

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Greenacres		STREET ADDRESS, CITY, STATE, ZIP CODE 6414 13th Rd S Green Acres, FL 33415	

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** 39142</p> <p>Based on interview, observation, and record review, the facility failed to provide appropriate supervision to prevent an elopement, which resulted in a who was able to leave the facility and travel along a busy roadway with a likelihood of being hurt, killed or lost, for 1 of 1 sampled resident reviewed for elopement risk (Resident #1).</p> <p>The deficient practice allowed Resident #1 to exit the facility on [DATE] between 8:12 PM and 8:18 PM. Resident #1 ran approximately 1.3 miles away from the facility, before being stopped by staff. Resident #1 was transported back to the facility by the same staff.</p> <p>There were eighty (80) residents in the facility at the time of the survey. Two residents were identified at risk of elopement or wandering after the elopement. Resident #1 was subsequently discharged to the care of his family on [DATE].</p> <p>The facility's Administrator was notified of Immediate Jeopardy and given the IJ Immediate Jeopardy Template on [DATE] at 5:31 PM. The Immediate Jeopardy was Ongoing at the time of the facility exit on [DATE].</p> <p>The findings included:</p> <p>The facility policy titled Elopement/Wandering Risk Guideline, Revision Date: [DATE]. Under the section labeled Process: there is a bullet point that states Initiate individualized interventions based on Patient/Residents' risk.</p> <p>Resident #1 was admitted to the facility on [DATE]. Resident #1 had been evaluated as an elopement risk upon admission with an elopement bracelet placed on [DATE]. Resident #1's care plan was developed to include elopement risk as of [DATE]. Resident #1 had his admission comprehensive assessment on [DATE]. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated cognitive impairment. The resident had a Mood score (Section D) of 00, which indicates he had no issues with poor mood at the time of the assessment. Resident #1 had no behavior concerns indicated in Section E - Behaviors. Resident #1's diagnoses included the following: Malignant Neoplasm of the Head, Neck, and Face, Squamous Cell Carcinoma, Depression, Anxiety Disorder, and unspecified Protein-Calorie Malnutrition.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], a review of the facility's report revealed that on [DATE] at approximately 7:45 PM, Resident #1 was showing exit seeking behaviors at the back door on the South Wing. Staff B redirected the resident to his room, and informed Staff A to place the resident under observation. Staff A called the DON to inform her of the elopement attempt. When Staff A returned to the South Wing, she was unable to locate Resident #1. Staff A called the DON again, and called the police. Staff began a search. Two staff members went out with their cars and located Resident #1 about 1.3 miles north of the facility, and returned the resident to the facility at approximately 8:30 PM.</p> <p>On [DATE] at 10:55 AM, an interview was conducted with the Regional Nurse Consultant. A root cause analysis was conducted and determined the nurses failed to properly adhere to 1:1 eye contact on a resident who was actively exit seeking.</p> <p>On [DATE] at 10:11 AM, a telephone interview was conducted with Staff A-RN (Registered Nurse), who was the nurse assigned to care for Resident #1 on [DATE], which was the date of the elopement. Staff A-RN stated that she arrived at 8:00 PM on [DATE]. Staff A-RN stated that when she came in, she saw two staff members trying to contain Resident #1, and Resident #1 was very agitated. She stated the door alarm was ringing at the same time. The nurse stated she called the Director of Nursing (DON) at that time to report what was going on and to obtain the code to silence the alarm. The nurse stated the DON instructed her to get a C.N.A. (certified nursing assistant) to put Resident #1 on 1:1 observation. The nurse stated that when she went back to the hallway, she discovered Resident #1 was missing. Staff A-RN stated she asked a resident in the hall if he had seen Resident #1. The resident in the hall told Staff A-RN that Resident #1 went out the back door. The nurse was unable to recall the name of the resident she spoke to. Staff A-RN stated she called the DON at that time and was instructed to search the grounds and the facility. Staff A-RN stated at that time two other staff members went in their cars to find the missing resident. Staff A-RN stated she called 911 to get the police to assist with the search. Staff A-RN stated she called the police again when Resident #1 was returned to the facility. Staff A-RN stated Resident #1 was placed on 1:1 observation following his return.