STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105331	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura Rehab and Nursing Center	1800 N E 168th Street North Miami Beach, FL 33162

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on observation, record review and interviews, the facility failed to provide supervision to prevent the elopement of one (Resident #1) out of three sampled residents; as evidenced by, on 04/18/2025 newly admitted Resident #1 who is moderately impaired left the facility undetected at approximately 11:22 AM and boarded a city bus; was located 10 hours later 2.0 miles from the facility by a stranger that observed Resident #1 pacing back and forth before his home and alerted law enforcement. According to Accu weather. com on that day the temperature ranged between 72 degrees and 86 degrees. The findings included: Review of a photograph provided by the facility's Administrator revealed on 04/18/2025 at 11:22 AM Resident #1 was observed ambulating towards the 1st Floor East Exit dressed in long black pants, long sleeve pink top and white sneakers. Record review of a demographic sheet revealed Resident#1 was admitted on [DATE]; according to the admission assessment the resident was alert and oriented times three with diagnosis that include but not limited to: Major Depression, and Open-Angle Glaucoma. Review of Resident # 1's incomplete Entry Minimum Data Set (MDS) with reference dated 4/17/2025, revealed the resident is moderately impaired. Review of Resident #1's clinical documents from the transferring facility revealed an order dated 4/14/2025 for a wander alert device. Review of an email provided by the Administrator dated 4/15/2025 from the transferring facility indicated Resident #1 was not at risk for elopement. Review of an Admission / Readmission Nursing Packet dated 4/17/2025 Section II. Elopement Risk Evaluation indicated Resident #1 was a low risk for Elopement. Review of an Elopement Care Plan initiated on 04/18/2025 and revised on 04/18/2025 revealed Resident #1 was an exit seeker and had interventions that included: ensure staff are aware of resident's high risk for elopement, assist resident to and from activities, keep identification bracelet on resident at all times, monitor resident's whereabouts routinely and reorient and redirect in a calm reassured manner. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Physicians Order sheet revealed orders dated 4/17/2025 for Depakote Oral Tablet Delayed Release 500 milligram (mg) directions give one (1) tablet by mouth two times a day related to Unspecified Mood [Affective] Disorder, Citalopram Hydrobromide Tablet 10 mg directions give 1 tablet by mouth one time a day for depression, Mirtazapine Tablet 7.5 mg directions give 1 tablet by mouth at bedtime related to depression. Review of the Nursing Progress Note dated 04/18/2025 at 09:30 AM indicate: Resident out of bed, able to ambulate without difficulty and carry her breakfast tray to the dining room with some assistance. Review of Nursing Progress Note dated 04/18/2025 timestamped 10:13 AM revealed: resident walked accompanied by activities staff, to participate and engaged with staff and other residents in stable condition. During that time, she demonstrated steady ambulation. Nursing Progress Note dated 04/18/2025 timestamped 11:17 AM indicated: [Resident#1] returned to the unit from activities appeared stable with no signs of distress. Nursing Progress Note dated 04/18/2025 timestamped 11:22 AM indicated: When the nurse ran to the elevator area, the resident was not there. The nurse pressed the elevator button in attempt to follow the resident downstairs, when the nurse reached to the first floor, the resident could not be found. Review of the Director of Nursing's (DON) Progress Note 04/18/2025 timestamped 11:23 AM revealed: the nurse in charge of the resident informed the DON that Resident #1 went down the elevator alone. Staff tried to stop her, but the resident jumped to the elevator quickly. The nurse attempted to follow the resident by pressing the elevator and was unable to locate the resident downstairs. Code orange (elopement code) was activated. The administrator was informed, and she organized a prompt search for the resident. One team searched inside the facility and another team searched the parking lot and adjacent neighborhoods. Review of DON's Progress Note dated 04/18/2025 at 12:45 PM revealed: Thorough search of the facility was completed and was unsuccessful. Staff also called area hospitals, and the resident was not located. Review of the DON's Progress Note dated 04/18/2025 at 12:55 PM revealed law enforcement was called and provided with a description and profile of the resident. The DON Note's dated 04/18/2025 revealed at approximately 1:00 PM Resident #1's daughter [daughter # 4] was notified via telephone. The daughter was not surprised that her mother had left the facility and reported her mother had done this multiple times before . however, she has always returned unharmed. Resident #1's daughter reported that her mother likes shopping [NAME] and cafes and is likely in a nearby shopping center. Review of DON's Progress Note dated 04/18/2025 at 6:30 PM revealed the facility's administration remained in contact with law enforcement for updates and the search was upgraded to [NAME] (Be on the Look-Out) Tri-County Search per law enforcement. The DON called and informed the daughter of the law enforcement update. