STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105496	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isles of Boynton Nursing and Rehab Center	3001 South Congress Avenue Boynton Beach, FL 33426

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142 Based on interview, record review and observation, the facility failed to protect the residents' right to be free from neglect by failing to provide appropriate supervision to meet the needs 1 of 3 sampled residents (Resident #1), who displayed exit seeking behaviors. The deficient practice allowed Resident #1, on 12/25/24 between 7:15 AM and 7:20 AM, after he removed the right window panel from the window frame in his room, to fall from the window approximately 20 ft to the ground. Resident #1 was found on the ground, in an area approximately three feet wide, between the building and a mature palm tree. Resident #1 was transferred to the hospital by ambulance for evaluation and treatment after suffering from serious injuries. The findings include: Record review revealed the facility's policy titled, Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation, dated October 2019, defined Neglect as follows: Neglect means the failure of the center, its associates or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Record review revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included, Traumatic Subarachnoid Hemorrhage without a Loss of Consciousness, History of Falling, Major Depressive Disorder, Alcohol use with Intoxication, and Scalp Laceration without foreign body. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was noted to have a Brief Interview of Mental Status (BIMS) score of 99, which indicates Resident #1 was either unable or refused to complete the evaluation. The staff assessment portion of Section C, used when a BIMS score is a 99, indicated Resident #1 was severely cognitively impaired. The MDS also indicated that Resident #1 had 1 to 3 days of wandering behavior. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the facility's incident report and Resident #1's progress note written by the Director of Nursing (DON), dated 12/20/24, revealed Resident #1 was observed trying to exit the building. On 12/20/24, Resident #1 was then placed on one-to-one (1:1) observation until a bed was available on the second floor. When the bed later became available on 12/20/24, the resident was then moved to the second floor and the 1:1 observation was lifted the same day. The DON's note explained that the second floor of the facility is considered the secured floor because all exits plus the elevator require a keycode to be used before access is granted. Review of Resident #1's care plan created on 12/23/24, documented the following: Focus: Potential/Actual Alteration in Thought Process, AEB [as evidence by]: Inability to respond appropriately to questions; short-term memory deficits; R/T [related to]: brain injury. Goals: Resident will maintain current level of cognitive function through this review period date, target date 3/29/2025. Interventions: Encourage Involvement with Daily Decisions. Give Resident Simple Choices that will not Cause Confusion or Frustration (i.e., Choice Between 2 Items at a Time). Encourage Resident to Attend Activities of Choice. Encourage Resident to Participate as Independently as Possible with ADLS. Provide Simple Clear Directions and Cue Resident as Needed. Ensure Routines are Followed as Closely as Possible Each Shift. Explain All Procedures Prior to Start Minimize/Eliminate Distraction as Much as Possible When Talking to Him. Face Him When Speaking. Speak Clearly and Slowly. On 01/02/25 at 11:13 AM, an interview was conducted with Staff A, a Licensed Practical Nurse (LPN) who was the assigned nurse who was working the 11:00 PM to 7:30 PM that spanned from 12/24/24 to 12/25/24. Staff A explained that in the change of shift report from the 3:00 PM to 11:30 PM shift nurse, Staff A had been informed Resident #1 was alert with confusion and had been going from room to room, wandering in and out of residents' rooms, during the shift. Staff A stated this was her first time working with Resident #1 and she was not informed that Resident #1 had been exit-seeking prior to 12/24/24. Staff A stated that on 12/25/24 at around 4:00 AM she noted Resident #1 was wandering in the hall. Staff A stated that she was at the nurses' station when she went to redirect Resident #1 back to his room. Staff A stated that Resident #1 returned to his room on his own before Staff A reached him. The nurse stated that she and Staff C were monitoring Resident #1 every 20 minutes but admitted that the observations were not documented. Staff A stated that she last saw Resident #1 sitting on his bed at around 7:15 AM. Staff A stated that had she had known