

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2025
NAME OF PROVIDER OR SUPPLIER Unity Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1404 NW 22nd Street Miami, FL 33142	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews, the facility failed to provide adequate supervision to prevent elopement for one out of three sampled residents as evidenced by; on 08/21/2025 at 6:22 AM Resident # 5, a newly admitted resident who is cognitively intact, exited the building undetected through the door used for the linen delivery that was left open and eventually exited the facility's grounds through the back gate. There were four residents at risk for elopement residing in the facility at the time of the survey. The findings include. Observation on 08/22/2025 at 12:55 PM revealed the door Resident # 5 exited through has an alarm system. Review of a photograph provided by the facility's Administrator revealed Resident # 5 wearing blue short sleeved with horizontal stripes, green cargo pants, black socks and black sandals, exiting the facility at 6:22 AM through the emergency exit door that was wide open. Record review of Resident # 5's medical records revealed the resident was admitted to the facility on [DATE] to a room on the facility's first floor. On 08/21/2025 Resident # 5 eloped. Resident # 5's clinical diagnoses include but not limited to non-Pressure related Chronic Ulcer of Right Heel and Midfoot, adverse effect of other Antipsychotics and Neuroleptics, Schizophrenia unspecified, and other Specified Persistent Mood. Review of Resident #5's Physician orders included: Risperidone 2 milligrams (mg) oral tablet-Give 1 tablet by mouth two times a day related to adverse effect of other Antipsychotics and Neuroleptics, Order dated 8/20/2025 21:00-Valproic Acid 250 mg oral capsule-Give 1 capsule by mouth two times a day related to Specified Persistent Mood. Review of the Social Services Baseline Care Plan documentation indicated: (Mood and Behavior): Resident exhibits a potential for alteration in mood and/or behavior. Resident will maintain current level of mood state and will not exhibit adverse behaviors. Resident will refrain from harming self/others. On 08/22/2025 at 1:14 PM, the Nursing Home Administrator (NHA) revealed, the incident occurred yesterday at approximately 7:00 AM and the patient is alert, oriented and make his own decision. He was admitted on 08/19/ 2025 from [local Hospital] for an arterial wound on the right foot he ambulated through the entire facility, and on 8/21/2025 he woke up at around 6:00 AM asked for towels to take a shower; at 7:13 AM the nurse did a head count and noticed he was not in bed at that point she told the supervisor, and the supervisor called a code green. I was notified by the maintenance we called the relative on file to check if he was with her, at this time we are treating it as a missing person. The last person that saw him was the laundry vendor and he did not know he was resident. The resident went through the back gate after he exited through the laundry room exit. The RCA (Root Cause Analysis): [Staff D, Floor Tech] should have stayed at the door when he opened and disarmed it. The CNA (Certified Nursing Assistant) have at least 11 residents and she was taking care of other residents, so she was not really at fault. Security had a delivery for dietary so he was not able to be at the laundry, and the Floor tech should have stayed and monitor. Floor tech was suspended pending further investigation. Interview on 08/22/2025 at 2:15 PM, Staff A, Certified Nursing Assistant (11:00 PM to 7:00 AM shift) stated: I got to know him for a short period of time before that happened he wanted to know where the front patio and back patio was located this was on the 20th at approximately 2:00 AM he asked if there is a place to go out to have some fresh air I told him it too late to go out on the patio, he said he was hungry and we gave him some apple sauce, he ate the applesauce and he said he was still hungry so the supervisor went to the kitchen got two sandwiches and gave them to him he ate and went to sleep. Before I left at the end of my shift, I changed him and left him in his room. The next day (08/21/2025) when I came in at the start of my shift he was on the back porch with the security guard and other residents, he said he was hungry, and we gave him some apple sauce and he said he was still hungry so he supervisor went with the supervisor to the kitchen, and he got two sandwiches he ate the and went to bed. On the 21st He woke up early in the morning and went to take a shower the nurse was with him, and we gave him towels he dressed himself, about 6:30 AM he went through the double doors, and I continued working with my other patients. The other shift came, and they were asking if we saw [Room Number], I never knew he would leave because he was compliant. Interview on 08/22/2025 at 2:28 PM Staff B, Registered Nurse (RN)- Day Shift stated, On that day the outgoing nurse told me I can do my rounds, and I asked her where he (Resident #5) was, and she told me he may be on the patio. She told me that the last time she saw the resident was about at 6:30 AM. I told her I needed to see the patient because I did not know him. When I went to his room he was not there. I called the supervisor and the DON (Director of Nursing); and the outgoing nurse stayed and helped to look for him but we did not find him so they called code green (elopement code) I did not know him and they</p>		