</p> <p>On [DATE] at 11:54 AM, a telephone interview was conducted with Staff B-RN. Staff B-RN stated on [DATE] she had finished her shift (7A to 7P) she heard the door alarm and saw other staff looking for Resident #1. The nurse stated she asked the other staff members if they had looked in the rooms, bathrooms, and closets and when they said yes, she said we need to get our cars and search. Staff B-RN stated she and Staff C-RN drove to the main road where she went north, and Staff C-RN went south. Staff B-RN stated she saw Resident #1 running up the sidewalk when she pulled over. She stated she called Staff C-RN to come back and help her. Staff B-RN stated she started to run after Resident #1 on foot. Staff B-RN stated Staff C-RN drove ahead of Resident #1, pulled over and approached Resident #1 on foot. Staff B-RN stated they were able to stop Resident #1 and convince him to come back to the facility with them.</p> <p>On [DATE] at 12:05 PM an interview was conducted with Staff D-CNA (Certified Nursing Assistant). Staff D-CNA stated that when Resident #1 was missing she searched inside and outside the building. Staff D-CNA stated she helped bring Resident #1 back to his room after he was found. Staff D-CNA stated they put him on 1:1 observation and the CNAs took turns watching him. Staff D-CNA stated they watched him until the next shift and then turned the duty over to the CNA for the ,d+[DATE] night shift.</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 [DATE] at 3:00 PM, an interview was conducted with Resident #2 who witnessed Resident #1's elopement. Resident #2 stated that Resident #1 was very angry and was first at the front door. Resident #2 stated Resident #1 was yelling where is my nurse. Resident #2 stated he pointed towards the south hallway and said She's down there [NAME]. Resident #2 stated Resident #1 then ran down the hall to the exit door, opened it, went out and climbed over the fence. When asked which side Resident #1 went to, Resident #2 said the left side. When asked, was that the side with gate, Resident #2 said yes. The gate was verified by this writer to be on the left side when facing the rear of the building.</p> <p>On [DATE] at 3:15 PM, an interview was conducted with Resident #3 regarding the elopement. Resident #3 stated he was wheeling himself around (the hallways) when he saw Resident #1 go out the back door. When asked what he saw, Resident #3 stated he saw a guy (Resident #1) go over the fence. When asked which side of the fence he said the left side. This confirmed what Resident #2 had stated as well.</p> <p>On [DATE] at 9:35 AM, a telephone interview was conducted with Staff C-RN, who confirmed that on [DATE], Resident #1 attempted to leave the facility by the rear exit of the south wing at approximately 7:45 PM. Staff C-RN indicated Resident #1 had been agitated and attempted to leave through the exit doors resulting in the alarm sounding. Staff C-RN stated he redirected Resident #1 back to his room. Staff C-RN stated he then informed Staff A-RN, Resident #1's assigned nurse, to place Resident #1 on 1:1 observation related to the elopement attempt.</p> <p>Based upon interviews and record review, on [DATE] at between 8:12 PM and 8:18 PM, Resident #1 left the facility by the backdoors of the South wing. Resident #1 then allegedly climbed the wooden, 6-foot-high fence into the back parking lot of the facility. Resident #1 was running north along a 6-lane main roadway adjacent to the facility with a 45-mph speed limit. Resident #1 was found 1.3 miles north of the facility near a traffic controlled intersection of the main roadway and an intersecting side street. While he was out of the facility Resident #1 passed multiple residential communities and crossed two intersections with traffic lights, indicating a need for traffic control. Resident #1 could have fallen, gotten lost, or gotten struck by a car, and suffered a serious injury or died .</p> <p>Photographic evidence obtained.</p>		