Resident #1 had been exit-seeking prior to his being moved upstairs she would have placed him on 1:1 observation when he was found by an exit door with the alarm ringing at approximately 6:15 AM, as she reported in the incident report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/02/2025 at 2:23 PM, an interview was conducted with Staff C, a Certified Nursing Assistant (CNA) stated that Resident #1 was awake when she came on the shift at 11:00 PM and she checked on him again at 12:00 AM. Staff C stated Resident #1 was asleep when she checked him around 1:00 AM. Staff C stated Resident #1 was sleeping until about 4:00 AM, when she went on her break. Staff C stated Resident #1 was wandering in the hallway around 4:00 AM and she redirected him back to his room before she went on break. Staff C stated that when she came back from break, at around 4:45 AM she found Resident #1 in his room. Staff C stated the nurse on duty informed her that Resident #1 had tried to flush his diaper in the toilet when she was on break. Staff C stated that the resident was in his room when she helped the nurse clean up the toilet incident. Staff C stated Resident #1 was walking in the hall at 5:00 AM. Staff C stated Resident #1 was in his room from about 6:00 AM to 7:00 AM, which is when change of shift occurs. Staff C stated the last time she saw Resident #1 he was sitting on his bed at 7:16 AM, before she left for the day. On 01/08/25 at 1:06 PM an interview was conducted with Staff E, a CNA, regarding neglect training. Staff E described neglect as not taking care of a resident, leaving them dirty or wet. Staff E stated that the residents should be checked on every 2 hours. Staff E stated if a resident is exit seeking, they have been instructed to stay with the resident and inform the nurse or the supervisor of the situation. Staff E stated exit seeking would be a resident pushing on the door and setting the alarm off. Staff E stated that if a resident states they want to leave or are packing a bag that those are exit seeking behaviors. Staff E stated, in his opinion, if Resident #1 had been on 1:1 observation that the accident that occurred would not have happened. Staff E stated the facility reviewed the incident with staff and they, the staff, were taught what exit seeking behavior was and the importance of 1:1 observation to prevent a resident from exiting the facility. On 01/08/25 at 2:31 PM, an interview was conducted with Staff F, an LPN. Staff F stated he works both the 7:00 AM to 3:30 PM (1st) shift and the 3:00 PM to 11:30 PM (2nd) shift. Staff F stated he has had Abuse/Neglect training and Elopement training within the last few weeks. Staff F stated the facility has been having elopement drills at least once a week. Staff F stated the facility does elopement drills both shifts that he works. The nurse stated the facility was educating the staff regarding exit seeking behavior and how to respond to exit seeking. The nurse stated that a resident going to the stairwells or trying to go on the elevator are physical signs of exit seeking. The nurse stated if the resident tells you he wants to go home or is seen packing his bags those are also signs of exit seeking. Staff F stated that if he had a resident that showed signs of exit seeking, he would assign the CNAs to do 1:1 observation and call the DON to inform her of the situation. Staff F stated that given the information provided about the accident he believes that placing a person on 1:1 observation for elopement would more likely prevent the person from having the accident that occurred on 12/25/24. 01/08/25 at 3:53 PM an interview was conducted with Staff G, a CNA. Staff G explained that when the staff does not provide care to a resident then that is neglect. Staff G explained that if a resident tries to open an exit door, she tries to stop the resident and tells the nurse or supervisor that the resident wants to leave. Staff G stated that if she sees a resident packing and that resident is not discharged then that is a sign of exit seeking. Staff G stated she would call the supervisor to let the supervisor know what the resident was doing and then follow the supervisor's instructions. Staff G stated that if Resident #1 had been on 1:1 observation then the chances that Resident #1 would have gotten out of the window would have gone down. Staff G stated the facility has been doing elopement drills every day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/08/25 at 4:15 PM, an interview was conducted with Staff H, an LPN and Unit Manager on the 2nd floor, Staff H stated she conducts the elopement drills for both the 7:00 AM to 3:30 PM shift and the 3:00 PM to 11:30 PM shift. Staff H stated the DON or night shift, or weekend supervisor conduct the drills for the 11:00 PM to 7:30 AM