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
	AL11964318	A. BUILDING: _____ B. WING _____	07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLARIS SENIOR LIVING STUART	860 S.E. CENTRAL PARKWAY STUART, FL 34994

(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
A 000	Initial Comments An unannounced Licensure Complaint survey, #2020011505, and Control Special survey, was commenced on and concluded on at Solaris Senior Living Stuart. The facility had a deficiency identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	A 025		

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A 025	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide care and services and supervision, appropriate to meet the needs of each resident within the facility for 1 out of 5 sampled residents (Resident #1). As evidenced of the facility's failure to have knowledge of the general awareness of the whereabouts in which Resident #1 . . . . . away from the facility and was found laying on the ground in a nearby shopping center parking lot by a random indivdual whom contacted local law enforcement. The findings included: A review of the facility's Elopement standards policy with an effective date of (revised on . . . . .), revealed the following. The facility will assess all residents for risk of elopement in a manner consistent and in compliance with the minimum standards required	A 025		

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A 025	Continued From page 2	A 025		

by current statute and rule.
The facility policy states that the facility shall adhere to the following procedures for elopement standards:
1. Identify all residents assessed at risk for elopement or with any history of elopement so staff can be alerted to their needs for support and supervision.
2. Assess for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to the facility.
a. If the resident has had a health assessment performed prior to admission pursuant to the statute, the requirement has been met.
3. Make, at a minimum, a daily effort to determine that at-risk residents have identification on their persons that include their name and the facility's name, address, and telephone number.
4. Be generally aware of the location of all residents assessed at high risk for elopement at all times.
5. Have a photo identification of at-risk residents on file that is accessible to all facility staff and law enforcement as necessary.
a. The file will contain the resident's photo identification upon admission or upon being assessed at risk for elopement after admission.
b. The photo identification may be provided by the facility, the resident or the resident's representative.

Facility Resident Elopement Response:
Policy: The facility will respond with the following procedures when a resident has appeared to elope from the facility or from a planned activity away from the Community property.
1. Staff will check the Resident Sign Out Log to see if the resident has signed out from the facility.
2. The resident's immediate family (if applicable)

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A 025	Continued From page 3 will be contacted to see if the resident is currently with them, and they have failed to sign out. 3. A search of the resident's room, building, grounds and surrounding areas will be conducted by Staff. 4. Staff will immediately notify the Administrator on Duty of the possible resident elopement. 5. At the direction of the Administration or Administration on duty, Staff will notify the local authorities of the missing resident. After the resident is located: 6. Staff shall notify the resident's family or responsible party of the resident status. 7. Staff shall notify the resident's physician of the elopement. 8. Staff shall be notified of the resident's continued need for supervision and security. 9. The Administrator and Risk Manager shall review the elopement for determination of an adverse incident and refer the incident to Risk Management to prevent future occurrences. 10. If a determination is made whereby the missing resident was at risk of danger of serious injury, an initial adverse incident report shall be completed and forwarded to AHCA within 1 business day of the resident elopement. 11. A complete adverse incident report shall be completed and forwarded to AHCA within 15 business days of resident elopement. A review of the facility policy entitled Resident Care - Supervision, effective date and revised on revealed the following. The facility will provide supervision as appropriate for each resident in a manner consistent and in compliance with the minimum standards by current statutes and rules. Procedure: The facility will adhere to the following supervisions procedures: 1. Monitor the quantity and quality of resident's	A 025		

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A 025	Continued From page 4 diets in accordance to state statutes. 2. Provide daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. 3. Maintain a general awareness of the resident's whereabouts. The resident may travel independently in the community. 4. Contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate or case manager it the resident exhibits a significant change. 5. Contact the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. 6. Maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration or other changes that resulted in the provision of additional services. A review of the Adverse Incident report(s) submitted by the facility to the Agency revealed the following . The facility submitted the preliminary report (1 day report) to the Agency on . . . . . at 4:28 PM. Incident date noted as . . . . . and time of incident noted as 0630. The outcome is noted as . . . . . The circumstances of the incident read as follows. 5:30 AM, Nurse supervisor attempted to contact resident for morning . . . . . check. Resident did not respond to call and at approximately, 5:45 AM, Nurse went to resident's apartment and found resident was not in his apartment. Resident had not been identifed for as an elopement risk. Independent in ADLs.	A 025		

