STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105565	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Health and Rehabilitation Center	820 N Clyde Morris Blvd Daytona Beach, FL 32117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28892 Based on record review, observations, interviews, and review of facility standards and guidelines for elopement and wandering, the facility failed to immediately report, or within 24 hours of the event, an alleged violation of neglect for one (Resident #2) of two residents sampled for elopement, to the State Survey Agency. The findings include: Review of the facility's 2024 Federal Reports revealed no reports had been filed electronically as required for Resident #2. A review of Resident #2's medical record revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and left the faciity on [DATE]. His diagnoses included pneumonia, unspecified organism, anxiety disorder, anemia, other chronic pain, dorsalgia, unspecified, hypertension, chronic kidney disease, stage three, unspecified, difficulty in walking, not elsewhere classified, and muscle weakness (generalized). The resident was prescribed Ativan, one milligram (mg) twice a day for anxiety. A review of a local hospital progress note dated 4/17/2024 documented that although Resident #2 is alert and oriented to person and place, the resident appears to lack the insight into his overall medical condition and the related judgement to make good medical decisions for himself. A hospital psychiatry progress note documented that Resident #2 does not have decisional capacity and next of kin agrees with placement into a skilled nursing facility for rehabilitation when the resident is medically stable for discharge. On 6/13/2024 at 10:00 AM, observations of the exterior perimeter of the facility revealed no fence surrounding the facility, a busy parking lot, busy boulevard and uneven terrain. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/2024 at 5:59 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #2. The DON revealed that on 4/28/2024, at approximately 1:00 AM, the Supervisor or former supervisor called her to inform her that the Resident #2 wanted to leave. The DON contacted the Regional Nurse at 1:37 AM to inform him the Resident left. The DON phoned the Advanced Registered Nurse Practitioner (ARNP) call service and the ARNP called the DON at 2:28 AM and asked why the DON was calling so early in the morning. The DON informed the ARNP that the Resident #2 wanted to be discharged . The DON received the discharge order. A nurse went to the resident's room to inform him that he was going to be discharged and found that the Resident was gone. The nurse called the DON back to inform her that the Resident was gone. Staff called the Resident #2's primary emergency contact (resident's daughter) to inform her that the resident was missing. The daughter said that the Resident was at his home. At 9:00 AM, the DON had a conference call with Corporate to discuss the incident regarding the Resident. It was agreed that DON would perform a wellness check on Resident #2. The DON arranged to be accompanied by the facility wound care nurse (Employee A). Upon arrival at the resident's home, the resident's roommate answered the door and said that Resident #2 was too embarrassed to speak to the DON. The resident gave verbal consent for the roommate to sign his discharge paperwork and receive his medications. The resident's roommate signed the discharge paperwork and received the resident's medications. The DON explained that there were no elopements at the facility prior to this incident. Review of a progress note dated 4/24/2024 at 4:30 AM, documented that Resident #2 expressed a desire to be discharged . The Resident was noted as alert with signs of confusion and fixated on wanting to leave. Review of a psychology evaluation progress note dated 4/25/2024, documented the chief complaint for Resident #2 as anxiety. The progress note documented Resident #2 as compliant with the evaluation and needed frequent redirection due to confusion. The Resident scored 10 out of 28 on mini mental status exam suggesting moderate to severe cognitive impairment. A Social Service progress note documented that Resident #2 was confused, and the Resident was found putting plastic bags on his feet reporting that he had to go outside to paint. Review of a progress note on 4/28/2024 at 12:55 AM, documented Resident #2 was not present, supervisor advised. Review of a progress note dated 4/28/2024 at 02:28 AM, documented that an order from Resident #2's ARNP was received to discharge home instead of waiting for a discharge order on Monday. Review of a progress note dated 4/28/2024 at 10:15 AM, documented that the writer spoke with Resident #2's daughter concerning the resident being discharged early this morning due to not wanting to wait until Monday to be discharged . This writer also informed resident's daughter that a wellness check will be done. Review of a progress note dated 4/28/2024 at 11:45 AM, documented that a wellness check on Resident #2 was completed. The resident was noted as sitting on a couch. Discharge instructions and medications were given. The resident was informed that home health services were initiated. The resident's friend signed the discharge summary per resident's request. Review of a progress note dated 4/28/2024 at 11:51 AM, documented that the DON placed a call to the Resident's daughter. A message was left noting a wellness check visit was conducted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/2024 at 2:45 PM, an interview was conducted with Employee B, Receptionist. She requested Employee C, Certified Nursing Assistant be present during the interview. Employee B explained that an elopement book was kept at the front desk and each nurse's station. She reported she had elopement training about two or three weeks ago. She described the facility process after an elopement, which included a code orange. All employees have designated spots to search for a missing resident. If the resident cannot be found inside the building, a search should be made outside the building, including the parking lot, the front of the building and the sides of building. A search is made close to the streets, and if the resident is not found, the facility gets the police involved. When questioned how staff knew which resident(s) were an elopement risk, she stated, they should have a file, it has their picture in it, and it lets you know if they have tried to exit before or if they are exit seeking. The employee reviewed the facility elopement book retrieved from the from desk and was asked to pick someone in the book who was an elopement risk or exit seeker and responded, there is no one in the book. I can give you the names, but I can't show you because there is nothing in the book. She was asked to provide the names of residents who were elopement risks and recalled the names of several residents who were deemed as an elopement risk. On 6/14/2024 at 3:27 PM, an interview was conducted with Employee A, Licensed Practical Nurse (LPN). When asked to describe the events of the incident surrounding Resident #2, she stated, I know he left against medical advice (AMA), he went to his house, the DON and myself, went to his house and did a wellness check. His daughter knew he had left the facility. The facility received the discharge order, and the DON received the discharge papers. She and the DON went to the resident's home and the resident's friend came to the door. She and the DON saw the resident sitting on a couch and his friend came out of the home and explained that the resident was fine. The resident's friend signed the discharge papers at the patient's request. The resident's friend was made aware that home health services were notified. When Employee A was asked how Resident #2 left the facility, she stated, out of the window. When asked if anyone witnessed him going out the window, she stated, I don't know. The employee explained that she did not know what time the Resident got out the window or how he got home. On 6/14/2024 at 4:22 PM, an interview with the Administrator was conducted. The Administrator confirmed the facility did not report the elopement. The Assistant Administrator was present during the interview. The Administrator reported that elopements are tracked through elopement screening and elopement books. He explained that the Administrator and the DON are responsible for tracking elopements. The nurses do the assessments, but the DON and I have the responsibility of tracking. At this time, we have zero residents who are elopement risks. After the incident, law enforcement arrived, staff explained the resident's cognition and that there was an order for discharge, and the officer canceled the call. The Administrator confirmed no federal report or adverse incident report was submitted related to Resident #2. Review of the facility's Standards and Guidelines: Elopement and Wandering (issued 11/2021, Revised: 11/2022, 7/17/23 and 1/1/24) documented, Resident will be seen at risk for elopement if: 1. Noted with a cognitive impairment and deemed incapacitated. 2. Actively expressed desires to leave the facility by an incapacitated resident or actively exit seeking behavior with a cognitive impairment . 5. (h) Report the incident according to state and federal regulations.