shift. Staff H stated that the drills were ongoing every day. Staff H stated that if she was informed that a resident is exit seeking, she instructs to staff member to staff with the resident on 1:1 observation until instructed otherwise. Staff H stated she then contacts the DON to inform her and to get instructions for continued 1:1 observation. Staff H stated that if a resident is on 1:1 observation there should be no way the resident could climb out a window. On 01/06/25 at 5:00 PM, the Immediate Jeopardy Removal Plan for Neglect was verified, and the facility was notified that the Immediate Jeopardy was removed. Immediate Jeopardy Removal Plan and Corrective Action plan implemented by the facility: 1. On 12/25/24, Resident was assessed and 911 called to transport to hospital for higher level of care. The resident was transported to Delray Medical Center. -This was verified by review of hospital records provided by the facility on 01/02/25. 2. On 12/25/24, Director of Nursing (DON) notified Interim Administrator, Regional Director of Operations (RDO), Nurse Consultant, [NAME] President of Clinical Services of incident. -This was verified by direct interactions with those identified, excluding the [NAME] President of Clinical Services who was not onsite, during the survey process which began on 01/02/25 and concluded on 01/08/25. 3. On 12/25/24, the Facility conducted a head count of residents currently residing in the facility, all were accounted for and safe. -This was verified by a review of the Midnight Census that was used as a checklist to identify the residents present. There were no missing residents identified. 4. On 12/25/24, RDO and DON notified the Regional Maintenance Director to report to the center to make sure the windows are secure. No new findings. -This was verified by Direct Interactions with the Regional Maintenance Director during the facility tour conducted on 1/3/25 at 11:14 AM. During the tour, the window in room [ROOM NUMBER] was inspected and found to be secured with a screw at the bottom of the window frame that was placed in both the left and right-side window panels. Neither panel was moveable. The security was checked on random windows in resident rooms on both floors. All were secured in the same fashion. 5. Resident is responsible for self. No family. -This was documented in the resident's profile. 6.On 12/25/24, Medical Director, Primary and Advanced Registered Nurse Practitioner (ARNP) notified of incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A brief interview was conducted with the Medical Director and the ARNP on 1/8/25 at approximately 9:30 AM, when they were making rounds. They both confirmed they had been notified of the incident on 12/25/24. 7. On 12/26/24, Wandering risk User-Defined Assessment (UDA) was completed on all wandering/elopement risk residents. -A review of documentation provided in the facility's incident binder revealed documentation of the evaluations completed. This review was conducted on 1/2/25 and repeated on 1/8/25 for the removal plan. Two resident records were selected for review, one with a low-risk score of 4 and one with a high-risk score of 10. A comparison was made to the elopement book where it was found the resident with a high-risk score was not in the elopement book. The DON explained that the high-risk score was generated because the resident was taking two or more antipsychotic medications which increase the risk score. The DON further explained that the resident did not have any wandering or exit seeking behaviors. The explanation provided was also documented on the evaluation along with the medications in use. The DON explained that the residents currently were not exhibiting exit-seeking behaviors. The DON stated that under the new protocols any resident who shows exit-seeking behaviors would be placed on a 1:1 observation. 8. On 12/26/24, A Facility wide audit was conducted by DON/Designee to identify other residents who are at high risk for exit seeking and to prevent recurrence of the event. No new findings identified. -This was confirmed in item 7 above as the same evaluation was used for wandering and elopement risk. 9. On 12/25/24, Signs were placed at the main exit doors to residents from exiting. -These signs were noted upon entry into the facility on [DATE] and during the entire survey. 10. On 12/25/24 initiated every shift behavior management drill X 2 weeks then Bi-Weekly drills X 30 days. Monthly X 3 months. Post-test included for drills. -Completed post tests were provided as evidence. On 1/8/25 interviews were conducted with staff regarding the education provided. These interviews were conducted as part of the removal plan evaluation. 