evaluation was conducted on [redacted], the day of the elopement incident, which was not done prior to that. The assessment showed a score of 4, which indicates that Resident #1 is at risk for elopement.

Record review revealed Resident #1 Physician's orders for medications in [redacted], (prior to the elopement that occurred on [redacted]) included the following: [redacted] 81 milligrams (mg) one tablet daily for [redacted]; 20mg one tablet daily for [redacted]; [redacted] 20mg one tablet daily for ([redacted]); [redacted] 325mg one tablet daily for a supplement; [redacted] 100mg one tablet daily for [redacted]; [redacted] Extended-release 24 hour 60mg one tablet daily for [redacted]; [redacted] 20mg one tablet daily for [redacted]; [redacted] 20mg one tablet daily for [redacted]; [redacted] 75mg in the morning for [redacted]; [redacted] D3 tablet 5000 units 1 tablet daily for [redacted] D deficiency; [redacted] tablet 1 mg every 12 hours for [redacted] symptoms; [redacted] tablet 0.25mg one tablet two times a day for [redacted]; [redacted] tablet 15mg one tablet three times a day for [redacted].

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F 600	Continued From page 5 During the Medication Administration Record (MAR) review, there were blank sections where the nurses would put their initials indicating if the medication was given or why it was not given. The medication , , had blanks for the dates of , , , , , , at bedtime. The medication , 0.25mg had blanks for the dates of , , , , , at 5:00 PM. 100mg had blanks for , , , , for the bedtime doses. The medication , had blanks for , , , , , , , and for the 5:00 PM doses. A review of the Elopement drills that were provided by the facility showed no indication that and Elopement in-services were given in , as listed on the Education Calendar for 2021. This surveyor was provided education in-service attendance reports for /mistreatment dated and Missing Resident/Elopement/ dated . The facility also conducted elopement drills on and after the incident on . A closer review of the Elopement drills after did not show an education that included: an outside search that needs to be done outside the facility as far as the , distance from the alarming exit door as a point of reference. An interview was conducted on at 2:00 PM with the facility's Director of Nursing, who was asked why there were blank spaces when the nurse's initials should be there, and she was unable to provide a reason why.	F 600		

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Resident #1's care plan reveals a focus of Resident "has potential for drug-seeking type behaviors. History of drug and drug-seeking since admission." Date initiated . Interventions include " , and meet" resident's "needs" (dated), "Educate" resident "on successful coping and interaction strategies" (dated), and resident "will not out of facility" (dated). An additional focus of the care plan includes a focus of the resident "is an elopement risk/ related to , safety awareness" (date initiated) with interventions that include "actual elopement on " (dated), "assess for elopement risk" (date initiated) "electronic monitoring to place on the resident" (dated).

In an interview conducted with Staff H, CNA, via telephone on at 11:59 AM, she was asked about the incident on . Staff H stated that she was leaving the facility when Staff G, a Licensed Practical Nurse (LPN) asked her to look for Resident #1 on her drive home. At approximately 7:15 AM, Staff H located Resident #1 by a Speedway gas station located on US-1 and 16th street. Staff H stated that Resident #1 was about to turn right onto Highway US-1 going North. The Resident was observed wearing sweatpants, a shirt, and sneakers and carrying her purse. Staff H pulled into the gas station and approached the Resident on . Resident #1 stated, "I do not want to go to the hospital." Staff H reported that Resident #1 did not recall her name but knew her by . Resident #1 agreed to get in the car, and Staff H then brought her to the facility at

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approximately 7:20 AM. Staff H further stated that Resident #1 was very restless the night before. During the night, she kept coming out of the room and asked to leave, and she had her shoes and purse. She asked to leave multiple times during the night shift and was monitored by staff. According to Staff H, Resident #1 was more than usual. When asked about her status before leaving the facility, she reported that Resident #1 was . She also said that Resident #1 exhibited exit behaviors before her leaving on but nothing to the extent of her leaving the facility.

An interview with Staff E, Certified , Assistant (COTA), was conducted on at 12:15 PM. Staff E stated that on , between 7:00 AM and 7:05 AM, she was in the gym working on her notes when she heard an alarm. She walked in the direction of the door that the alarm sounded from and poked her out of the door but did not step out. The exit door was located between . On her way to the exit door, she stated that the Resident in told her that the skinny lady in was walking in the hallway toward the exit door earlier, but he did not see her leave. Staff E further stated that she returned to the nurse's station and alerted additional staff to what the Resident in told her. She then asked Staff F, Certified Nursing Assistant (CNA), to check Resident #1's room to see if she was there. She did not call the police and is unsure if anyone called the police. The Director of Nurses and the Administrator had not arrived at the facility yet. Resident #1 was not located in her room or inside the facility. Staff immediately initiated a search of the grounds, including the

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parking lot. Staff G, who worked the night shift, went outside looking for Resident #1.

In an interview with the Director of Maintenance on at 4:25 PM it was revealed that the will only lock the front door. Last Friday ( ) they changed the whole system but the keypads at the 7 other exit doors are not wired yet for the system. The will lock the door within 3 of the door and , of pressure will open the door in case of fire. The Director of Maintenance is not sure when all doors will be fully wired for a to be working on all 8 doors.

In an interview conducted on at 10:20 AM, with Staff J, Certified Nursing Assistant, she arrived at the facility at 7:00 AM, on the morning of . On her way to the nursing station, she heard from another staff that Resident #1 had escaped and that they listened to the alarm. According to Staff J, Resident #1 always says that she wants to go out and wants to leave and is known to be a little . On the morning of the incident, staff started looking for her outside and inside the facility. She was told to look for Resident #1 outside in the front parking lot of the facility. When asked if Resident #1 had a guard before she attempted to leave the facility, she said no. She further stated that because she had never left the facility before, she did not need one. According to Staff J, on , they did not have a supervisor in charge because it was too early. She further said that when she was educated on elopement, she was told to first check each room before searching outside the premises. Then you go out

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to look for the resident. When an elopement happens, they are supposed to tell someone in charge and follow the directions of the supervisor. Staff J stated that she did not participate in any elopement drills after . When asked as to how many exit doors does the facility have, she did not know.

