

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Tiffany Hall Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 SE Hillmoor Drive Port Saint Lucie, FL 34952	

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>(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, record and policy review, the facility failed to protect the resident's right to be free from neglect when it failed to provide supervision to protect resident safety as evidenced by disregarding the procedure to prevent the resident from eloping, failed to search for the missing resident timely, and failed to provide essential medications, for 1 of 3 sampled residents (Resident #1). The deficient practice allowed Resident #1 to exit the facility undetected on 06/18/25 at 8:26 PM. There were 111 residents in the facility at the time of the survey. The facility's Administrator was notified of Immediate Jeopardy on 06/25/25 at 4:09 PM. The immediate jeopardy was removed at the time of the facility exit on 06/26/25. Cross reference to F689. The findings included: Review of the facility's policy titled, Abuse and Neglect Prohibition revised 8/2023, documented, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, exploitation, and misappropriation of property. Neglect means failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Speech and Language Deficits Following Other Nontraumatic Intracranial Hemorrhage, Schizophrenia, and Traumatic Subarachnoid Hemorrhage. Resident #1 was readmitted to the facility on [DATE] post hospitalization for a fall with tibial fracture. He ambulated without assistance. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13 that indicated the resident was cognitively intact. On 06/19/25, the resident's BIMS score was 15 that indicated the resident was cognitively intact. Review of a psychiatry note dated 06/19/25 revealed the resident had a speech impairment that can make communication challenging, but he is alert to person, place and time. Resident #1 had an elopement risk screen completed on 12/06/24 with an elopement risk screen score of 2, which indicated the resident was at elopement risk. An alert bracelet was applied to the resident's left ankle and a care plan was developed. The goal of the care plan was to maintain safety. At the time of elopement, the alert bracelet was worn on his left ankle. The alert bracelet alarms when the resident is near a door that has a sensor on it. The door automatically locks. A staff member can use a secure code to bypass the system. The video of the elopement event was viewed by the surveyor. The video had no sound. The video noted that on 06/18/25 at 8:09 PM, the pharmacy courier entered the exterior door of the facility which was unlocked. Once inside, the courier rang the doorbell of the inside interior door and waited until 8:11 PM for someone to open the door. When no one came to answer the doorbell, he pushed the inside interior door open at 8:11 PM. This is a fire door and when pushed for 15 seconds, the door will unlock, the alarm will sound, and it will disarm the bracelet alert system. He entered the facility at 8:11:41 PM. At that time, Resident #1 was in the courtyard walking around. At 8:26:12 PM, the courier left the building through the front door. At 8:26:17 PM, Resident #1 walked out the front door. No staff were observed by the door until the Maintenance Director reset the alarm at 8:36 PM. At the time of the elopement, there were 5 nurses and 11 certified nursing assistants working in the facility. When the front door alarmed, no staff initially responded to the alarm. It was alarmed for 25 minutes and was turned off by the Maintenance Director. The surveyor heard the alarm volume at the current sound level on 06/23/25 at 10:30 AM, then asked for the sound to be heard at the level it was at the time of the elopement, and it was at softer level at that time. The facility is shaped as a square. An observation was conducted on 06/19/25 at 10:00 AM of Resident #1's room. Resident #1's room was located on the west, front side of the facility. There is a west front unit, a nurse's station, and a west back unit. A hallway joins the west back to the east back unit. There is an east back unit, a nurse's station, and then an east front unit. A hallway joins the east front to the west front and the front door is in the middle of the joined hallway. The courtyard is opposite of the front door. In an interview with the Maintenance Director at 3:10 PM on 06/23/25, he stated he was working in the back section of the facility, and when he walked through the facility before he left for the evening, he noticed the annunciator and buzzer sounding and a light which told what door it was (this was located at the nurse's station). The front door was unlocked, and the alarm was beeping. He punched in the pass code which is on the side of the door, to reset it. He stated that the alarm stays beeping until it is reset. Staff A, Registered Nurse (RN), who worked the 3-11 shift, stated in a phone interview on 06/23/25 at 12:30 PM that she was aware of the alarm at the time the Maintenance Director turned it off. She worked the 3PM-11PM shift that day (06/18/25) in the 200 unit (east side). She heard the alarm on 06/18/25 around 8:00 PM. When she stepped out of one of the residents' rooms on the east side</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>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>

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The findings included: Review of the facility's policy titled Resident Elopement revised 8/2023, documented when a resident is unable to be located on the premises, staff will: Determine if the resident is out on an authorized leave or pass. If not: Notify the Administrator and the Director of Nursing Services. Conduct a thorough search of the center and premises. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Speech and Language Deficits Following Other Nontraumatic Intracranial Hemorrhage, Schizophrenia, and Traumatic Subarachnoid Hemorrhage. Resident #1 was readmitted to the facility on [DATE] post hospitalization for a fall with tibial fracture. He ambulated without assistance. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13 that indicated the resident was cognitively intact. 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