11. On 12/25/24, In-services and competencies-initiated by the Director of Nursing/ Designee, facility-wide on prevention of Neglect and placing a resident on 1:1 observation when exit seeking is identified, regardless of the security of the unit, behavioral residents' management. in-services and post-in-service competencies completed on the following dates: a. 12/25/2024 - 50% completed b. 12/26/2024 - 75% completed c. 12/27/2024 - 83.5% completed (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. 12/30/2024 - 92%completed e. 12/31/2024- 100% completed f. 30 certified letters sent on 12/27/24 to remaining associates that could not be contacted. g. 2 not contacted due to out of the country. h. No staff members were permitted to work until education and post in-service were completed. The facility provided an Excel file of all departments with completion dates for employee training. 12. Upon hire and as necessary, staff will complete an in-service education on neglect and the elopement system and management of behavioral residents. -This was part of the Performance Improvement Plan that was reviewed and verified on 1/8/25. 13. On 12/25/24, A Performance Improvement Plan was created and an Ad-hoc QAPI initiated as it relates to F600: Freedom from Abuse, Neglect and Exploitation and meeting conducted on 12/26/24. 14. On 12/26/24, Adult Protective Services (APS) was notified online. -This was documented as part of the facility's investigation. 15. Beginning 12/26/24 all newly admitted residents will continue to be screened for exit seeking behaviors on admission, quarterly, annually and as needed. The DON/Designee will audit screens weekly X 4 weeks and monthly for 2 months to ensure that all precautions measures are implemented. -This documentation was reviewed as stated above in item 7. 16. The findings of the above audits will be reported to the Quality Assurance/Performance Improvement Committee weekly until the committee determines substantial compliance has been met. 17. In summary all items required for removal were completed as of 12/27/24 except for ongoing prevention of Neglect and placing a resident on 1:1 observation when exit seeking is identified, regardless of the security of the unit, behavioral residents' management education and practice tests (No staff members were permitted to work until education and post in service were completed). 100% of the education and post-test were completed on 12/31/24. All items above were reviewed prior to exit on 1/8/25 at 5:00 PM. The final removal plan was accepted with the removal date of 12/31/24 as requested. Photographic Evidence Obtained.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 39142 Based on interview, record review and observation, the facility failed to provide appropriate supervision to prevent 1 of 1 sampled resident, Resident #1, from falling from a second-floor window. The deficient practice allowed Resident #1, on 12/25/24 at between 7:15 AM and 7:20 AM, after he removed the right window panel from the window frame in his room, to fall from the window approximately 20 ft to the ground. Resident #1 was found on the ground, in an area approximately three feet wide, between the building and a mature palm tree. Resident #1 was transferred to the hospital by ambulance for evaluation and treatment after suffering from serious injuries. The findings include: Record review revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included, Traumatic Subarachnoid Hemorrhage without a Loss of Consciousness, History of Falling, Major Depressive Disorder, Alcohol use with Intoxication, and Scalp Laceration without foreign body. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was noted to have a Brief Interview of Mental Status (BIMS) score of 99, which indicates Resident #1 was either unable or refused to complete the evaluation. The staff assessment portion of Section C, used when a BIMS score is a 99, indicated Resident #1 was severely cognitively impaired. The MDS also indicated that Resident #1 had 1 to 3 days of wandering behavior. According to the facility's incident report and Resident #1's progress note written by the Director of Nursing (DON), dated 12/20/24, revealed Resident #1 was observed trying to exit the building. On 12/20/24, Resident #1 was then placed on one-to-one (1:1) observation until a bed was available on the second floor. When the bed later became available on 12/20/24, the resident was then moved to the second floor and the 1:1 observation was lifted the same day. The DON's note explained that the second floor of the facility is considered the secured floor because all exits plus the elevator require a keycode to be used before access is granted. Review of Resident #1's care plan created on 12/23/24, documented the following: Focus: Potential/Actual Alteration in Thought Process, AEB [as evidence by]: Inability to respond