In a second interview conducted on at 11:07 AM with Staff E, she stated that she was educated on elopement twice a year. The drills consisted of a code called "BODYBEAR" as an indication that a resident was missing. They needed to get to the nurse's station and receive the individual assignment from the supervisor. Once you have your instructions, you follow them and report your findings. On the morning of , she heard the alarm and told the nurses what the Resident in told her. She tried getting the staff around the facility to search for Resident #1, and she even looked outside the front of the facility. After the incident, the facility conducted an in-service on elopement which she did not participate. When she returned, she completed a test on elopement. According to Staff E, nothing new was part of the education, and that they re-educated staff on the same instruction you would follow if an elopement happened again. She did not know if the facility completed another drill after the incident on . When asked by the surveyor if she could see Resident #1 walking away when she peeked outside the door on , she said: "I can see a partial view of the street, on both sides but more to the left." She then said Resident #1 must-have walked very fast.

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In an interview conducted on [redacted] at 11:57 AM, Staff K, Housekeeping, stated that on the day of the incident, she passed by [redacted] to go to the nurses' stations. She is familiar with Resident #1, who usually comes out of her room at around 8:00 AM and goes outside the patio across from her room. On the morning of [redacted], she saw Resident #1 walking out of her room and did not think much of it. The next thing she heard was the alarm on the door. She walked in the direction of the sound and was told by Staff E, who was by the exit door, that Resident #1 had already gone and could not see her. She then started looking for Resident #1 around the building. She also reported that by the time she was ready to go into her car and drive around to look for Resident #1, another staff brought Resident #1 to the facility. She could not remember when the last time was, she participated in elopement drills. When asked if this happened again: she said, "they would not have to tell me anything; I would go looking for [Resident #1] right away".

In an interview conducted on [redacted] at 12:15 PM with the Maintenance Director, he stated he helps with the elopement drills. He noted that elopement drills are conducted once a month for every shift. Before this year, they used to have a dressed-up teddy bear called BODYBEAR, which the facility would hide either inside or outside. Once announced, staff would have to come to the nurse's station to receive their assignments. Now they have changed the drills, they will call the name of the missing resident, and staff will follow the supervisor's instructions.

In an interview conducted on [redacted] at 2:10 PM, during the Resident Council meeting,

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Resident #33 stated that when an alarm goes off in one of the 8 exit doors, there is no sense of urgency by staff. He further said that staff would take a long time before _ the loud noise of the alarm. Resident #9 stated that the last time one of the alarm doors went off, it took staff 15 minutes to come to the door to check as to why the alarm sounded off.

Record review of Resident #33 showed that he was initially admitted to the facility on . A review of the Quarterly Minimum Data Set (MDS) dated showed that Resident #33 has a Brief interview of Mental Status ( ) score of 15, which is

Record review of Resident #9 showed that he was initially admitted to the facility on . A review of the Quarterly MDS showed that Resident #9 is with score of 15, which is

2. Resident #39 was admitted to the facility on with diagnoses that include 's , Major , , and Type 2 . A review of the Physician's orders for Resident #39 revealed an order for a guard dated

A review of a nursing progress note dated revealed: "patient attempted to go out the door re-oriented patient to facility patient appeared to be ."
An elopement assessment was not completed on Resident #39 until , when it was determined that the resident was at risk for elopement. An interview with the Director of Nursing (DON) on at 10:30 AM revealed

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there are no additional elopement assessments for Resident #39.

A review of the resident's care plan for elopement risk initiated and revised on revealed the following: a focus of resident is "an elopement risk/ ...history of attempts to leave the facility unattended ...secondary to ..." Interventions dated and revised on include "identify a pattern of ", and "provide electronic monitoring device (guard)" date initiated and modified on .

An interview was conducted with the Minimum Data Set (MDS) coordinator on at 11:00 AM, which revealed the original order for the guard is uncertain due to medical records dating to his admission are not in the facility anymore.

3. Resident #6 was admitted to the facility on with diagnoses that include , and , following affecting the left non-dominant side, , , and , of . The Quarterly minimum data set (MDS) dated revealed in section C a brief interview of mental status ( ) score of 13, indicating an intact response.

A review of nursing progress noted date reveals Resident #6 was" up and about pacing in the hallway. The resident appeared to be very , screaming and yelling at staff, and very difficult to redirect. A call was placed to (Psychiatrist). New order received for 0.25mg q 12 hrs. as needed (PRN) for . Noted and carried out."

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An interview with the DON on at 10:15 AM reveals Resident #6 refused to have the guard put on his ankle, so they put it on the walker since he always uses his walker. Questioned the DON on why the guard was not put on when exit-seeking behaviors were identified on , and she stated that after he was seen by psych, he didn't have any more exit-seeking behaviors. The first elopement risk evaluation for Resident #6 was done on and he was identified as at risk for elopement so the guard was placed on his walker on .

An interview with Resident #6 on at 10:45 AM revealed a guard on his walker. He further stated that he is not going anywhere because his are bad, and he would not get that far. Resident #6 also said that he wanted to leave when he was first admitted to the facility. He did not like the condition of the facility, but he knows now that he isn't going anywhere.

The facility Immediate Jeopardy Removal Plan included:

1. On The Director of Clinical Services and designee completed elopement risk assessments on all current residents to identify others that may be at risk. One new resident at risk was identified.

2. On and Elopement books were updated.

3. On , the Director of Clinical Services

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and designees-initiated education for Licensed Nursing Staff on completing the Elopement Risk Evaluation which is to be completed at the time of admission. This consisted of on-site education, phone education when available and education documentation if needed via mail. Education includes 18 licensed nurses.

4. On . . . . , the Director of Clinical Services was educated by the Regional Nurse Consultant on conducting New Admission Chart reviews during the clinical meeting.

5. On The Director of Clinical Services and designee-initiated education for Licensed Nurses and unlicensed staff on Change of Condition policy and reporting to the Director of Clinical Services any event of exit seeking behaviors. Staff included are . . . . (7), Housekeeping/Laundry (5), Dietary (7), CNAs (28), and Nurses (18) Administrative/department heads (12).

6. On11/4/21 The Director of Clinical Services was educated by the Regional Nurse Consultant on initiating interventions related to increasing supervision needs.

7. Licensed staff and unlicensed staff including . . . . (7), Housekeeping/Laundry (5), Dietary (7), CNAs (28), and Nurses (18) Administrative/department heads (12), will be in-serviced on any new resident identified with exit seeking behaviors by the Director of Clinical Services and/or designees.

8. On . . . . Licensed staff and unlicensed staff education were initiated on reporting and communicating resident exit-seeking behaviors to

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their supervisor. Staff included are [redacted] (7), Housekeeping/Laundry (5), Dietary (7), CNAs (28) and Nurses (18) and Administrative/department heads (12).

9. On [redacted] - Licensed Nursing Staff education was initiated on the administration of [redacted] meds. Education includes 18 Licensed Nursing staff.

