

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Palm Garden of Aventura		STREET ADDRESS, CITY, STATE, ZIP CODE  21251 E Dixie Highway North Miami Beach, FL 33180	
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019</b></p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision for one out of three residents sampled as evidenced by failure to ensure the safety of a vulnerable resident (Resident #1) exited the facility through the first-floor dining room door undetected by the facility's staff. Resident #1 was found in the parking lot of the facility. There were 106 residents residing in the facility at the time of the survey.</p> <p>The findings included:</p> <p>On 8/5/24 at 1:02 PM Resident #1 was observed in his room seated in his wheelchair eating lunch.</p> <p>During a tour and walk through on 8/6/24 at 10:49 AM with the Director of Plant Operations all exit doors were checked (Fifteen exit doors), North dining room door, courtyard and front lobby doors. All alarms noted to be in working condition. The daily alarm door logs were reviewed.</p> <p>Review of the facility Policy and Procedure titled Missing Resident and Elopement revision date 03/11/2024 states: The purpose of this policy is to clearly define resident elopement and to provide guidance in the management of all reports of missing residents. Elopement occurs when a resident who needs supervision leaves a safe area without supervision.</p> <p>If any resident should leave the premises at any time without following the center procedure for voluntary leave, the missing resident/elopement procedure should begin immediately.</p> <p>Record review of the Abuse/Neglect Log dated November 2023-August 2024 documented the incident occurred on 04/21/24 at 07:41 PM.</p> <p>Record review of the Incident note on 4/23/2024 timestamped 1 6:15 documented: On Sunday, April 21, 2024, at approximately 7:57 PM resident was observed in his wheelchair in the facility parking lot propelling himself towards the sidewalk, Nurse approached the resident, and he told her he was going to post a letter. The nurse offered to return him to the facility, he did not resist. At approximately 8:01 PM the resident was returned to the unit. He was alert, responsive in no distress, there was no change in his status and apologized for leaving. Assigned Certified Nursing Assistant assisted resident to his room and provided care. Incident report was completed, and staff made aware to monitor resident.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Palm Garden of Aventura		STREET ADDRESS, CITY, STATE, ZIP CODE  21251 E Dixie Highway North Miami Beach, FL 33180	
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>Review of the medical records for Resident #1 revealed resident was admitted to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses included but not limited to: Atherosclerotic heart disease of native coronary artery without angina pectoris, Unspecified psychosis not due to a substance or known physiological condition, Unspecified dementia, unspecified severity, with psychotic disturbance and Dependence on a wheelchair.</p> <p>Review of the Physician's Orders Sheet for August 2024 revealed Resident #1 had orders that included but not limited to: Monitor and document behavior concerns using codes provided Behavior code:0-no behavior, 1-Fear/panic, 2-Anger, 3-Scream/yell, 4-Danger/self/others, 5-Delusions, 6-Hallucinations, 7-Sad/tearful, 8-Emotion/Act Withdrawal ,9- exit seeking/wandering Interventions.</p> <p>Record review of Resident # '1's Annual Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score 8, on a 0-15 scale indicating the resident is cognitively moderately impaired. Section E for Behaviors documented no behaviors exhibited. Section GG for Functional Abilities documented resident is dependent for care, partial moderate assistance required. Section O for Special Treatments and Procedures documented no special treatments received. Section P for Restraints and Alarms documented no restraints or alarms used.</p> <p>Record review of Resident #1 's Care Plans Reference Date 06/27/2024 revealed: Resident has a history of elopement risk with wandering behavior. 4/21/24 Resident actively left the facility unattended. Focus-Resident's safety will be maintained through the review date. Interventions include-Distract resident from wandering/exist seeking by offering pleasant diversions, structured activities, food, conversation, television, book. Evaluate for fall risk. Identify pattern of wandering: Is wandering purposeful, aimless. Is the resident looking for something. Does it indicate the need for more exercise. Intervene as appropriate. Involve family on plan of care as needed. Move to secured unit if appropriate Refer, as needed, to nursing restorative and/or therapies. Resident triggers for wandering/elopement. Take photograph of resident and place in the elopement binders and notify staffs of elopement risk.</p> <p>On 8/6/24 at 9:26AM Risk Manager revealed the Licensed Practical Nurse (Staff B) involved in the elopement incident no longer works at the facility, she was a weekend per diem nurse. Staff B was the person that saw the resident in the parking lot and brought him back inside the facility. The surveyor was unable to contact Staff B. The risk Manager revealed Staff B reported she was on her break sitting in her car eating when she saw the resident in the parking lot.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Palm Garden of Aventura		STREET ADDRESS, CITY, STATE, ZIP CODE  21251 E Dixie Highway North Miami Beach, FL 33180	
