STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105335	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades Health and Rehabilitation Center	2105 SW 11th Court Delray Beach, FL 33445

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** Based on observation, interview and record review, the facility failed to implement and follow appropriate interventions for resident at risk for elopement for 1 of 1 resident reviewed for elopement, with the potential to affect 5 residents at risk for elopement (Resident #85).The findings included:Review of the facility policy titled Elopement and Wandering revised on 01/01/25 revealed the following: 1. A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. 2. Each incapacitated resident will be assessed for wandering and elopement upon admission, re-admission, and whenever an elopement attempt or new wandering behavior is observed or identified. Assessments are also done quarterly and annually.Record review revealed Resident #85 was admitted to the facility on [DATE] to the memory care unit. Diagnoses included metabolic encephalopathy and hypertensive urgency. The Minimum Data Set (MDS) assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 15/15, which indicated no cognitive impairment. No prior Elopement Risk Evaluations were found in his clinical record. Review of the Care Plan dated 09/26/2025 documented that Resident # 85 is at risk for exit seeking behaviors. Goals were to decrease episodes of exit seeking behaviors; resident will remain safe within the facility and will make no attempt to exit facility without being accompanied. Interventions were to increase supervision, admit resident to a locked unit and distract resident from exit seeking.Resident #85 also has a care plan dated 09/26/2025 documenting that Resident #85 has a history of exhibiting aggressiveness, violence and yelling. Goals were to decrease the identified behaviors. Interventions were to offer psychology and psychiatry services as needed and encourage/assist the resident to develop more appropriate methods of coping and interacting as able.Review of the assessments indicated that no assessments for risk of elopement were conducted for Resident #85.Review of the progress notes dated 12/01/2025 at 1:00 PM indicated the following: Staff observed resident attempting to exit window. The resident is alert with a BIMS a 15 and not easily redirected. While staff attempted to redirect the resident, the resident became aggressive and started yelling. Nursing assessment completed and revealed the resident deny any pain or discomfort. No change in the resident's loc or rom. No new skin impairments noted. The resident's daughter and the medical provider notified. BP 148/63, p89, O2 97%, R19.In an interview conducted on 12/01/2025 at 10:35 AM, Resident #85 stated that all he can think about is going home to Thailand. Resident further explained that he does not wish to talk because he wants to go back home.In an observation conducted on 12/01/2025 at 12:40 PM, Resident #85 was seen outside by his roommate's window with staff present trying to redirect resident to get back to the facility. Closer observation showed that the window screen was pushed outside with the window partially open.In an interview conducted on 12/02/25 at 10:00 AM with Registered Nurse (RN), Staff A stated that he has been working in the facility for 15 years and usually works the morning shift (7:00 AM to 3:30 PM). RN further explained that he is very familiar with Resident #85. According to RN, Resident #85 is very friendly and never mentioned to him that he wanted to go home. Staff A was very shocked after the attempt to elope incident and stated that Resident #85 was not at risk for (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elopement. Resident #85 was placed in the memory care unit due to an episode of wandering prior to being admitted in the facility.In an interview conducted on 12/03/25 at 10:35 AM with the Minimum Data Set (MDS) Director, she stated that she has been working for the facility for 6 months. She further stated that they have morning meetings every day, which is where they discuss residents' particularities. For Resident #85 the behavior care plan was put in place during a morning meeting. The MDS Director explained that the expectation when a resident is found to be at risk of elopement is to be placed in the locked unit and conduct an assessment. She stated for Resident #85, an elopement risk assessment was conducted on 09/25/25. The surveyor informed her that she was unable to locate an elopement risk assessment for Resident #85 in his clinical record. The MDS Director was not able to show the surveyor a copy of this elopement risk assessment. She further explained that Resident #85 came to the facility from the hospital. Review of the hospital records revealed the resident initially came from Canada where he hopped on a plane to Florida and wandered around, lost his ID and got transported to the hospital.During an interview on 12/03/25 at 10:52 AM with the Certified Nurse Assistant (CNA) Staff B, who stated that he has worked at the facility for 17 years and always on the memory care unit. He stated he is familiar with the resident. Usually, he would come to the dining room for breakfast and lunch. The day in question, the resident was not in the dining room for lunch and he (CNA) went to the resident's room to let him know that lunch was in the dining room; the resident stated he would be right there. A few minutes prior to the dining room closing for lunch, he heard from security that the resident had escaped. The CNA stated the resident never mentioned to him that he wanted to go outside. He also acknowledged that he was not aware that the resident was at risk for elopement.In an interview conducted on 12/03/25 at 10:30 AM, the Director of Nursing (DON) stated that residents at risk of elopement are put in the binder with their picture and the face sheet. There are 3 binders, one at the front desk, one at the nurses station of Poinciana, and one in memory care unit. It's updated whenever they are aware of a new person. It's discussed in daily meetings. When the binder is being updated, they make sure the staff knows and are used during the elopement drills. The elopement drills are conducted once a month, and they try for all shifts. The DON acknowledged the elopement incident that happened on 12/01/25 and further stated that staff members had their eyes on the resident at all time.A tour of the facility was conducted on 12/03/25 at 11:20 AM with the DON, with the objective of locating the 3 elopement risk binders. Two binders were found, 1 at the front desk that had a list of all residents at risk for elopement excluding Resident #85, and was last updated on 10/27/25. The second binder was found on the locked memory care unit, and did not have a list of residents at risk of elopement and updated date, but Resident #85's face sheet was in this binder. The third binder was not found at the nurses station on Poinciana. The DON further stated that she updates the front desk binder and staff make copies and update the binders on the memory care unit and on the Poinciana unit.