10. On [redacted] - The Director of Clinical Services/designee will conduct a daily audit of the Electronic Administration Record to ensure resident psych medication is documented as given, and/or documented for refusal.

11. On [redacted] The Executive Director and Director of Clinical Services were educated on determining the root causes specific to elopements by the Regional Vice President of Operations.

12. The Executive Director led an additional Quality Assurance and Performance Improvement meeting on [redacted] with the Executive Director, Medical Director, Director of Clinical Services, Social Services Director, Plant Operations, Activities, Dietary Supervisor, Housekeeping Supervisor, CNA, Business Office Manager, [redacted] Director and Unit Manager present. The Elopement Policy and Procedures were reviewed, and the root cause of elopement was discussed.

13. An additional ad hoc quality assurance performance improvement meeting was held on [redacted] with the participation of the Center Medical Director, Executive Director, Director of Clinical Services, Social Services Director, Unit

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F 600	Continued From page 16 Manager, MDS Coordinator, Plant Operations Manager, Human Resources, Housekeeping Supervisor, Dietary Director, , , , Director, and Activities Director. The plan along with the root cause for the incident was discussed and approved by the Medical Director. The Facility's policy on Elopement was reviewed during the QAPI meeting. 14. An ad hoc quality assurance performance improvement meeting was held on with the participation of the Center Medical Director, Executive Director, Director of Clinical Services, Social Services Director, Unit Manager, MDS Coordinator, Plant Operations Manager, Human Resources, Housekeeping Supervisor, Dietary Director, , , , Director, and Activities Director. The plan along with the root cause for the incident was discussed and approved by the Medical Director. The facility's policy on and Neglect was reviewed during the QAPI meeting. 15. Plant Operations and or Designee will be responsible for conducting monthly elopement drills. Results will be brought and reviewed during the Quality Assurance Committee meeting. 16. 8:30 am The Plant Operations Manager rounded in the facility to validate all exit doors were secure and alarms functioning properly.	F 600		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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F 689	Continued From page 17 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, observations, record reviews and policy review, the facility failed to prevent a resident with memory and [illegible] from exiting the facility unsupervised. The facility did not provide supervision to prevent an elopement of 1 of 5 sampled residents reviewed for elopement risk (Resident #1). The deficient practice allowed Resident #1 to elope from the facility undetected on [illegible] between 7:00 AM and 7:05 AM. The findings included: The facility's Policies and Procedures titled "Missing Patient/Resident" effective date [illegible] and revised on [illegible] has an Overview "Staff will investigate cases of missing patient/resident and possible elopement. An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so, placing the patient/resident at risk for harm or injury. Procedure: Check Leave of Absence (LOA) book and Medical Record to ensure patient/resident is not on an authorized leave or medical [illegible]. Announce "resident name) please return to your room", over PA system. Repeat three times to alert staff of a missing patient/resident. Assigned staff to search the grounds. If the patient/resident is not located after the initial search the point person will notify the Executive Director and Director of Nurses,	F 689	F689 1.Resident #1's Risk Assessment Evaluation and [illegible] score was updated. Resident #1's [illegible] guard remains in place with no other episodes of elopement and is scheduled to be discharged from the facility. The Licensed nurses were educated on the Policy and Procedure of Following Physician Orders as they relate to [illegible] medication administration and guard placement. Staff E was educated on the Elopement Plan Policy and Procedure and participated in the elopement drill conducted by the facility. 2.The Director of Clinical Services and/or designee conducted an audit of elopement drills completion, residents' elopement risk assessment evaluation for elopement, Physician orders related to [illegible] medication administration, and measures to include but not limited to guard use for residents identified with high risk for exit seeking, to ensure that the Elopement Plan and Procedure is followed. Corrective actions were	

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Resident Representative, and Physician. The Executive Director and/or Director of Nursing or designee to notify local Law Enforcement. Upon return to the Center a physical evaluation will be completed to determine if further treatment is needed. Document in the Medical Record. Notify Physician, Resident Representative, Executive Director, Director of Nurses and Law Enforcement (if applicable) of patient/resident's return. Review and revise the interventions as indicated related to elopement and risk and update the Care Plan and Kardex."

Record review revealed Resident #1 was admitted to the facility from an acute care hospital on with diagnoses that include , and . The Resident's Minimum Data Set (MDS) Comprehensive assessment dated revealed Resident #1 had a ( ) score of 11, which indicates moderate loss in ability and can be associated with poor decision-making skills. In Section E of the MDS, Resident #1 was assessed not to have behaviors. In Section G of the MDS under Functional Status, Resident #1 needs supervision with walking in her room, corridor, and locomotion on and off the unit. Under Section N-medications, Resident #1 was assessed to take medication for the past 7 days, medications for the past 7 days, and medication for the past 7 days. Under Section P- and alarms, the /elopement alarm was coded as not used. Another test was conducted on , which showed a new score of 13 out of 15, indicating intact cognition.

addressed as necessary.

3.The Director of Clinical Services and/or designee educated staff with return demonstration on Elopement Plan and Procedure, Risk Evaluation for elopement, timely conduction of elopement drills, and Following Physician orders Policy and Procedure as they relate to medications and guard use.

4.The Executive Director and/or designee will conduct an audit of the Elopement drills, Elopement Plan and Procedure, residents Elopement risk assessment, Following Physicians orders as they relate to medication and guards, to ensure of timely implementation, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.

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Record review revealed a skilled nursing note dated showed that Resident #1 was identified as an elopement risk. An elopement risk evaluation was conducted on , the day of the elopement incident, which was not done prior to that. The assessment showed a score of 4, which indicates that Resident #1 is at risk for elopement.

Resident #1's care plan reveals a focus of Resident "has potential for drug-seeking type behaviors. Hx. [History] of drug and drug-seeking since admission." Date initiated . Interventions include " and meet" resident's "needs" (dated), "Educate" resident "on successful coping and interaction strategies" (dated), and resident "will not out of facility" (dated). An additional focus of the care plan includes the resident "is an elopement risk/ related to safety awareness" (date initiated) with interventions that include "actual elopement on " (dated), "assess for elopement risk" (date initiated) "electronic monitoring to place on the resident" (dated).

Record review revealed Resident #1 Physician's orders for , (prior to the elopement that occurred on) included the following: 81milligrams (mg) one tablet daily for ; 20mg one tablet daily for ; 20mg one tablet daily for ( ); 325mg one tablet daily for a supplement; 100mg one tablet daily for ; ;

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F 689	Continued From page 20 Extended-release 24 hour 60mg one tablet daily for ,, ; 20mg one tablet daily for ; 20mg one tablet daily for , ; 75mg in the morning for , ; D3 tablet 5000 units 1 tablet daily for D deficiency; , , tablet 1 mg every 12 hours for , symptoms; , tablet 0.25mg one tablet two times a day for , ; , tablet 15mg one tablet three times a day for . During the Medication Administration Record (MAR) review, there were blank sections where the nurses would put their initials indicating if the medication was given or why it was not given. The medication , , had blanks for the dates of , , , , , at bedtime. The medication , 0.25mg had blanks for the dates of , , , , , at 5:00 PM. , 100mg had blanks for , , , for the bedtime doses. The medication , had blanks for , , , , , and for the 5:00 PM doses. An interview was conducted on at 2:00 PM with the facility's Director of Nursing, who was asked why there were blank spaces when the nurse's initials should be there, and she was unable to provide a reason why. In an interview conducted on at 11:00 AM with the facility's the Director of Rehab, he stated that they use the BCAT (Brief Cognition Assessment Tool) to assess the level. Residents must be able to meet a specific criterion to be able to perform the test. The social worker will do her , and the SLP (Speech	F 689		

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Language Pathologist) will conduct the BCAT to assess status. The is used as a baseline test when residents are admitted. The BCAT is more intensive with specific based questions that have 1 step command and 2 step commands. The test is very standardized and needs to be done by the book. He further stated that the BCAT could show specific goals for needs assessment and 1 to 2 steps goals. It is an excellent tool recognized by the American Speech-Language-Hearing Association (ASHA). A nursing referral must be sent to have the SLP conduct the BCAT test. The lower the score on the BCAT, the more dependent the residents may be on all their Activities of Daily Living (ADL's). Someone with a low BCAT score will need , supervision, and everything must be structured for them. Someone with a score of 20 and below will have a high risk of getting hurt if they walk outside the facility and start walking, and they will need constant monitoring to avoid any accidents. A resident with a score higher than the BCAT will have to be reassessed with a new score. The Director of Rehab stated that levels could change and fluctuate from one day to another. The BCAT is more standardized, and it is a more accurate test.

Resident #1 had a BCAT (Brief Assessment Tool) conducted after the incident on . The assessment was completed by the facility's Speech-Language Pathologist on , 3 days after the incident. The BCAT assessment showed a score of 18 out of 50, indicating severe -linguistic , . The Resident presents with severe , in sustained attention, , comprehension for following basic directions, short-term memory

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recall, and problem-solving skills. Resident required max verbal cues for redirection to structured tasks throughout the examination.

An elopement risk evaluation was conducted on , the day of the incident, which was not done prior to that. The assessment showed a score of 4, which indicates that Resident #1 is at risk for elopement.

In an interview conducted on at 11:10 AM with Resident #1, she could not have a conversation with the surveyor and did not provide appropriate responses when answering the surveyor's questions.

In an interview conducted with Staff H, CNA, via telephone on at 11:59 AM, she was asked about the incident on . Staff H stated that she was leaving the facility when Staff G, a Licensed Practical Nurse (LPN) asked her to look for Resident #1 on her drive home. At approximately 7:15 AM, Staff H located Resident #1 by a Speedway gas station located on US-1 and 16th street. Staff H stated that Resident #1 was about to turn right onto Highway US-1 going North. The Resident was observed wearing sweatpants, a shirt, and sneakers and carrying her purse. Staff H pulled into the gas station and approached the Resident on . Resident #1 stated, "I do not want to go to the hospital." Staff H reported that Resident #1 did not recall her name but knew her by . Resident #1 agreed to get in the car, and Staff H then brought her to the facility at approximately 7:20 AM. Staff H further stated that Resident #1 was very restless the night before. During the night, she kept coming out of the room

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and asked to leave, and she had her shoes and purse. She asked to leave multiple times during the night shift and was monitored by staff. According to Staff H, Resident #1 was more than usual. When asked about her status before leaving the facility, she reported that Resident #1 was . She also said that Resident #1 exhibited exit behaviors before her leaving on but nothing to the extent of her leaving the facility.

An interview with Staff E, Certified , Assistant (COTA), was conducted on at 12:15 PM. Staff E stated that on , between 7:00 AM and 7:05 AM, she was in the gym working on her notes when she heard an alarm. She walked in the direction of the door that the alarm sounded from and poked her out of the door but did not step out. The exit door was located between . On her way to the exit door, she stated that the Resident in told her that the skinny lady in was walking in the hallway toward the exit door earlier, but he did not see her leave. Staff E further stated that she returned to the nurse's station and alerted additional staff to what the Resident in told her. She then asked Staff F, Certified Nursing Assistant (CNA), to check Resident #1's room to see if she was there. She did not call the police and is unsure if anyone called the police. The Director of Nurses and the Administrator had not arrived at the facility yet. Resident #1 was not located in her room or inside the facility. Staff immediately initiated a search of the grounds, including the parking lot. Staff G, a Licensed Practical Nurse (LPN) who worked the night shift, went outside looking for Resident #1.

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In a tour conducted on at 12:10 PM, surveyors walked the path that Resident #1 walked when she left the facility on . Resident #1 walked out from Harbor Beach Nursing and Rehabilitation Center through the exit door on the North-West side. She walked down the ramp and turned left onto 16th Street, going West towards US-1. The side street (16th Street) did not have any sidewalk on one side of the road and had cracked uneven pavement. Highway US-1 had 6 lane highway, with 3 lanes on each side. Further, observation showed no crossing light/or traffic light at the intersection of US-1 and 16th street. It is unknown what side of the road the Resident walked on or if she walked in the street. The resident could have gotten lost, , or been hit by a car. While Resident #1 was out of the facility unsupervised there was a high likelihood that she could have been seriously injured, seriously harmed, or (Photographic evidence obtained).

In an interview conducted on at 12:33 PM with Staff I, Social Services Director, she reported that scores could vary from one day to the other. If a resident has a , ( ), or other , their score might be affected. She may repeat the test for the depending on the discrepancies after a resident is all better. When asked if she is aware of the BCAT test, she said that SLP does it, but she is not very familiar with it. The BCAT may be done on residents with or because it is more detailed. Staff said that the BCAT is more accurate than the because they are going into more details with the questions, and it takes longer to do the test. Staff

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I, further stated that Resident #1's [illegible] level and speech have improved since her admission to the facility. On [illegible], Resident #1's repeated [illegible] score was at 13, which is [illegible].