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A 025	Continued From page 5 Ambulated without use of adaptive equipment. Nurse initiated search for resident and contacted DON at 6:27 AM. Nurse contacted Power of Attorney (POA) at 6:30 AM to inform of search. Police notified POA at 6:31 AM and the nurse that resident had been found expired on sidewalk of campus. On , the Agency requested additional information about the report from the facility. On at 4:23 PM, the report (prelimary report) was withdrawn by the facility. During an interview with the Adminsitrator and Senior Administrator (of the adjacent Nursing Home) on at 11:30 AM, they revealed the following regarding the circumstances involving Resident #1. The Administrator and Senior Administrator (of the adjacent Nursing Home) both confirmed that when they watched the surveillance camera on , the following day, they saw the time stamp of 11:51 PM on , when Resident # 1 was seen leaving out of the front door. The Administrator stated, she assumed the main door alarm sounded after Resident #1 left the building due to video footage showing Staff H (Nursing Supervisor) coming out of the Nursing station on the second floor shortly after Resident #1 left and looks over the balcony to the area near (lobby area), the entrance door where Resident #1 was seen sitted earlier. Then, Staff H proceeded to walk down the stairs pass the lobby and heads towards the 1st floor wing rooms. At this time, Resident #1 was not seen in the lobby area during Staff H's walk in the area and Staff H was not seen to check the main entrace door. The Administrator also indicated that the detective advised her of the location that Resident # 1 was found . At this time, the surveyor requested to review the incident report and/or any	A 025		

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A 025	Continued From page 6 documentation related to the facility's investigation and the surveillance video footage on the day of the incident for Resident #1. The facility Administrator indicated she would provide the surveillance video on . . . . . and . . . . . for viewing by the surveyor at the facility. However, the video was not provided for review as requested on this date and provided on a later date (after additional requests) by the Administrator. She stated, she didn't have a formal incident report regarding Resident #1's incident due to Staff H refusal to come to the facility and write the report. However, she stated she had a written investigation report, that she formulated regarding the incident that included handwritten witness statements from staff on duty and the staff member (Staff A) assigned to Resident #1, Elopement Report Decision Tree (completed . . . . .), a Mini Mental State examination (completed . . . . .) and 2 health assessments. She stated based on her review and analysis of this information, she determined Resident #1 was not an elopement risk and independent. She further stated that the Adverse Incident Report that was submitted prior to AHCA was withdrawn based on investigation, because she determined Resident # 1 was not coded as an elopement risk. She stated based on the facility's investigation, and interpretation of the regulation, the facility was not at fault. Further interview with the Administrator on at 12 PM, she stated that prior to the incident involving Resident # 1, the facility did not have a written policy regarding setting the door alarms on the main entrance/exit door to indicate the time and designated person identified to set the alarm. She stated that the outside doors of the entrance to the facility are always locked due	A 025		

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A 025	Continued From page 7 to the COVID pandemic, there are 2 doors at the front entrance (1 on the exterior and 1 interior) that lead to the main lobby of the facility. The exterior door (door #1), opens to an enclosed patio area for residents to sit, then there is door #2 that leads into the facility main lobby. She also stated that the front door (door #2) entrance is attended by the Receptionist daily until 7:30 PM, after 7:30 PM the door (door #2) is left unattended. She stated that when the staff manually sets the alarm, no time specific but usually is set by the 11 PM to 7 AM Supervisor. She stated, once the door is armed the staff are notified when a resident is exit seeking through the door (door #2) by the door alarm sounding. She stated the alarm is located inside of the Nurse's station on the second floor. It was revealed that a staff member is not stationed at the Nurses Station at all times. If the alarm sounds, staff are to go to the front door, the alarm stops after 20 seconds. She stated there is not an electronic log to determine what time the alarm was set by the staff or when it is disarmed. Record review revealed Resident #1 was admitted to the facility on . Resident #1's initial Health Assessment form (AHCA 1823 form) dated , revealed the following. The form documented the resident suffers from Uncontrolled , Meningioma ( ), , Right Paresthesia, . The resident's or behavioral status is noted as normal. The resident's Activities of Daily Living (ADL's) noted as independent. The AHCA 1823 form indicates that the resident requires general oversight with daily observation to observe wellbeing, observing whereabouts and reminders for important tasks. Resident is not noted as an Elopement Risk.	A 025		

