

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Gardens Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 190 NE 191st Street Miami, FL 33161	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42532</p> <p>Based on record reviews, observation, and interviews, the facility failed to prevent the neglect of one (Resident #1) out of six residents sampled documented for elopement risk. The facility's failure in ensuring an adequate alert monitoring system was in place and staff's negligence in ensuring supervision and failure in implementing measure to prevent the elopement of Resident #1 who was care planned as an elopement risk. Resident #1's exited the facility undetected on 07/17/2024 through the facility's laundry room door that was not latched by staff. Resident #1 who was last seen between 7:00 PM and 7:30 PM was located at approximately 2:30 AM by local law enforcement at the county dump site one and a half miles (1.5) from the facility). The facility is a three-story building with residents rooms on the second and third floor; located in an area that has high traffic volume, busy intersections and is in a residential area. The county dump site (1.5 miles from the facility) has 2-way traffic, with a 40 miles per hour speed zone traffic. The resident has risk factors that that could likely have resulted in an adverse outcome based on the resident's clinical diagnoses</p> <p>The findings included.</p> <p>Records reviewed revealed on 07/17/2024 Resident #1 who has exit seeking behavior and wanders was not adequately supervised and left his room on the second floor, took the elevator to the first-floor laundry room and exited the facility through the unlocked door in the laundry room.</p> <p>On 07/29/2024 at 10:25 AM Resident #1 was observed in his room seated on his wheelchair in his room watching television with assigned one to one (1:1) Certified Nursing Assistant (CNA) Staff A.</p> <p>Interview on 07/29/2024 at 10:26 AM; Staff A reported the resident is not agitated and she will take the resident to activities.</p> <p>On 07/30/2024 at 10:45 AM; Resident#1 was sleeping, and no distress was noted.</p> <p>Staff A reported the resident requested to be in bed and at lunch time she will wake up the resident.</p> <p>Review of Resident #1's clinical records revealed, an initial admission to the facility on [DATE] and readmitted on [DATE]. Clinical diagnoses include, but not limited to, Alzheimer's Disease with Late Onset; Altered Mental Status; Dementia; Restlessness and Agitation.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1 who was listed as an elopement risk had was being monitored for behaviors that were being documented on the Medication Administration Records (MAR) by the day and night shift.</p> <p>The Quarterly Minimum Data Set (MDS) 07/05/2024 documentation indicated a Brief Interview of Mental Status (BIMS) score of 00 out of 15 to suggest the resident has severe cognitive impairment; Section E for Behaviors documented the resident exhibited wandering behaviors.</p> <p>Review of Resident #1's Care Plan initiated on 2/21/2024 with next review date 10/5/2024 revealed: The resident is an elopement risk/wanderer related to History of Elopement, Dementia, Disoriented to Place, History of Attempts to Leave Facility Unattended, Impaired Safety Awareness, Resident Wanders Aimlessly, Significantly Intrudes Privacy or Activities. Goal: The resident will not leave facility unattended through the review date. The residents' safety will be maintained through the review date. Interventions: Distract residents from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Increased supervision (Resident is on 1:1 supervision always). Monitor location frequently. Document wandering behavior and attempted diversional interventions. Place resident's picture, and information in Elopement Book.</p> <p>Review of the Federal Report #644710 revealed: On 07/17/2024 between 7:00 PM to 7:30 PM Resident #1 was seen by Staff D Certified Nursing Assistant, after she provided care for him. She reported she took the resident downstairs from the third floor to the second floor to get him ready for bed, after she gave him care, she left, and he left his room shortly afterwards. He usually can be found walking up and down slowly on the second-floor hallway. He sometimes wanders into other resident rooms, but he is easily redirected when that occurs. He sometimes sits on the floor and was once found hiding in a closet in a resident room. When the nurse went to give him his medications between 8:00 PM and 8:30 PM she noticed that he was not in his room, and she began to look for him throughout the second floor. When he could not be located, she called the third floor and asked for them to look for him. 9:00 PM Staff were looking for the resident for 30-40 minutes. Once everywhere was checked and he still could not be located, the nurse notified the Registered Nurse (RN) Supervisor who was onsite at around 9:00 PM. The RN supervisor then began to search for him. He looked in every room, bathroom, office, dining room, break room, daycare, laundry, therapy, etc. He then got in his car and drove around the area. The facility then called the police and notified the resident's son and physician. The police showed up at around 12:00 AM. While onsite the police got a call over the radio at about 2:30 AM that he was located at the county dump. The security guard at the dump observed him enter the property on foot. He approached him and noticed the resident was confused. The security guard asked the resident his name and Resident # 1 gave his name the security guard gave the police officer the name. The police already had patrol cars in the area looking for him, so they went there and picked him up. They brought him back to the facility at about 2:45 AM.