On [illegible] at 1:00 PM, Staff I indicated a new [illegible] test would be completed for Resident #1 . In this test, Resident #1 was only able to answer the present year and scored 3 out of 15, indicating severely [illegible].

In a phone interview conducted on [illegible] at 1:48 PM with Resident #1's father, he stated that Resident's #1 communication and [illegible] status have worsened since she was admitted to the facility. He further reported that Resident #1 is not able to verbalize her needs to him.

A review of the Elopement drills that were provided by the facility showed no indication that [illegible] and Elopement in-services were given in [illegible] as listed on the Education Calendar for 2021. This surveyor was provided education in-service attendance reports for [illegible] /mistreatment dated [illegible] and Missing Resident/Elopement/ [illegible] dated [illegible]. The facility also conducted elopement drills on [illegible] and [illegible] after the incident on [illegible]. A closer review of the Elopement drills after [illegible] did not show an education that included: an outside search that needs to be done outside the facility as far as the [illegible] distance from the alarming exit door as a point of reference.

In an interview conducted on [illegible] at 10:20 AM, with Staff J, Certified Nursing Assistant, she arrived at the facility at 7:00 AM, on the morning

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F 689	Continued From page 26 of . On her way to the nursing station, she heard from another staff that Resident #1 had escaped and that they listened to the alarm. According to Staff J, Resident #1 always says that she wants to go out and wants to leave and is known to be a little . On the morning of the incident, staff started looking for her outside and inside the facility. She was told to look for Resident #1 outside in the front parking lot of the facility. When asked if Resident #1 had a guard before she attempted to leave the facility, she said no. She further stated that because she had never left the facility before, she did not need one. According to Staff J, on , they did not have a supervisor in charge because it was too early. She further said that when she was educated on elopement, she was told to first check each room before searching outside the premises. Then you go out to look for the resident. When an elopement happens, they are supposed to tell someone in charge and follow the directions of the supervisor. Staff J stated that she did not participate in any elopement drills after . When asked as to how many exit doors does the facility has, she did not know. In a second interview conducted on at 11:07 AM with Staff E, she stated that she was educated on elopement twice a year. The drills consisted of a code called "BODYBEAR" as an indication that a resident was missing. They needed to get to the nurse's station and receive the individual assignment from the supervisor. Once you have your instructions, you follow them and report your findings. On the morning of , she heard the alarm and told the nurses what the Resident in told her. She tried getting the staff around the facility to	F 689		

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search for Resident #1, and she even looked outside the front of the facility. After the incident, the facility conducted an in-service on elopement which she did not participate. When she returned, she completed a test on elopement. According to Staff E, nothing new was part of the education, and that they re-educated staff on the same instruction you would follow if an elopement happened again. She did not know if the facility completed another drill after the incident on . When asked by the surveyor if she could see Resident #1 walking away when she peeked outside the door on , she said: "I can see a partial view of the street, on both sides but more to the left." She then said Resident #1 must-have walked very fast.

In an interview conducted on at 11:57 AM, Staff K, Housekeeping, stated that on the day of the incident, she passed by to go to the nurses' stations. She is familiar with Resident #1, who usually comes out of her room at around 8:00 AM and goes outside the patio across from her room. On the morning of , she saw Resident #1 walking out of her room and did not think much of it. The next thing she heard was the alarm on the door. She walked in the direction of the sound and was told by Staff E, who was by the exit door, that Resident #1 had already gone and could not see her. She then started looking for Resident #1 around the building. She also reported that by the time she was ready to go into her car and drive around to look for Resident #1, another staff brought Resident #1 to the facility. She could not remember when the last time she participated in elopement drills. When asked if this happened again: she said, "they would not have to tell me

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anything; I would go looking for [Resident #1] right away".

In an interview conducted on at 12:15 PM with the Maintenance Director, he stated he helps with the elopement drills. He noted that elopement drills are conducted once a month for every shift. Before this year, they used to have a dressed-up teddy bear called BODYBEAR, which the facility would hide either inside or outside. Once announced, staff would have to come to the nurse's station to receive their assignments. Now they have changed the drills, they will call the name of the missing resident, and staff will follow the supervisor's instructions.

In a tour conducted on at 6:00 PM, with the Regional Director of Clinical Services, she was asked to accompany the surveyor to the exit door that Resident #1 escaped from. Surveyor opened the exit door and peeked outside. Surveyor could not see a full view of the street from right to left, and only the ramp to the street was visible from the door (Photographic evidence obtained). The Regional Director of Clinical Services agreed that Staff E, should have stepped outside the door, and walked down the ramp, to have a full view of the street.

The facility Immediate Jeopardy Removal Plan included:

1. On the Director of Clinical Services and designees initiated education for staff on how to search for a resident who has eloped from an alarming door to include an immediate perimeter area search from the starting point of distance. The responder to the alarming door will be assigned to conduct the initial/immediate

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search. This education consisted of return demonstration to validate knowledge and phone education when available and education documentation if needed. Return education demonstration will continue upon staff return.

2. On ... The Plant Operations Manager was educated by the Senior Maintenance Director on conducting monthly Elopement Drills.

3. The Director of Clinical Services and designee conducted elopement drills on each shift, daily for 3 days starting on ..... then weekly through , drills included post drill education based on response.

4. On ... the Director of Clinical Services and designees initiated staff education on demonstration to follow elopement plan. Education initiated on . Staff includes ... (7), Housekeeping/Laundry (5), Dietary (7), CNAs (28), Nurses (18), and Administrative/department heads (12).

5. On ..... Licensed nursing staff education was initiated to ensure the Elopement Risk evaluation is conducted at the time of admission. Education includes 18 licensed nursing staff.

6. On Staff education was initiated on reporting and communicating resident exit-seeking behaviors to their supervisor. The Director of Clinical Services will be notified, and appropriate interventions will be reviewed. Staff Education includes ... (7), Housekeeping/Laundry (5), Dietary (7), CNAs (28) Nurses (18), and Administrative/department heads (12).