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A 025	Continued From page 8 A second Health Assessment was completed for Resident #1 on [illegible] by his Healthcare Provider. Review of this Health Assessment revealed that Resident # 1 suffers from [illegible] Type II, [illegible], History of [illegible] Placement, [illegible] Prostatic Hyperplasia and Meningioma. The form documents N/A for physical/sensory limitations and [illegible] status. Resident is noted to require medication management. The form also notes special precautions as "N/A" and elopement risk marked as "no". The form failed to identify the resident's ADLs; section left blank (section 1). The form on Page 3 (section 2A and 2B) of the assessment entitled, Self-care and General Oversight Assessment were left blank, the Health Care Provider failed to complete the form reflecting resident's need for staff to observe his wellbeing, observe his whereabouts and reminders for important tasks. A review of the nurse's progress notes for Resident #1 revealed the following. 1) at 10:30 AM- Resident admitted from home with granddaughter, oriented x3. Will contine to monitor adjustment. 2) [illegible] at 7 AM - Resident slept all night. 3) at 08:00 PM - Some kind of [illegible] or sleepless night. Resident came to Nursing looking for the group event out for the night. Explained there was no group that went out and redirected to his room. 4) [illegible] at 1 PM- Resident coughing up a lot of phelgm, c/o [illegible] sound rhonchi. Temp 97.8 F, sent to ER. Notified POA. 5) at 10:45 AM - Doctor notified resident in the hospital 6) - resident admitted to the hospital for	A 025		

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A 025	Continued From page 9 7) (no time)- resident returned from hospital. 8) (no time)- Resident complained he choked on meat ball. He then and got it out. 9) at 12:30 AM - . in lobby at 12:30 PM. Patient (.) in chair, unable to sleep. told to go to room to go to sleep. responded "I can't sleep. 10) - . in lobby at 02:00 AM, in chair, unable to sleep. 11) at 05:30 AM - called . room for verification (bsv). . not answering. Went to 's room and he was not there. Initiated search and could not find him. Notified Director of Nursing (DON), called daughter to see if she had picked up. Daughter denied picking up . Not found on first or second levels. Daughter called approximately 06:00 AM, and stated, police found Father expired at 06:30 AM, by (building material store) expired. DON notified police officer, notified staff members, and Nursing Supervisor of finding resident expired and asked questions of . history. On at 1 PM, an interview was conducted with the Administrator and Sr. Nursing Home Administrator regarding Resident #1's progress notes. They confirmed that the date of the nursing progress notes should reflect " " instead of " ", since the writer (Staff H) of the nursing notes was very nervous. The observation notes also failed to identify any notification to Resident #1's Primary Care Provider regarding the resident's increased and/or restlessness. This was discussed with the Administrator, she stated that she didn't see a problem with the resident up late at night sitting in the lobby. She stated that was	A 025		

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A 025	Continued From page 11 . . . . . The police officer stated the resident was dressed in shorts, shirt, shoes, and hat. There were glasses found next to his . . . . He was carrying an Assisted Living Facility Identification Card (ID) card in his wallet along with his personal ID. He goes on to state, while on the scene, the resident's cell phone rang. The resident's daughter advised the Sergeant of Fire Rescue that the facility had called her at 5:30 a.m. and told her that her Father was missing. The police officer then called the facility and spoke with the Nursing Supervisor, Licensed Practical Nurse (LPN). The LPN told the officer that the resident was last seen at 2:00 AM by the Certified Nursing Assistant (CNA). The LPN went on to state the resident has and . . . . . . A review of the Staffing schedule for the month of revealed Staff H, Staff A and Staff B were on duty the night Resident #1 left the facility on after 12 AM. An interview with the Administrator on . . . . . at 12 PM, confirmed aforementioned. She also stated these staff members were interviewed regarding the incident of Resident #1 on and . A review of the witness statements provided by the Adminstrator dated . . . . . was conducted, the following was noted. a) Staff A (caregiver assigned to Resident #1) writes verbatim: On , Resident # 1, sitting in the chair by front door. At 12:30 AM, I said don't you want to go to bed. He said no he just sitting here. So, I told him the alarm is on you can't go out, he said I know it's dark. About 1:30 PM, I saw hi after assured he went to his room at 5:15 PM. I went outside to get the paper. b) Staff B writes verbatim: I didn't see Resident # 1 when I came into the facility. The alarm was set	A 025		