appropriately to questions; short-term memory deficits; R/T [related to]: brain injury. Goals: Resident will maintain current level of cognitive function through this review period date, target date 3/29/2025. Interventions: Encourage Involvement with Daily Decisions. Give Resident Simple Choices that will not Cause Confusion or Frustration (i.e., Choice Between 2 Items at a Time). Encourage Resident to Attend Activities of Choice. Encourage Resident to Participate as Independently as Possible with ADLS. Provide Simple Clear Directions and Cue Resident as Needed. Ensure Routines are Followed as Closely as Possible Each Shift. Explain All Procedures Prior to Start Minimize/Eliminate Distraction as Much as Possible When Talking to Him. Face Him When Speaking. Speak Clearly and Slowly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/02/25 at 11:13 AM, an interview was conducted with Staff A, a Licensed Practical Nurse (LPN) who was the assigned nurse who was working the 11:00 PM to 7:30 PM that spanned from 12/24/24 to 12/25/24. Staff A explained that in the change of shift report from the 3:00 PM to 11:30 PM shift nurse, Staff A had been informed Resident #1 was alert with confusion and had been going from room to room, wandering in and out of residents' rooms, during the shift. Staff A stated this was her first time working with Resident #1 and she was not informed that Resident #1 had been exit-seeking prior to 12/24/24. Staff A stated that on 12/25/24 at around 4:00 AM she noted Resident #1 was wandering in the hall. Staff A stated that she was at the nurses' station when she went to redirect Resident #1 back to his room. Staff A stated that Resident #1 returned to his room on his own before Staff A reached him. The nurse stated that she and Staff C were monitoring Resident #1 every 20 minutes but admitted that the observations were not documented. Staff A stated that she last saw Resident #1 sitting on his bed at around 7:15 AM. Staff A stated that had she had known Resident #1 had been exit-seeking prior to his being moved upstairs she would have placed him on 1:1 observation when he was found by an exit door with the alarm ringing at approximately 6:15 AM, as she reported in the incident report. On 01/02/2025 at 1:40 PM, an interview was conducted with Staff B, an LPN. Staff B was the first employee to find Resident #1 after his fall. Staff B explained that when she arrived at work on 12/25/2024 she was late for work. She stated that she had parked her car near the building but not in a spot and went to punch in. Staff B stated Resident #1 had not fallen when she entered the building. Staff B stated that after she punched in, she moved her car to a parking spot. When she was going back in, she saw a person lying on the ground, on his right side, in the fetal position (curled in). Staff B stated that this was around 7:18 AM. Staff B stated she did not know that the person was a resident at the time. The nurse stated she went into the facility and told other staff about the person she just saw outside. The staff followed the nurse outside to investigate and realized the man on the ground was a resident. The nurse stated one of the staff members, she believed he was a housekeeper, saw the resident was lying on top of a window screen. This was how the staff realized the resident had fallen from the 2nd floor window. The nurse stated that some of the other staff were nurses who then assessed the resident and called 911. Staff B stated the primary nurse was informed by that time as well. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/02/25 at 11:13 AM, an interview was conducted with Staff A, a Licensed Practical Nurse (LPN) who was the assigned nurse who was working the 11:00 PM to 7:30 PM that spanned from 12/24/24 to 12/25/24. Staff A explained that in the change of shift report from the 3:00 PM to 11:30 PM shift nurse, Staff A had been informed Resident #1 was alert with confusion and had been going from room to room, wandering in and out of residents' rooms, during the shift. Staff A stated this was her first time working with Resident #1 and she was not informed that Resident #1 had been exit-seeking prior to 12/24/24. Staff A stated that on 12/25/24 at around 4:00 AM she noted Resident #1 was wandering in the hall. Staff A stated that she was at the nurses' station when she went to redirect Resident #1 back to his room. Staff A stated that Resident #1 returned to his room on his own before Staff A reached him. The nurse stated that she and Staff C were monitoring Resident #1 every 20 minutes but admitted that the observations were not documented. Staff A stated that she last saw Resident #1 sitting on his bed at around 7:15 AM. Staff A stated that had she had known Resident #1 had been exit-seeking prior to