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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105577 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Palm Garden of Orlando | | STREET ADDRESS, CITY, STATE, ZIP CODE 654 N Econlockhatchee Trail Orlando, FL 32825 | |
| 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 - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45646</p> <p>Based on observation, interview, and record review, the facility failed to implement appropriate interventions to mitigate elopement risk and failed to provide adequate supervision to maintain a secure environment to ensure vulnerable residents did not exit the facility without supervision for 1 of 9 residents reviewed for elopement, out of a total sample of 9 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury/impairment/death. While resident #1 was out of the facility unsupervised, there was reasonable likelihood he could have fallen, become lost, been accosted/harmed by a stranger or been hit by a car.</p> <p>On 7/12/24 at approximately 8:40 PM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until a neighbor in the adjacent community called the facility at 9:18 PM and informed Licensed Practical Nurse (LPN) B he had resident #1 in his vehicle. The facility failed to recognize and implement appropriate interventions/increased supervision for resident #1 after 3 incidents in the same evening of escalating exit seeking behaviors/agitation. Registered Nurse (RN) A allowed resident #1 to go out onto the porch alone, unsupervised creating opportunity for him to elope from the facility porch without staff knowledge.</p> <p>There was a total of 9 residents who were identified as at risk for elopement.</p> <p>The facility's failure to implement appropriate interventions and to provide adequate supervision resulted in Immediate Jeopardy. The Immediate Jeopardy began on 7/12/24 and was removed on 7/15/24. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings:</p> <p>Resident #1 was a [AGE] year-old man, admitted to the facility on [DATE]. His diagnoses included emphysema, chronic obstructive pulmonary disease, alcohol dependence, type 2 diabetes, essential hypertension, aphasia and unspecified dementia.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 105577 |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the Minimum Data Set quarterly assessment with assessment reference date of 4/11/24 revealed resident #1 had a Brief Interview for Mental Status score of 0 which indicated he had severe cognitive impairment. He had unclear speech and rarely made himself understood. The document indicated resident #1 required supervision for mobility and did not use any mobility devices. The assessment did not indicate resident #1 wandered or exhibited other behaviors during the look-back period, but used a wander/elopement alarm daily.</p> <p>Review of physician orders revealed resident #1 began use of the wander/elopement alarm on 7/16/22, a few weeks after he arrived to the facility.</p> <p>Review of the medical record revealed elopement risk evaluations dated 8/13/23, 1/08/24, 4/10/24, 6/26/24, and 7/08/24. Each of the evaluations indicated resident #1 was at risk for elopement.</p> <p>Review of the medical record revealed a progress note dated 3/18/24 which indicated resident #1 was exit seeking on the evening shift; a progress note dated 5/31/24 which indicated he was exhibiting aggressive behaviors and trying to open exit doors on the evening shift; another progress note dated 6/21/24 which indicated he was exit seeking and exhibiting aggressive behaviors on the evening shift; and an additional progress note dated 7/04/24 which indicated he was wandering, exit seeking and very aggressive toward staff.</p> <p>Review of the psychiatric progress notes revealed resident #1 was seen 1/24/24, 2/21/24, 3/20/24, 4/17/24, 5/01/24, 5/15/24 and 6/12/24. Each progress note indicated resident #1 had moderate to severe cognitive impairment with poor insight and poor judgement. On 6/16/24, resident #1 was seen by psychiatric services due to, recent worsening behaviors. The progress note indicated staff reported resident #1 was extremely restless, exit-seeking, difficult to redirect and had increased agitation.</p> <p>A care plan for wandering behavior and at risk for elopement was initiated 7/16/22. No revisions to the care plan interventions were made following resident #1's increased exit seeking behavior.</p> <p>On 7/22/24 at 3:18 PM, Certified Nursing Assistant (CNA) B confirmed she was assigned to resident #1 on the night of the elopement. She explained she worked a double that day and was assigned to him on both shifts. CNA B stated she worked with him often and was familiar with the resident. She described resident #1 as aggressive at times and wandered around the building constantly. She recalled resident #1 was wandering the hallway the night of 7/12/24 and she attempted to redirect him to the unit dining room or into the hallway by the nurse's station where everyone could see him. CNA B stated she last saw resident #1 around 8:30 PM, in a chair across from the nurse's station. She explained she went to provide care to another resident when she came out of the room around 9:00 PM, RN A asked her where resident #1 was. She informed RN A resident #1 sometimes went to the 200 unit. CNA B stated she went to the 200 unit but did not see him. She explained everyone was looking for him when one of the nurses received a phone call telling her resident #1 was found outside the building.</p> <p>On 7/24/24 at 3:57 PM, CNA D stated he was working on the 300 unit the night resident #1 eloped. He recalled resident #1 wandering back and forth between units. CNA D stated between 8:00-8:30 PM, resident #1 tried to open the exit door to the courtyard which set off the alarm. CNA D explained he redirected resident #1 back to the 100 unit. He recalled resident #1 attempted to come to the 300 unit again but one of the nurses closed the door between the units. CNA D stated he did not see resident #1 anymore that night.