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on at 11:30 PM by Staff A. While during my rounds, Staff H was on the walkie talkie and asked if anyone had seen Resident # 1. She looked on the side of the building outside and checked both floors inside the facility. Staff D when he came on duty even helped with the search.
c) Staff D writes verbatim: Came in on at 5:50 AM. I was told by the staff that Resident # 1 was missing. I went to his room and went down the hall. At 6:30 AM - 6:40 AM, I went around the of the facility and went on the nearby highway going South. I saw the police near the building material store and 4 police squad cars. I drove down to the nearby road and made a U-turn and saw a police car coming to the facility. I arrived at 7:14 AM to the facility. I was told that the resident had ,

On and , an observation of the surveillance camera footage provided by the facility was conducted with the Administrator. The footage was dated (11 PM) - (12:07 AM). The following was observed.
1) On at 11:00 PM, it was revealed that there were four frames (sections) of the facility seen. The top left showed the view of the front lobby door. The top right frame showed the view of the lobby receptionist desk. The bottom left frame showed the upstairs Nurse's station and the right bottom frame showed the hallway of the second floor and the elevator doors. No staff or Resident #1 seen at this time.
2) On at 11:38 PM, Staff A, who was assigned for the care of Resident # 1, was seen passing the resident seated in his chair. She was observed leaning over him. She

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A 025	Continued From page 10 the resident's right and that he was alert and oriented. On , a review of Resident #1's Medication Observation Records (MORs) for revealed the following. Staff H, (Nursing Supervisor) signed the MOR dated , indicating that Resident # 1 was assisted with his AM medications by Staff H, exact time given is unknown (time is not documented) . 1) , 5 mg, to be given at 9:00 AM 2) ., 81 mg, to be given at 9:00 AM 3) Omega ,000 mg, to be given at 9:00 AM 4) Levetracetam 500 mg, to be given at 9:00 AM 5) , sub q, to be given at 6:00 AM However, the facility was notified of Resident #1 's on at 6:30 AM by the daughter and local law enforcement (copy of MOR obtained). Further review also revealed Resident #1 received medication assistance around 9 PM on (the prior night) by Staff H. A police report was received from the local Police Department on . The report is labeled investigation. It reads, on at 5:43 AM, the officer was met by an unknown female. She told the officer she was on her way to work and saw the male on the ground. She thought he was intoxicated and patted him on the . She felt something was wrong and called the police. Police state they found him on the ground in the prone position. The officer noticed insects on his and . He had on his , semi-dried. His was blue. He noted an on his left . The officer also stated the resident's skin was . There was slight . When Fire Rescue arrived on the scene, the Sergeant pronounced the resident	A 025		

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	AL11964318	A. BUILDING: _____ B. WING _____	07/22/2020

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SOLARIS SENIOR LIVING STUART	860 S.E. CENTRAL PARKWAY STUART, FL 34994

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A 025	Continued From page 13 proceeded to pass the resident and walk down the first-floor hall. Resident #1 is left in the area with no staff present. 3) On at 11:59 PM, Resident # 1 was observed walking up toward the door from the bottom frame. At this time, he didn't go out the door , he stood at the door for a few moments (approximately 2 minutes) and walked away from the door and returned to the door.. He was observed dressed in the following: Shirt, shorts, socks, shoes, jacket and baseball cap. He was not wearing a covering. 4) On at 12:01 AM, the Nursing Supervisor (Staff H) was seen looking over the open banister on the second floor speaking to the resident. He turned and walked away and went into the Nurse's station.Resident #1 still seen in the lobby area, no staff present. 5) On at 12:02 AM, Resident # 1 is seen walking out of the front lobby door by pushing on the door with his and the door opens. After Resident #1 walked out the door, the door swung closed by itself. 6) On at 12:05 AM, the Nursing Supervisor (Staff H) looked over the balcony again. He then walked down the stairs (next to the balcony) , he is seen looking around the lobby; then, proceeds to walk down the first- floor hall in the opposite direction of the lobby door. Resident #1 is not seen in the area on the footage. (Video footage obtained). Neither are any staff seen exiting the door after Resident #1 walks out . (Video evidence obtained). An additional request was made to the Administrator on to view additional video footage time after the 12:07 AM scene on due to discrepancies with timeframes noted on the Progress Notes for Resident #1.	A 025		