his being moved upstairs she would have placed him on 1:1 observation when he was found by an exit door with the alarm ringing at approximately 6:15 AM, as she reported in the incident report. According to the incident report, there were two times Staff A did not determine as exit seeking. The first time was when she found Resident #1 standing at the exit door where the alarm was ringing, indicating he attempted to open the door and set off the alarm. The second time mentioned in the report was when Resident #1 followed Staff A to the supply room and asked for the exit. Resident #1 was redirect to his room on both occasions without further interventions being placed. On 01/02/2025 at 2:23 PM, an interview was conducted with Staff C, a Certified Nursing Assistant (CNA) stated that Resident #1 was awake when she came on the shift at 11:00 PM and she checked on him again at 12:00 AM. Staff C stated Resident #1 was asleep when she checked him around 1:00 AM. Staff C stated Resident #1 was sleeping until about 4:00 AM, when she went on her break. Staff C stated Resident #1 was wandering in the hallway around 4:00 AM and she redirected him back to his room before she went on break. Staff C stated that when she came back from break, at around 4:45 AM she found Resident #1 in his room. Staff C stated the nurse on duty informed her that Resident #1 had tried to flush his diaper in the toilet when she was on break. Staff C stated that the resident was in his room when she helped the nurse clean up the toilet incident. Staff C stated Resident #1 was walking in the hall at 5:00 AM. Staff C stated Resident #1 was in his room from about 6:00 AM to 7:00 AM, which is when change of shift occurs. Staff C stated the last time she saw Resident #1 he was sitting on his bed at 7:16 AM, before she left for the day. On 01/02/2025 3:03 PM, an interview was conducted with Staff D, an LPN. Staff D was one of the nurses who assessed Resident #1. Staff D stated when she was informed by a housekeeper that there was an emergency outside, she and another nurse ran out to see what happened. Staff D stated that she had a portable wrist blood pressure cuff in her pocket and started taking vital signs. Staff D stated the resident's blood pressure was 200 (Systolic Blood Pressure) over something, she did not remember the number (Diastolic). Elevated blood pressure is common with trauma. Staff D stated she remembered the resident's heart rate was around 116 (beats per minute). Staff D stated the other nurse called 911 and the DON. Staff D stated the resident was on his back moving his arms but not moving his legs when she was assessing him. Staff D stated she checked the resident's legs for unusual length and found none. Changes in leg length or unusual positioning can indicate a fractured hip or a hip dislocation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105496	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isles of Boynton Nursing and Rehab Center	3001 South Congress Avenue Boynton Beach, FL 33426

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospital records, provided by the facility, revealed the following information pertaining to Resident #1: A Computerized Tomography (CAT or CT) scan of the head was performed with the following results: New small acute left subdural hemorrhage measuring up to 4 mm. New small amount left occipital horn intraventricular hemorrhage. Low density right subdural collection may indicate a small hygroma measuring 6 mm. There was also a compression fracture of the third Lumbar Vertebra (L3) that was being treated with a brace. There was no neurosurgery interventions planned. On 01/03/25 at 11:14 AM, a walking tour of the facility was made with the Regional Maintenance Director (RMD) who made the changes to the windows in all resident rooms to prevent the windows from being opened. These changes were made to prevent residents from eloping and to prevent residents from removing window panels and falling from the second floor. The windows were secured with 1-inch self-tapping screws that were placed through the window frame tracks and the bottom of the windows. Windows were tested and found to be unmovable. All residents have fire sprinklers which allows this change to occur as verified by AHCA Life Safety surveyors. On 01/08/25 at 1:06 PM an interview was conducted with Staff E, a CNA, regarding neglect training. Staff E described neglect as not taking care of a resident, leaving them dirty or wet. Staff E stated that the residents should be checked every 2 hours. Staff E stated if a resident is exit seeking that they have been instructed to stay with the resident and inform the nurse or the supervisor of the situation. Staff E stated exit seeking would be a resident pushing on the door and setting the alarm