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/29/2024 at 3:40 PM the Chief Nursing Officer revealed, the Administrator texted her on 07/17/2024 at 11:17 PM. The Administrator informed her one resident was missing and all-staff member were looking for him, they were looking in all rooms in the facility, the lobby dining rooms etc. The Administrator called the police department, and a police officer arrived at the facility; and the resident was found around one and a half miles from the facility at the county dump site. The police took the resident back to the facility. The Administrator informed her when the resident was taken back to the facility. The administrator decided to send the resident to the hospital for further evaluation. She stated the resident come back from the hospital on the same date with no injuries,</p> <p>Interview with Staff C Registered Nurse/Supervisor (RN) on 07/29/2024 at 3:56 PM. He reported the nurse approached him and informed him [Resident # 1] was missing they started to search for the resident on every floor. They search all rooms, under the bed and in the closets because the resident has a tendency to hide under the beds and inside the closets. When they finished looking for the resident on the second and third floors, they came down to the lobby and realized the laundry room was not latched. They went to the laundry room and saw the exit door open, that exit door goes to the parking lot and the street. He then called the Director of Nursing and the Administrator. They search around the area outside the facility. When the resident was not found the police was called and the resident was reported missing.</p> <p>Interview on 08/01/2024 at 3:45 PM the Director of Nursing (DON) reported; the Nurse Supervisor called him at approximately 10:00 PM and he was informed that a resident was missing, and staff were looking for the resident in all areas of the facility, and outside the facility. When he arrived at the resident eloped through the laundry room door that was not latched. The DON reported he went around the area in his car looking for the resident. The police found the resident and took him back to the facility around 2:45 AM and the resident was transferred to the hospital for evaluation. The back to the facility the same date with no injuries. He reported Immediate Jeopardy removal plan included unannounced elopement drills every other day in different shifts and in-services education for the staff. All residents were reassessed for risk of elopement initiated 7/17/2024 and completed 7/18/2024. There was a facility wide head count of current residents completed 7/17/2024. One resident eloped and was unaccounted for until 7/18/2024. All the facility doors were immediately checked to ensure proper functioning by the Administrator on 7/17/2024. All doors are checked 7 days a week to ensure proper functioning by a department head initiated 7/18/2024. The resident was placed on 1:1 supervision as of 7/18/2024 and will remain on 1:1 supervision until further assessment by the physician and psych services. The laundry staff who did not latch the door properly was educated by the Administrator 7/18/2024. Residents at risk for elopement have names and photos in a binder at the front desk and nursing stations are at 100% as of 7/17/2024. Care Plans were reviewed for current residents at risk for elopement and will have individualized interventions as of 7/17/2024. There is a dedicated staff member to monitor the front lobby area 24 hours 7 days a week with documentation that was initiated on 07/17/2024 and ongoing, hourly checks are being done for all elopement risk residents initiated 7/18/2024. The department manager will complete a head count of all residents upon arrival and before leaving five times a week to ensure all residents are accounted for was initiated on 7/18/2024. A screamer alarm was placed on the identified laundry room door 7/18/2024.</p> <p>The facility's Immediate Jeopardy Removal Plan was verified through records reviewed and interviews. The removal plan included: The immediate actions taken to remove the Immediate Jeopardy related to F600 based upon root cause analysis:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1-100% of all current residents reassessed for risk of elopement initiated 7/17/2024 and completed 7/18/2024.</p> <p>2-100% facility head count of current residents completed 7/17/2024. One resident eloped and was unaccounted for until 7/18/2024.</p> <p>3-All facility doors were immediately checked to ensure proper functioning by the Administrator on 7/17/2024.</p> <p>4-Doors are checked 7 days a week to ensure proper functioning by a department head initiated 7/18/2024.</p> <p>5-Resident was placed on 1:1 supervision as of 7/18/2024 and will remain on 1:1 supervision until further assessment by the physician and psych services.</p> <p>6-Facility to conduct unannounced drills 4 x a week to include off shifts and weekends initiated 7/17/2024.</p> <p>7- Laundry staff who did not latch the door properly was educated by the administrator 7/18/2024.</p> <p>8-Residents at risk for elopement have names and photos in a binder at the front desk and nursing stations are at 100% as of 7/17/2024.</p> <p>9-Care Plan reviewed and current for residents at risk for elopement to include individualized interventions as of 7/17/2024</p> <p>10-Dedicated staff member to monitor the front lobby area 24/7 with documentation initiated 07/17/2024 and ongoing.</p> <p>11-Hourly checks for all elopement risk residents initiated 7/18/2024.</p> <p>12-A department manager to complete a head count of all residents upon arrival and before leaving five times a week to ensure all residents are accounted for initiated 7/18/2024.</p> <p>Staff to be educated upon hire, annually and as indicated based on facility need related to the Elopement and Abuse / Neglect policies.</p> <p>Quote initiated for a keypad type system for the elevator 7/29/2024.</p> <p>[Wander management alarm] vendor contacted, and initial phase of quotes and equipment needed initiated 7/31/2024.</p> <p>Residents identified as at risk for elopement will be monitored by the electronic tracking system.</p> <p>(continued on next page)</p>		

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