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 7/22/24 at 3:34 PM, RN A confirmed she was assigned to resident #1 on 7/12/24, the night he eloped. She stated resident #1 was very confused and sometimes aggressive with the staff. She recalled he wandered all the time, every day and would go close to the exit doors. She stated the wander/elopement alarm would beep and staff would redirect him away from the doors. RN A recalled resident #1 was in the day room when she came to work at 3:00 PM. She explained he became restless and began to walk up and down the hallways after dinner, going to each unit. RN A recalled he set off the wander/elopement alarm on the 200 unit and was redirected back to the 100-unit. She recalled staff were trying to redirect him but his behaviors increased. RN A stated she last saw resident #1 at approximately 8:40 PM, when he went to the exit door again and tried to open it. She explained she tried to redirect him but he was very aggressive, turned towards her and then went onto the screened in porch. RN A stated resident #1 had gone out to the screened patio before, calmed down and came back in without incident. She explained she just let him go outside since he was so aggressive and went to give medication to two other residents. RN A remembered she came back to check on resident #1 at about 9:00 PM, and did not see him on the porch. She recalled she did not see him in the hallway and went to his room and did not see him there. She asked CNA B if she knew where he was but she did not know either. RN A stated someone from the community called while they were looking for him at the facility and informed them the resident was located in a nearby community. She explained she had no idea how he got out. She stated resident #1's behavior was not unusual for him so she did not think to put him on increased supervision. She then clarified she had never seen him actually push on the doors before and acknowledged this behavior was new to her. RN A was unable to answer whether or not increased supervision could have prevented resident #1 from eloping from the facility without their knowledge.</p> <p>In a phone interview on 7/22/24 at 5:00 PM, LPN C confirmed she worked 7/12/24, the night of the elopement. LPN C explained resident #1's behavior seemed to worsen in the evenings when he would wander the facility and exhibited exit seeking behavior. She recalled it was a hectic night and alarms could be heard a couple of times from resident #1 getting too close to a door. LPN C stated she last saw resident #1 when he was redirected from the 300-unit after he pushed on an exit door. She recalled resident #1 was agitated as he came to her medication cart, cursed at her and shook her cart before he walked away toward the nurse's station. She stated she continued to pass her medications. LPN C recalled she was at the nurse's station when the phone rang and a man from the community said he had gotten the facility's number off resident #1's identification band. He identified the resident who he said was stumbling and abruptly got into his vehicle when he drove up alongside him. The man informed her he had already placed a call to emergency services (911). LPN C stated she then informed the nurse assigned to resident #1 and the Director of Clinical Services. LPN C recalled law enforcement brought resident #1 back to the facility about 20 minutes later.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 7/23/24 at 1:06 PM, the civilian who located resident #1 stated he saw the resident standing in the middle of the road inside the neighborhood community as he was leaving his home. He recalled a female passerby was walking her dog and was talking to the resident. The civilian stated he could tell something was wrong, so he drove his truck up beside resident #1 and rolled down his window to ask if he needed help. He explained resident #1 then opened the passenger side door and without invitation, got into his vehicle, ripped off the ID band from his arm, tossed it on the floor and proceeded to take off his shirt. The civilian asked resident #1 if he had family in the area and offered to take him home. He recalled resident #1 then became aggressive so he stopped the vehicle and went around to the passenger side and opened the door. He stated resident #1 then became physically aggressive and attempted to hit him. The civilian stated a nearby neighbor came over and tried to calm resident #1 down and distracted him while the civilian retrieved the ID band and called the facility to inform them of resident #1's whereabouts. He explained he had already called the police. He recalled the officer arrived and it took some coaxing to get resident #1 into the police vehicle. The civilian stated the officer told him he was familiar with resident #1 and had dealt with him before. The officer left with resident #1 to return him to the facility. The civilian expressed he was thankful nothing had happened to the resident. He pointed out the woods next to the neighborhood and stated they were very wide, went back for miles and could be dangerous.</p> <p>In a phone interview on 7/23/24 at 2:52 PM, resident #1's daughter stated she had only recently become involved in her dad's care. She explained her brother had been the care provider, but was unable to do so currently. She explained when resident #1 lived with her brother, he was prone to leaving the yard and wandering off, down the road. She stated the police would pick him up and bring him back. Resident #1's daughter did not have all the details as she became disconnected from her father years ago. She confirmed she was notified of the elopement the same night and agreed he should go to a locked unit.