off. Staff E stated that if a resident states they want to leave or are packing a bag that those are exit seeking behaviors. Staff E stated, in his opinion, if Resident #1 had been on 1:1 observation that the accident that occurred would not have happened. Staff E stated the facility reviewed the incident with staff and they, the staff, were taught what exit seeking behavior was and the importance of 1:1 observation to prevent a resident from exiting the facility. On 01/08/25 at 2:31 PM, an interview was conducted with Staff F, an LPN. Staff F stated he works both the 7:00 AM to 3:30 PM (1st) shift and the 3:00 PM to 11:30 PM (2nd) shift. Staff F stated he has had Abuse/Neglect training and Elopement training within the last few weeks. Staff F stated the facility has been having elopement drills at least once a week. Staff F stated the facility does elopement drills both shifts that he works. The nurse stated the facility was educating the staff regarding exit seeking behavior and how to respond to exit seeking. The nurse stated that a resident going to the stairwells or trying to go on the elevator are physical signs of exit seeking. The nurse stated if the resident tells you he wants to go home or is seen packing his bags those are also signs of exit seeking. Staff F stated that if he had a resident that showed signs of exit seeking, he would assign the CNAs to do 1:1 observation and call the DON to inform her of the situation. Staff F stated that given the information provided about the accident he believes that placing a person on 1:1 observation for elopement would more likely prevent the person from having the accident that occurred on 12/25/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/08/25 at 3:53 PM an interview was conducted with Staff G, a CNA. Staff G explained that when the staff does not provide care to a resident then that is neglect. Staff G explained that if a resident tries to open an exit door, she tries to stop the resident and tells the nurse or supervisor that the resident wants to leave. Staff G stated that if she sees a resident packing and that resident is not discharged then that is a sign of exit seeking. Staff G stated she would call the supervisor to let the supervisor know what the resident was doing and then follow the supervisor's instructions. Staff G stated that if Resident #1 had been on 1:1 observation then the chances that Resident #1 would have gotten out of the window would have gone down. Staff G stated the facility has been doing elopement drills every day. On 01/08/25 at 4:15 PM, an interview was conducted with Staff H, an LPN and Unit Manager on the 2nd floor, Staff H stated she conducts the elopement drills for both the 7:00 AM to 3:30 PM shift and the 3:00 PM to 11:30 PM shift. Staff H stated the DON or night shift, or weekend supervisor conduct the drills for the 11:00 PM to 7:30 AM shift. Staff H stated that the drills were ongoing every day. Staff H stated that if she was informed that a resident is exit seeking, she instructs staff member to staff with the resident on 1:1 observation until instructed otherwise. Staff H stated she then contacts the DON to inform her and to get instructions for continued 1:1 observation. Staff H stated that if a resident is on 1:1 observation there should be no way the resident could climb out a window. On 01/06/25 at 5:00 PM, the Immediate Jeopardy Removal Plan for Accident Hazards/Supervision was verified, and the facility was notified that the Immediate Jeopardy was removed. Immediate Jeopardy Removal Plan and Corrective Action plan implemented by the facility: 1.On 12/25/24, Resident was assessed and 911 called to transport to hospital for higher level of care. The resident was transported to the local hospital. -This was verified by review of hospital records provided by the facility on 01/02/25. 2. On 12/25/24, Director of Nursing (DON) notified interim Administrator, Regional Director of Operations, Nurse Consultant, [NAME] President of Clinical Services of incident. -This was verified by direct interactions with those identified, excluding the [NAME] President of Clinical Services who was not onsite, during the survey process which began on 01/02/25 and concluded on 01/08/25. 3. On 12/25/24, the Facility conducted a head count of residents currently residing in the facility, all were accounted for and safe. -This was verified by a review of the Midnight Census that was used as a checklist to identify the residents present. There were no missing residents identified. 4. On 12/25/24, Regional Director of Operations and Director of Nursing notified the Regional Maintenance Director to report to the center to make sure the windows are secure. No new findings. (continued on next page)

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