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>Interview on 8/6/24 at 11:50PM Director of Plant Operations reported; I have been working at this facility since December of last year, regarding the alarms after the elopement we wanted to improve the alarm to make it much louder, we did in-services with all staff about the new alarms installed with the blue light blinking in the hallway near the elevators, the blue light will alert staff someone is trying to go out the first floor dining room door or the ambulance door. Currently all the doors have a regular 30 seconds alarm egress (When you push the door, it makes a loud sound and it does not open for 30 seconds), we now have installed extra alarms on the dining room door and the ambulance door, makes a very loud screaming noise when the door is open, the dining room exit door has a regular alarm, a <input type="checkbox"/> alarm and a screamer alarm so staff very far away can hear and the kitchen staff can hear also. A delay alarm was placed on the service door-if the door stays open more than 15 seconds, it triggers the alarm to go off. I check the alarms and the exit door on a daily basis to make sure the alarms are working. There are only three (3) doors that the staff have the code to and are allowed to go through-the main entrance door during working hours, the ambulance door for after hours and the service door near the time clock which is 2 doors and they both require a code to enter and exit.</p> <p>Interview on 8/6/24 at 3:03PM Certified Nursing Assistant (Staff A) revealed: I usually work the 3-11PM shift, on the night the resident eloped I recall seeing the resident around 7:30 PM, I gave him a snack in his room on the first floor, I remembered it was peanut butter and jelly and we had a conversation about his table, we talked for a few minutes. Later on, when I was providing care for another resident, one of my co-workers told me, we found your resident outside, I saw the resident, he was in his room, he was brought back to his room, I asked him what happened, the resident stated he was going to go somewhere, he was saying sorry for causing trouble, I reassure the resident that everything was ok. For the rest of my shift, I kept an eye on the resident and made sure he was ok. I reported to the next shift to keep an eye on him also. The resident was moved to the second floor after the incident. Every time he sees me, he always tells me how much he misses me because I am assigned to the first floor, and he does not get to see me. I take very good care of my residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Palm Garden of Aventura		STREET ADDRESS, CITY, STATE, ZIP CODE  21251 E Dixie Highway North Miami Beach, FL 33180	
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>Interview on 8/7/24 at 10:52 AM Risk Manager reported: on 4/21/24 the elopement incident occurred; the resident exited the facility through the fire exit door in the main dining room on the first floor undetected. At approximately 7:57 PM the resident was observed in the parking lot by Licensed Practical Nurse [Staff B] in his wheelchair. Resident told [Staff B] that he was going to post a letter, [Staff B] returned the resident to the facility through the ambulance exit door. Resident entered the facility around 8:00 PM with [Staff B]. The investigation revealed the last time the resident was seen in the facility was approximately 7:30 PM, reported by the resident's assigned Certified Nursing Assistant [Staff A]. [Staff B] conducted an evaluation on the resident, a head-to-toe assessment and alerted the staff of the incident and requested that the resident be closely supervised. On 4/22/24-supervision continued for resident one to one, Federal reports were filed, Local police department was contacted, facility head count was completed, resident's mental score was reevaluated, psychological evaluation was completed, physician and family was notified, and interior and exterior exits were checked for functioning, all magnetic locks and doors were checked. The resident's elopement care plan was updated on 4/22/24 to include 1-1 monitoring until 5/29/24. The Elopement Book with the resident's information and pictures was reviewed, the elopement books are located in the lobby and at each nursing station. On 4/22/24 we conducted a reenactment of the elopement with the resident to find out how he got out of the facility. We collected statements from all staff on the shift the incident occurred. On 4/23/24 the door codes were changed for the three approved exit doors for staff-Front lobby, service entrance and ambulance entrance. Staff were educated to not share the codes, after hours we only use the ambulance door, education was completed on neglect, supervision, elopement practices, notification for all staff. On 4/22/24 we started elopement drills for each shift for 1 week. On 4/25/24 the stop alarm (loud alarm) was installed on the main dining room exit door, a [] alarm (loud alarm) was installed on the ambulance exit door and the dining room exit door. Also flashing bright blue lights were installed in the hallway that coordinates with the opening of the main dining room exit door and the ambulance exit door. In addition, we did a facility wide audit of all residents for elopement risk, and we are checking all the new admissions to see if any residents pose a risk for elopement. We are also inspecting all the exit doors daily to make sure the alarms are sounding and working. The Quality Improvement team met on 4/23/24 and went over all the plans we have put in place at the facility, we also created a Performance Improvement plan relating to the elopement.</p>		