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A 025	Continued From page 14 She stated the facility was unable to obtain that time frame for additional viewing, she also stated the facility staff (Management) were unable to view the time frame also. Therefore, the facility was unable to determine any other actions by Resident #1 at the facility until his time of . On at 09:20 AM, an interview was conducted with the daughter of Resident # 1. She stated that she was never advised of what took place concerning her father (Resident #1). She stated the Administrator has given her several different stories regarding the events. She stated that at first, they told her that the Nurse (Staff H) checked on her father at 04:30 AM on , then, she stated they told her that the camera showed her father leaving the building at 11:54 AM on . She stated that she does not understand how the staff could have allowed her Father to be present in the lobby area, fully dressed with a baseball cap and not inquire about where he was going at that time of night, nor even check on him prior to 6:30 AM, the following day. She stated they had the " " to call her at 6:30 AM on and ask her if she had come to pick him up. She said of course she hadn't, because she was still asleep. She stated that this was a horrific incident involving her Father. She stated she is "heartbroken as the facility allowed him to die on the side of the road, just like roadkill". She stated she put him in the facility so that he would receive care. She stated they told her that they couldn't keep him from leaving because he was independent. She stated she didn't understand how her Father could leave during a Pandemic. She stated, she has gotten about 9,000 emails from the facility regarding their "No Visitors' policy" and that the residents were not able to leave. She stated, the facility was very callous.	A 025		

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A 025	Continued From page 15 She stated, when she went to pick up her Father's clothing, on her way out she pushed the door in the lobby and realized it would not open. She stated normally the door automatically opens (door #2) and is not locked. She stated the Administrator told her that the door no longer opened automatically. She stated it took her Father's to force them to lock the door in the lobby. On at 10:05 AM, an interview was conducted with Staff G (an LPN), who works the 7:00 AM - 07:00 PM shift. She stated, she had routine contact with Resident # 1, giving him medications on her assigned days of work. She stated, he would come up to the Wellness Room for his medications daily. She stated , Resident # 1 was becoming more and more about time. She also stated, that when she worked late (usually until 7:30 or 8 PM), they (the Nursing Supervisor) usually lock the door. Staff G, was questioned regarding if Resident #1 was an elopement risk, she never indicating he was an elopement risk. On at 11:49 AM, an interview was conducted with Staff B (caregiver) who works the 11 PM to 7 AM shift. She stated, she was working on the bottom floor of the facility on - She stated, she did not see Resident # 1 when she came into the facility around 11 PM or throughout the night. She stated, she knows they had the alarm on at 11:30 PM on per Staff A. She stated at 05:15 AM on , she did her rounds on the bottom floor. She says at this time, the Nurse Supervisor, Staff H was on the walkie talkie and asked if anyone had seen Resident # 1. She looked on the side of the building outside. She and another Aide , checked both floors in the	A 025		

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building (floor# 1 and # 2). She says they were getting nervous. They had kitchen staff help them. One staff member (Staff D) drove around the streets near the facility and near the main road to see if he off. They knew they had the alarm on. She stated they have 3 alarms and when they go off, they immediately searched the building. The Nurse (Staff H), came on at 06:30 AM - 07:00 AM. The Nurse came and told them they found him in the store parking lot. She says she does her rounds every two hours. She says she knows the alarm must be set by Staff A. She didn't indicate, she heard an alarm on the night Resident #1 left the facility.

On at 2:55 PM, an interview was conducted with Staff D who works the 6 AM to 2:30 PM shift. He stated, he came on duty on at 5:50 AM. He was told by the staff that Resident # 1 was missing. He went to his (Resident #1) room on the second floor and went down the hall. He stated that at 06:30 AM - 06:40 AM, he went around the of the facility and drive south on nearby highway. He stated, he saw the police near the material store building during his search while driving. He stated he saw about 4 police squad cars. He made it down to the nearby road. He made a U-turn and saw a police car coming to the facility. He stated he arrived at 7:14 AM on and was informed that the resident had , . He stated, that it surprised him that Resident # 1, left the facility. He stated that usually he (Resident #1) is in the Dining Room. Normally, Resident # 1 would eat dinner and come in a few hours and think that it was breakfast; he was .