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F 689	Continued From page 30 7. On . . . . The Executive Director and Director of Clinical Services were educated on determining the root causes specific to elopements by the Regional Vice President of Operations. 8. The Executive Director led an additional Quality Assurance and Performance Improvement meeting on with the Medical Director, Director of Clinical Services, Social Services Director, Plant Operations, Activities, Dietary Supervisor, Housekeeping Supervisor, CNA, Business Office. 9. An additional ad hoc quality assurance performance improvement meeting was held on with the participation of the Center Medical Director, Executive Director, Director of Clinical Services, Social Services Director, Unit Manager, MDS Coordinator, Plant Operations Manager, Human Resources, Housekeeping Supervisor, Dietary Director, , , , Director, and Activities Director. The plan along with the root cause for the incident was discussed and approved by the Medical Director. The Facility policies on Elopement were reviewed during the QAPI meeting. 10. An ad hoc quality assurance performance improvement meeting was held on . . . . with the participation of the Center Medical Director, Executive Director, Director of Clinical Services, Social Services Director, Unit Manager, MDS Coordinator, Plant Operations Manager, Human Resources, Housekeeping Supervisor, Dietary Director, , , , Director, and Activities Director. The Plan along with the root cause for the incident was discussed and approved by the	F 689		

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F 689	Continued From page 31 Medical Director. The Facility policies on Elopement were reviewed during the QAPI meeting.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-ˬ ... and ˬ ... ˬ tubes, both ˌ ˬ ˬ and ... endoscopic ˌ ... ˌ and fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body ˬ or desirable body ˬ range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a timely nutritional assessment; failed to assist with ordered nutritious treats; and failed to prevent further ˬ loss for 2 of 11 sampled residents reviewed for nutrition (Resident #21 and Resident #200). The findings included:	F 692	F692 1.The Registered Dietician reassessed Resident #21 and #200s□ nutritional status to provide the necessary interventions for their ˬ losses. Staff were educated on assisting residents during meals and to their	

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F 692	Continued From page 32 A review of the facility's policy titled "Weighing the Resident," revised on , showed that residents will be unless ordered otherwise by the Physical on admission, weekly for 4 weeks and once a month after that. 1. A record review of Resident #21 revealed his readmission to the facility on with diagnoses of Aduit and (difficulty swallowing) following a . The annual Minimum Data Set (MDS) dated showed that Resident #21 had a Brief Interview of Mental Status ( ) score of 06, which is moderate to the severe . Review of the Care plan dated showed that Resident #21 has the potential for imbalanced nutrition, related to the process and . A review of the above MDS section G showed that for eating, Resident #21 was coded as requiring supervision and 1 person assist. In an observation conducted on at 11:00 AM, a container of a house shake (nutritional supplements) was noted unopened at the side table of Resident #21. Another observation conducted on at 1:00 PM noted the same unopened house shake at the side table in Resident #21's room. In an observation conducted on at 3:30 PM, Resident #21 was observed in his room. Closer observation showed a Vanilla house shake that was opened but not consumed at the bedside. A container of another house shake provided at 2:00 PM was also at the side table unopened.	F 692	nutritional supplements as necessary. 2.The Director of Clinical Services and/or designee conducted an audit of residents during meals and residents receiving nutritional supplements to ensure that they are receiving the assistance needed as necessary. The Registered Dietician conducted an audit of residents Nutritional Assessment record to ensure that losses are timely addressed as necessary. Corrective actions were made as necessary. 3.The Regional Dietician educated the Registered Dietician on the Nutrition/Hydration Status regulatory requirement. 4.The Registered Dietician and/or designee will conduct an audit of the residents during meals and residents with nutritional supplements to ensure that assistance are provided as necessary and nutritional assessments are in place for residents with losses for timely intervention, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	

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An observation was conducted on [redacted] at 6:00 PM. The meal cart arrived on the unit and was placed in the hallway. The meals were delivered to all residents while Resident #21 was waiting on his dinner tray. At 6:30 PM, the meal tray was brought into the room by staff, and at 6:40 PM, the team started assisting Resident #21 with his dinner meal (40 minutes later).

An observation conducted on [redacted] at 8:10 AM showed the meal cart that arrived on the unit between [redacted] to 117. At 8:40 AM, the staff brought the breakfast meal to Resident #21 in his bed (30 minutes later).

A review of the Order Summary Report showed an order for Health shake two times a day for a supplement with lunch and dinner and record amount dated [redacted]. A review of the [redacted]'s summary showed the following [redacted] recorded for Resident #21: on [redacted] at [redacted], on [redacted] at [redacted], on [redacted] at [redacted].

In an observation conducted on [redacted] at 2:30 PM, Staff B, Restorative Certified Nursing Assistants, was asked to take the [redacted] on Resident #21. Staff B used a bed scale to obtain the [redacted] for Resident #21. Continued observation showed a new [redacted] recorded at [redacted]. In this observation, Staff B stated that weekly [redacted] are conducted on all residents on Mondays and Wednesdays. The new [redacted] recorded for Resident #21 showed an additional 3-[redacted] loss from [redacted].

A record review of the progress note dated [redacted] by the facility's Dietitian revealed [redacted] trending gradually for Resident #21 in the

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past 6 months. In this note, recommendations were made for Medpass (nutritional supplement) twice a day for [redacted] management.

An interview conducted on [redacted] at 1:44 PM, with the facility's clinical Dietitian, revealed that she only comes to the facility in person once a week, but can review medical charts remotely. She said that [redacted] are given to her by Staff B when she comes into the facility on Fridays. The initial assessment is done up to 14 days from admission, but high-risk residents will be seen sooner. The facility's Dietitian reported that supplements can be provided to residents before her initial assessment if they have a history of [redacted] loss or are at high nutritional risk. She further stated that she will speak to nursing staff regarding the intake of meals on all residents. According to her, the house supplement shakes are always given between meals to aid with [redacted] gain. In this interview, she said that Resident #21 is not able to eat on his own and that he needs [redacted] with his meals.

In an interview conducted on [redacted] at 2:20 PM, Staff C, Patient Care Assistance ([redacted]), stated that Resident #21 needs full assistance with all his meals. She further stated that someone needs to sit with him for the duration of the meals. When asked if he can drink his House Shakes (nutritional supplements) on his own, she said no. Staff C reported that she needs to hold the Shake and the straw to his [redacted] for him to drink the shake.

In an interview conducted on [redacted] at 12:39 PM, the facility's clinical Dietitian reported that she did not know that a new [redacted] was obtained

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for Resident #21 and that he lost 3 more pounds. She also was not aware that Resident #21 is not assisted with his nutritional supplements between meals.

2. A review of the chart showed Resident #200 was admitted to the facility on [redacted] and discharged to the hospital on [redacted]. Diagnoses of severe protein-calorie [redacted], [redacted], and [redacted]. A review of the 5 days MDS dated [redacted] showed that Resident #200 had a [redacted] score of 15 which is [redacted]. Section G for eating showed limited assistance with one person's physical assist. The care plan initiated on [redacted] revealed Resident #200 has a nutritional problem due to her protein and calorie [redacted]. It further showed that Resident #200 will maintain adequate nutritional status and will consume over 50% of her meals.

A review of the [redacted] summary showed the following [redacted] recorded for Resident #200: on [redacted] recorded at [redacted], on [redacted] at [redacted], [redacted], at [redacted], [redacted], at [redacted], and on [redacted] at [redacted].

The Nutrition Evaluation Initial that was completed on [redacted] which was 7 days after Resident #200 admission, revealed no [redacted] history recorded, the usual [redacted], and that Resident #200 is at risk for [redacted] due to poor intake of meals. A review of the Order Summary Report showed an order for nutritional supplements dated [redacted] which was 8 days after admission.

A review of the hospital records showed that Resident #200 had a [redacted], [redacted] in 5 weeks. It further showed that her [redacted] was at

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F 692	Continued From page 36 , , and it was noted that she appeared to be somewhat . In an interview conducted on at 12:39 PM, the facility's clinical Dietitian stated that Resident #200 is considered at high nutritional risk because of her poor intake of meals and low body . When asked by the surveyor, if she reviewed the hospital records of Resident #200, she said yes, and that not much was said about her nutrition from the hospital records. When asked as to the missing admission for Resident #200 she did not know but said that a , was recorded on . The Dietitian did not review Resident #200 chart prior to completing her initial assessment 7 days later . She agreed with the surveyor that Resident #200 is at nutritional risk and that she needed nutritional supplements upon admission. In an interview conducted on at 2:00 PM, with the facility's Administrator, she was informed of the findings.	F		
F 695 SS=D	, , / , Care and Suctioning CFR(s): 483.25(i) § 483.25(i) , , care, including , care and suctioning. The facility must ensure that a resident who needs , , care, including , care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview	F 695	F695	

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F 695	Continued From page 37 and review of policy and procedure, the facility failed to 1) ensure that it obtained the attending physician's current orders for and indication for use, for a resident receiving for 1 of 2 sampled residents (Resident #10). 2) failed to ensure that it dated and properly labeled the tubing for 2 of 2 sampled residents receiving (Resident #10 and Resident #49). The findings included: Review of facility policy and procedure on at 5 PM for provided by the (DON) effective indicated that ....Procedure: Physician's order for shall include: Administration modality, FiO2 or liter flow, continuous or PRN, PRN orders must include specific guidelines as to when the resident is to use . Documentation shall include: Date and time of setup, Type of administration devices used, liter flow or FiO2 ...Instructions given to the resident for no smoking or flammable substances, while is in the room, " " sign placed on the resident's door ...Signature and credentials. Review physician's order ....Assess the resident ...Post " " signs on the resident's door, label tubing and humidifier with date and time ....Document initiation of in the resident's chart. Review of facility policy and procedure on at 5:15 PM for Administering Medications ( ) provided by the (DON) revised indicated for Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation ....Medications are	F 695	1.Resident #10 and #49s were checked for label and physician orders and were updated as needed during the survey. 2.The Director of Clinical Services and/or designee conducted an audit of residents with to ensure that a physician order is in place and is appropriately labeled. 3.The Director of the Clinical Services and/or designee educated licensed nurses on the regulatory requirement for as related to order. 4.The Director of Clinical Services and/or designee will conduct an audit of residents with to ensure that a physician order is on place and is appropriately labeled, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	

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F 695	Continued From page 38 administered in accordance with prescriber orders, including any required time frame. 1) During an observation conducted on at 11:24 AM, Resident #10 was observed receiving continuous ,,, infusing at two to three (...) liters per minute via ,,,. concentrator. There was no date/label noted on his ,,, tubing to indicate when it was last changed and there was no signage outside of the resident's doorway indicating ,,, in use. Resident #10 was initially admitted to the facility on ..... and re-admitted to the facility on ..... with diagnoses which included: ..... (...), ... ,,, Failure, and Dependence on Supplemental ,,, Record review revealed Resident #10 had a Brief Interview Mental Status (...) score of 15 (...). Photographic evidence obtained of the absent label on Resident #10's ,,, tubing and lack of ,,, signage outside Resident #10's door. On ..... at 11:26 AM, a computerized record review was conducted of Resident #10's current physician's orders. However, there was no current order noted for the ,,, with parameters, for this resident. Neither were there any orders or other documentation written on Resident #10's Medication Administration Record (MAR) nor on the Treatment Administration Record (TAR), to indicate any routine changing of the resident's ,,, tubing. On ..... at 11:33 AM further computerized record review of the physician's order dated ..... revealed that Resident #10's ,,, ,, was discontinued when he was transferred out of the facility to the hospital for	F 695		

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distress and not re-ordered upon re-admission to the facility on . Again, the resident was transferred out to the hospital on , per resident request for difficulty breathing and again his was not re-ordered/re-newed upon re-admission to the facility on .

However, on at 11:44 AM, a computerized record review was conducted of the Resident #10's Minimum Data Set (MDS) section O for assessment reference dates of and , in both of these instances it was indicated that the resident was receiving for dates-of-service (DOS).

On at 12:15 PM, a computerized record review of Resident #10's nursing care plan dated also reflected the following: Monitor sat per order and report to Medical Director (MD) if ( ) sat is less than (<) 90%, provide per MD orders, Settings: ( ) via prongs/mask per order, history of ( ) and use related to ( ).

On at 12:28 PM, an interview was conducted with Resident #10 in which he was asked about his usage, and he replied that his should be infusing at three (3) liters per minute. The resident was not noted to be in any acute distress or exhibiting any ( ), at the time. The resident also stated that he routinely uses his everyday (24/7) and has done so for over two (2) years. He added that the facility staff should be changing his tubing at least every three (3) days. However, he said that sometimes they don't change the tubing for about two to three ( ) weeks.

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	105578	A. BUILDING _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR BEACH NURSING AND REHABILITATION CENTER	1615 MIAMI RD FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 40	F 695		

On at 4:32 PM there was still no date/label noted on Resident #10's tubing to indicate when it was last changed and there wass still no signage outside Resident #10's doorway, indicating in use.

On at 2:35 PM there was still no date/label noted on Resident #10's tubing to indicate when it was last changed and there is still no signage outside resident #10's doorway indicating in use.

On at 10:41 AM there was still no date/label noted on Resident #10's tubing to indicate when it was last changed and there is still no signage outside resident #10's doorway indicating in use.

There was no "active" order noted/obtained for , for Resident #10.