</p> <p>On 7/23/24 at 11:10 AM, the Executive Director and Director of Clinical Services reviewed their investigation and findings. The Director of Clinical Services stated resident #1 had been on the screen porch before without any concerns. The Executive Director explained the lattice panels had been placed around the patio over the screen for added security. They explained Resident #1 pulled the lattice back and pushed through the screen within minutes of being on the patio. The Director of Clinical Services confirmed resident #1 had exhibited some exit-seeking behaviors previously. In reviewing resident #1's behavior on 7/12/24, it was identified he had several escalating incidents that night. The investigation showed he set off a wandering/elopement alarm on the 200 unit, attempted to open an exit door on the 300 unit, became aggressive with a nurse and attempted to open an exit door on the 100 unit prior to exiting the screened patio on the 100 unit. The Executive Director and Director of Clinical Services acknowledged staff should have identified resident #1's escalating exit-seeking behavior and intervened by placing him on increased supervision, and/or calling the physician. The Executive Director acknowledged if resident #1 had been adequately supervised by staff, it was unlikely he would have been able to elope from the facility without staff knowledge.</p> <p>Review of the policy and procedure Elopement Risk updated 10/18/23 revealed if a resident was identified as an elopement risk based on the evaluation, a care plan would be developed to reduce elopement risk. Center staff would provide supervision and engage the resident as needed to minimize wandering or exit seeking behavior according to the plan of care.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 7/24/24, resident #1's probable elopement route was retraced using video snapshots and the location resident #1 was ultimately located. Resident #1 pulled lattice from around the screened porch, pushed out a screen and exited the enclosed area by climbing through the open area in the screen. He then walked approximately 30 feet to the sidewalk. Resident #1 turned left and walked approximately 807 feet along the facility sidewalk from the east side of the building to the north side of building until he reached the sidewalk running alongside a 4-lane highly trafficked road with a median. Resident #1 turned left and continued down the sidewalk alongside this road to the adjacent neighborhood, approximately 0.2 miles from the facility parking lot. Along the sidewalk was a water drainage ditch filled with running water with steep sides approximately 3 feet high with a concrete drain. A densely wooded area just behind the drainage ditch stretched between the facility and the neighboring community. Approximately halfway between the facility and the neighboring community, the sidewalk veered around an open metal railing in front of a creek area with vegetation hiding water which ran through the wooded area. Upon entering the neighboring community, resident #1 encountered a female passerby walking her dog and a male civilian who lived in the community came over to assist her. The male civilian stated when he pulled up in his vehicle alongside resident #1 and the female passerby, he rolled the window down to ask if they needed help. Resident #1 immediately opened the front passenger door and got into the truck with him (a stranger). Resident #1 then removed his identification (ID) band, threw it on the ground and took off his shirt. The male civilian asked resident #1 if he lived in the area and offered to take him home. Resident #1 then became physically and verbally aggressive with him. The male civilian called emergency services (911) and then called the facility after retrieving the discarded ID band. The police returned resident #1 to the facility at approximately 9:40 PM.</p> <p>Historical weather data revealed on the evening resident #1 eloped, 7/12/24, the temperature at 8:53 PM was 84 degrees Fahrenheit and mostly cloudy. Sunset occurred at 8:26 PM, (retrieved on 7/28/24 from www.wunderground.com).</p> <p>Review of corrective measures to remove Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team:</p> <p>*On 7/12/24 at 9:00 PM, resident #1 was discovered to be missing and the facility implemented its elopement policy and procedures.</p> <p>*On 7/12/24 at 9:40 PM, resident #1 returned to the facility with local law enforcement. He was assessed on return to the facility and was noted to have an abrasion to his right shin and a lightly discolored area on his right foot. A head count was conducted to verify the safety of all residents. The required notifications were made to the physician and family. Resident #1 was placed on 1:1 supervision.</p> <p>*On 7/12/24 from 9:45-11:15 PM, the Executive Director checked all doors and alarms to ensure they were working properly. The area where resident #1 exited was identified and secured.</p> <p>*On 7/12/24, resident #1 was re-evaluated for elopement risk and the plan of care was updated to reflect 1:1 supervision.</p> <p>*From 7/12/24 to 7/13/24, education on elopement policy and procedure provided to staff by nursing administration with 100% completion achieved on 7/13/24 at 8:00 PM.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>*On 7/13/24, notebooks at each nurse's station and reception desk for residents at risk for elopement were reviewed and updated by nursing administration.</p> <p>*On 7/14/24, the facility re-evaluated all residents' elopement risk and there were no newly identified concerns. A quality review audit of the 8 residents who were at risk for elopement revealed no concerns related to their electronic wandering devices, care plans and physicians' orders. The elopement binders were reviewed to ensure identified residents at risk were in the books.</p> <p>*On 7/15/24, the facility held an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting and conducted a Root Cause Analysis and reviewed recommendations to develop a plan for correction to include education, drills and audits. The ad hoc QAPI committee including the Medical Director approved the recommendations.</p> <p>*From 7/12/24 to 7/15/24, the facility conducted 5 elopement drills that covered all three shifts.</p> <p>*Interviews were conducted from 7/24/24 to 7/25/24 with 22 staff members (10 CNAs representing two shifts, 3 RNs, 4 LPNs, 1 Unit Manager, 1 Unit Secretary, 1 RN Educator, 2 Housekeepers). Staff interviews revealed they were knowledgeable of the elopement policy and procedures and supervision of residents at risk for elopement.</p> <p>The resident sample was expanded during the survey to include 6 additional residents who were at risk for elopement. Observations, interviews, and record reviews conducted revealed no concerns related to supervision and care plan interventions for residents #4, #5, #6, #7, #8 and #9.</p> | | |