On at 02:30 PM, an interview was conducted with Staff A (Caregiver), the following was revealed. Staff A confirmed she was

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assigned to the residents on the 2nd floor and assigned caregiver for Resident #1 during the 11 PM to 7 AM shift. She stated that they (Staff A and Staff B) came into work at 11:00 PM on . . . . . She stated, she saw Resident # 1 in the lobby on the first floor, at approximately 11:27 PM on . . . . . , she didn't she him prior to this time. She stated that Resident # 1 was dressed wearing shorts, hat and a jacket. She says that was normal for him to sit in the lobby at this time of the night. She stated, she told him she was going to turn on the alarm, because it was dark outside. She stated, he said "no", he didn't want to go to bed. She stated, she went upstairs and turned on the alarm in the Nurse's station. She went on about her duties, she checked all residents requiring assistance (those identified by facility as level 3). She says Resident # 1 was independent. She says their , (direct care staff), are mainly on the level 3 residents. She stated, she saw Resident # 1 at about 12:00 AM -12:30 AM on . She stated, she is sure that she turned on the alarm. She stated, she uses the alarm to ensure that no one goes out of the door. She stated, she and another staff work (Staff B) at night. She stated, she sets the alarm as a third , . . She stated, she told the Nurse (Staff H) on duty, that she set the alarm, no specific time provided. Staff A was questioned, if she had heard the alarm go off on during her shift. She stated, she didn't hear the alarm go off. However, she says she has never known that the alarm had a problem in the past. She says they always hear the alarm when it goes off. She says she is very upset because she didn't hear the alarm ring. She says she has never known Resident # 1 to be an exit seeker previously.

On at 12:44 PM, an interview was

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conducted with Staff H (Nursing Supervisor), on duty . He confirmed that he worked the 7:00 PM - 7:00 AM shift on . He stated, he saw Resident # 1 at approximately 12:15 AM on . He stated, he was upstairs on the 2nd floor, he was in the Nurse's office. He stated, he told Resident # 1 to go to bed during a conversation he had with Resident #1 from the 2nd floor balcony bannister while Resident #1 was in the Lobby on the 1st floor. He says Resident # 1 didn't have any prescribed medications to go to sleep and normally was restless and at times. He stated, he had checked Resident #1's at 07:00 PM on and it was normal. He stated, Resident # 1 would show up and ask for his medication at all different hours of the night. He stated that everyone knew that Resident # 1 would be about the times; they would redirect him. He stated, Staff A informed him that she had seen Resident #1 at 2:00 AM on . They conducted a search on the outside perimeter of the grounds when they could not find him inside of the facility. He called his daughter to see if they picked him up possibly for Father's Day. He stated, the alarm was initially set at midnight by the Staff A, exact time was not provided. During further conversation with Staff H, he stated that he turned the door alarm off at 1:00 AM on , when he went to get his charger out of his car from the facility parking lot. Staff H stated, that the resident could have gone out of the building after the Staff saw him at 2:00 AM, because he forgot to reset the alarm after returning from his car.

During an interview with the Administrator and the Senior Nursing Home Administrator on at 02:00 PM, it was revealed that the facility had a "No Visitation" policy and that a

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A 025	Continued From page 19 resident(s) only left the building for medical , , due to the COVID and the Governor's Executive Orders issued on , prohibiting visitors and mandating additional safety protocols by facility to ensure the safety and well-being of residents. The Administrator also confirmed, that the facility had informed all residents and family regarding these orders and the facility's policy. The Administrator, further stated due to the Governor Executive Orders, the facility had established a verbal protocol which established one main entrance/exit door near the front lobby area on the 1st floor. Which was where Resident #1 managed to exit and elope( ) away from the facility. The Administrator also acknowledged during the investigation and review of the information with the surveyor, that there were multiple discrepancies with the events surrounding Resident #1 leaving the facility, the time the alarm was set and/or disarmed and whether the alarm system sounded when Resident # left. On at 11:00 AM, an exit conference was conducted with the Administrator and the Corporate Executive Staff. The findings were discussed. Class I	A 025		