On at 10:51 AM, an interview was conducted with Staff D, a Licensed Practical Nurse (LPN), in which she was asked the following three (3) questions regarding the resident's : 1) Is this resident on ? She replied, "Yes, on two (2) liters." 2) Did you have or get an order to administer this resident's ? She stated, "no." 3) If no, why not? Staff D, acknowledged that she did not take the time to verify whether or not the resident actually had an order for the , and she also acknowledged that the resident's tubing should have been labeled and dated as to when it was last changed by staff.

2) On at 10:59 AM Resident #49 was observed receiving his ordered at four to

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F 695	Continued From page 41 five ( ) liters via ..... via ox concentrator. However, there was no date/label noted on his ..... tubing to indicate when it was last changed. Record review revealed Resident #49 was originally admitted to the facility on and re-admitted on with diagnoses which included: ..... ( ) and history of ..... and ..... in ..... . He had a Brief Interview Mental Status (BIM) score of 12 (moderately). Photographic evidence obtained of absent label on Resident #49's ..... tubing. On ..... at 4:03 PM there was no date/label noted on ..... tubing to indicate when it was last changed. On ..... at 10:30 AM there was still no date/label noted on ..... tubing to indicate when it was last changed. On ..... at 11:05 AM, a computerized record review conducted of the resident's current physician's orders indicated ..... - Continuous at 2 liters (L)/minute (M) via ..... to increase resident's ..... to five (5) (L) via continuously, change tubing, mask and /or ..... weekly, may change sooner as needed and ..... ox. Computerized record review of Resident #49's Treatment Administration Record (TAR), further indicates for changing of this resident's ..... tubing, mask and/or ..... weekly, may change sooner as needed every night shift with the presence of ..... at two (2) liters per minute, to increase to five (5) liters via ..... continuously every shift for	F 695		

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F 695	Continued From page 42 On at 11:21 AM record review of Resident #49's nursing care plan dated also indicated for Settings: ( ) via (prongs) at two (2) (L) as needed (PRN) and a potential for ( ) related to prior history of ( ) episodes. On at 10:51 AM, an interview was conducted with Staff D, an (LPN), in which she acknowledged that the resident's tubing should have been labeled and dated as to when it was last changed by staff. In fact, the order, tubing label and signage were not obtained/put into place for Resident #10, until after surveyor intervention. During an interview conducted on at 11:20 AM, the Director of Nursing (DON) further acknowledged that Resident #10 should have had an order and signage in place, and she also acknowledged that both Resident #10 and Resident #49's tubing should have been labeled and dated; this was not done.	F 695		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record	F 810	F810	

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F 810	Continued From page 43 review, the facility failed to provide an eating device for 1 of 10 sampled residents reviewed for nutrition (Resident #21). The findings included: In an observation conducted on at 12:45 PM, Resident #21 was observed in his room with the lunch meal at his bedside. Closer observation showed a regular breakfast plate and not a Scoop plate. In an observation conducted on at 12:20 PM, Resident #21 was observed in his room with the lunch meal at his bedside. His lunch meal showed a regular lunch plate and not a Scoop plate. A record review of Resident #21 revealed his readmission to the facility on with diagnoses of adult and (difficulty swallowing) following a . The annual Minimum Data Set (MDS) dated showed that Resident #21 is with Brief Interview of Mental Status ( ) score of 06, which is moderate to severe . A review of the Physician's orders showed an order for Regular No Added Salt diet, Advanced texture, Regular/Thin Liquids consistency, Fortified Food, Scoop Plate with all Meals dated . The Nutrition Evaluation dated revealed that Resident #1 has adaptive equipment of a Scoop plate. Review of the Care plan dated showed that Resident #1 has potential for imbalanced nutrition related to the process and . It further showed to provide	F 810	1.Resident #1 and #21s missing scoop plates were corrected and were provided during the annual survey and are ongoing. 2.The Dietary Supervisor and/or designee conducted an audit of residents with adaptive equipment for meals to ensure of compliance. Corrective actions were made as necessary. 3.The Dietary Supervisor and/or designee educated the dietary staff on ensuring that adaptive equipment are serve for residents with orders for them, during meals. 4.The Dietary Supervisor and/or designee will conduct an audit of meal trays to ensure that residents with orders for adaptive equipment are in place, random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	

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F 810	Continued From page 44 a Scoop plate with all meals and requires assistance with feeding and cueing. In an observation conducted on at 6:00 PM, Resident #1 was in his bed with the dinner meal at his bedside. Closer observation showed a meal ticket that had a Scoop plate written on it. The actual dinner plate did not have a Scoop plate as per the Physician's orders (photographic evidence obtained). In an interview conducted on at 10:46 AM, with Staff A, Manager in Training, he was asked by the surveyor as to who is responsible for checking the meal tickets on the tray line. He said, "it is the diet aid on the tray line". The diet are responsible for checking the diet types, the correct number of fluids, diet consistency, and making sure that the right portion size is correct on the tray. Staff A further reported that the cook is responsible to make sure that the scoop plates are placed on the tray as per the Physician's orders. In an interview conducted on at 5:00 PM, with the facility's Administrator she was informed of the findings.	F 810		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to dispose of garbage and refuse properly to ensure a potential health hazard.	F 814	F814 1.The dumpster was addressed during the annual survey and is being maintained.	

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F 814	Continued From page 45 The findings included: During an observation conducted on at 8:25 AM of the outside garbage/refuse, an overpowering smell of rotting garbage was noted. Closer observation showed two large trash dumpsters that were located outside the main kitchen area. One of the dumpsters was propped open with a bag of garbage half out (Photographic evidence obtained). Noted gloves, bottles, food residue, and unidentified matter between and underneath the dumpsters. An interview was conducted on at 4:40 PM with the Regional Food Service Director and was informed of the findings. In an interview conducted on at 10:46 AM, with Staff A, Manager in Training, he was asked by the surveyor as to who is responsible for making sure that the dumpster area outside the kitchen is cleaned and free of debris. He stated that it is his responsibility, but that he only started working in the facility last week. Staff A acknowledged all findings and said "it needs to be checked on a regular basis". In an interview conducted on at 5:00 PM, with the facility's Administrator, she was informed of the findings.	F 814	Staff A was provided an education on the regulatory requirement for Garbage and Refuse Properly. 2.The Dietary Supervisor and/or designee audited the garbage disposal to ensure that they are properly disposed. Corrective actions were made as necessary. 3.The Executive Director educated the Dietary Supervisor on the regulatory requirement for proper disposal of garbage. 4.The Dietary Supervisor and/or designee will conduct an audit of the garbage disposal to ensure that they are properly disposed random weekly x 4 weeks, then random monthly, thereafter. Findings will be discussed in the monthly QAA meeting to sustain compliance.	