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON's Progress Note dated 04/18/2025 at 9:22 PM indicated: Call received from the Administrator revealed Resident #1 was located at North Miami Beach by [Law Enforcement] who reported he did the recovery and had informed [daughter #4] and she decided to take the resident home. A call was placed to [daughter # 4] to inform her that the resident needs to be evaluated by health care professionals. The daughter stated she lives too far, couldn't bring her to the facility at that time, and was advised to bring her to the facility in AM if not it will be considered as AMA (against Medical Advice). She verbalized understanding. Interview 04/22/2025 at 2:40 PM; the Housekeeping Floor Cleaning Staff revealed he was cleaning the hallway and saw Resident #1 going to the elevator. He tried to redirect the resident, but he couldn't, then he went to inform the nurse on the floor, while he was on his way to find the nurse; the resident took the elevator. When the nurse arrived the elevator door closed, and when she went down, the resident could not be found. Interview on 04/22/2025 at 02:57 PM via telephone Staff B, the Registered Nurse (RN) that was assigned to care for Resident #1 on 04/18/2025 revealed: On the morning of the incident the resident was in her room, alert, awake, and oriented times three. The resident had breakfast and then she went to therapy accompanied by rehab staff. When I saw her again, she had just come from activities. I spoke to her for a few minutes and two to five minutes later, a housekeeping staff called to tell me he saw the resident take the elevator. After that, I ran to the elevator immediately and pressed the button to the first floor, but I was not able to locate her. I checked the dining room, exit doors, and all the floors but was not able to locate her. I also checked outside up to 7th street and staff checked other places. We all went to the lobby, dining room, second floor, and fourth floor. I called the DON to let her know what was happening. Interview on 4/22/2025 at 4:20 PM, the MDS Nurse stated, A care plan for at risk for elopement is derived from the Elopement Risk Assessment done upon admission. For a score of 10 or more indicates the resident is at risk for elopement. Upon admission [Resident #1] did not require an elopement care plan based on her assessment score. Normally, I'd check the records from the previous facility to help determine if the resident is at risk for elopement. For [Resident #1] I did not check the previous records yet. I created the at-risk for elopement care plan after the resident eloped from the facility. Interview with the Administrator on 04/22/2025 at 3:45 PM. She reported that the resident went out by the back door by the elevator, that goes to the back to the facility, which is gated, but during the day it is open. On the day of the incident after she was informed, the orange code (elopement code) was activated by her. The facility's staff were divided into groups, some staff checked inside the facility, and some went out of the facility in different directions and searched for approximately 30 minutes. Law Enforcement was called, and an investigation was initiated. The Administrator revealed she was not aware that the resident was wearing a wander guard at the sister facility where she was admitted from. She revealed a nurse from the facility went to visit the resident at her daughter's house to do a wellness check and sign the Against Medical Advice (AMA) for discharge, because the resident did not want to return to the facility. Interview via telephone with Resident # 1's daughter on 04/23/2025 at 9:15 AM; [daughter # 3] revealed her mother had taken the trolley and ended up in the mall near facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Progress Note for the Wellness Check at Resident #1's home that was completed on 04/19/2025 revealed [daughter #5] was with Resident #1 were educated on the benefits of getting Resident #1 evaluated in the hospital or urgent care. Resident #1 stated she left the facility yesterday as she felt confined and took the bus to a plaza to go for a walk. I didn't tell my daughters that I left because they all work, and they all know that I like to go for a walk. I'm a grown woman and not a child. The resident and her daughter were informed that the Doctor's recommendation is for Resident #1 return to the facility. Resident #1 and her daughter were informed of the possible negative impact and outcomes if the resident did not return to the facility. Resident #1 and her daughter verbalized understanding. The daughter revealed they would rather keep mom home. Daughter # 5 signed the AMA form. Record review of Policy titled, Elopements revised March 2004 revealed a Policy Statement: Nursing personnel must report and investigate all reports of missing residents. Elopement Risks Identification. Policy Interpretation and Implementation: 1. On admission, residents will be evaluated for elopement risk based on resident's clinical indication and condition. Record review of Policy titled; Safety-Prevention of Accidents Reviewed January 20205 revealed Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation: Systems Approach to Safety: 2. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition