STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105939	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palmetto Subacute Care Center	7600 SW 8th Street Miami, FL 33144

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, interview and record review, the facility failed to provide adequate supervision for one (Resident #1) out of three residents sampled for elopement. to ensure Resident #1's safety as evidenced by On 03/03/2025 Resident #1 a vulnerable resident left the facility undetected through the first floor's exit door and walked seven to eight blocks to his home. There were 93 residents residing in the facility at the time of the survey. The findings included: Review of the facility policy titled wandering Elopements dated 01/28/25 indicate: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation: 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of the facility policy and procedure titled accidents and Incidents-Investigating and Reporting dated 01/28/25 states: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Record review of the Abuse/Neglect Log from January 2025 to May 2025 documented the incident occurred on 03/03/25 at 07:54 PM. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Incident note on 03/03/25 timestamped 20:30 (8:30 PM) documented: At approximately 7:50 PM, assigned Licensed Practical Nurse (Staff A) received a phone call from the resident's wife who informed him that the resident just called her and stated he wants to go home and does not want to remain at facility. Staff A informed wife that he saw the resident five (5) minutes ago but would go immediately to check on him. Staff A went to the resident's room and the resident was not there. Staff on the unit informed Staff A that they saw the resident ambulating towards the North Unit. Staff A went to the North Unit, checked all areas but did not locate the resident. Staff A notified Staff B, Registered Nurse (RN), Supervisor and Code Silver was initiated immediately. The resident's wife, Physician (MD), Administrator (NHA), and Director of Nursing (DON) were notified. Facility was checked inside and surrounding property; staff drove cars around surrounding streets. The resident was not located, RN Supervisor (Staff B) notified the local police department. A few minutes later, the resident's daughter arrived at the facility and stated that wife informed her resident walked home (8 blocks from facility). Stated he was fine but wanted to be home. Daughter wanted to collect his belongings and have him discharged . MD stated he may be discharged Against Medical Advice (AMA). The resident's daughter signed the resident out AMA. The local Police were canceled. RN supervisor (Staff B) informed daughter to contact facility in the morning to speak with Social Worker for referrals for home care and/or for prescriptions. Daughter stated that the family was aware of caring for him at home with a [indwelling urinary catheter] and they did not require anything from the facility, but if they did, the wife would call the next day. Daughter signed the resident out AMA. All belongings were sent with the resident's daughter. Review of the medical records for Resident #1 revealed the resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Elevated white blood cell count, Retention of urine, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Major Depressive Disorder, Unspecified Psychosis not due to a substance or known physiological condition. Resident #1 was discharged from the facility AMA on 03/03/25. Review of Resident #1's Physician's Orders Sheet for March 2025 orders included but not limited to: Resident discharged AMA 03/03/25 at 8:30 PM. Trazodone oral tablet 50 milligram (mg) tablet by mouth at bedtime for insomnia; Quetiapine Fumarate Tablet 25 mg tablet by mouth at bedtime for Psychosis; Donepezil Oral Tablet 10 tablet by mouth at bedtime for Alzheimer's and Buspirone Oral Tablet 5 mg mouth two times a day for anxiety. Record review of Resident #1 's Admission and Discharge Return Not Anticipated Minimum Data Set (MDS) dated [DATE], 03/03/25 revealed: Section C for Cognitive Patterns documented Brief Interview for Mental Status Score-unable to determine. Section E for Behaviors documented no behaviors exhibited. Section GG for Functional Abilities documented partial assistance to Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. Section H for Bowel and Bladder documented Indwelling catheter, always continent of bowel. Section J for Health Conditions documented no falls, no shortness of breath. Section N for Medications documented the resident was receiving antipsychotic, antidepressant, antianxiety, antibiotic and Antiplatelet medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plans Reference Date 03/03/25 revealed: Resident displays or report the following: Feeling down, depressed, hopeless easily annoyed and/or short-tempered Fidgety or restless, tired, sleep disturbance Diagnosis of anxiety, diagnosis of depression, on psychoactive medications. Date Initiated: 03/03/2025 Revision on: 03/03/2025. Resident will demonstrate improved mood through the next review date. Interventions include-Administer psychotropic meds as ordered, encourage family involvement, Provide support and reassurance, Psychological Consult. Interview on 05/28/25 at 7:28 AM, the Director of Nursing (DON) stated [Resident #1] was alert and oriented x 3 to person, place and situation, I met with the resident on 03/03/25 in the morning, he was a new admission from the weekend and that is our protocol. In addition, I interviewed the resident about his [indwelling urinary catheter], I wanted to get information pertaining to how long he had the [indwelling catheter] his care needs. The resident stated he had the [indwelling urinary catheter] since October of last year, the [indwelling urinary catheter] came out at home, and he had to go to the hospital to have it re-inserted. The resident was admitted to the facility on antibiotics. The resident and I had a lengthy discussion, he requested the facility reach out to his neurologist to find out about the timeline of him having to use the [indwelling urinary catheter]. Based on his records I reviewed before meeting with the resident he had some neurological and psychiatric diagnosis and was on a very small dose of psychotic medication. On 3/3/25 around dinner time, the resident's wife called the facility and spoke with Staff A, Licensed Practical Nurse (LPN). The resident's wife stated her husband wanted to go home and she was going to send her daughter to sign the resident out Against Medical Advice (AMA). LPN (Staff A) after speaking with the resident's wife, went to look for the resident, the resident could not be located on the unit, all the rooms on the unit were checked, a Code Silver Alert was initiated. The staff present at the facility at the time completed a head count of all the residents and started looking for [Resident #1] in the building and outside of the building in the neighborhood .Approximately 20 minutes later the resident's daughter showed up to the facility and stated The resident was at home, he walked home, the resident's house is 7-8 blocks from the facility. The daughter signed the resident out AMA and collected his personal belongings. The local police department, AHCA (Agency for Health Care Administration) and DCF (Department of Children and Families) were contacted. We have a video of the resident exiting the building with some other visitors that were leaving the facility. The resident's room was on the south unit on the second floor [Room number] it is a private room. The resident walked north to the elevator, got on, went to the ground floor and exited to the parking lot with a group of visitors that were leaving. There was a receptionist at the front desk helping other guests at the time. Visitors must be let in and out via the electronic door opener system. The resident was ambulatory, had the [indwelling urinary catheter] hanging from his waist when he exited the facility. We completed an elopement risk assessment for all the residents; we have an elopement book at all the nurses' station and at the reception desk. The elopement book contains the list of residents at risk for elopement, location of their [Wander Alert System], a photo, and resident identification information. Education was completed for all staff on elopement risk, code silver alert, and leave of absence. The residents that are identified as at risk for elopement [Wander Alert System] are checked for placement and functionality every shift by the nursing staff. The [Wander Alert System] is checked weekly to ensure it is working correctly. The system is checked by placing a close to all the exits doors to ensure the alarm is working and the actual [Wander Alert System] is checked for functionality also. Elopement drills were conducted on 03/10/25 and 03/11/25 two times per day with all staff. A resident was hidden, a code silver alert was called, and the staff had to follow the elopement risk procedure to find the resident. The resident council president volunteered to be the hidden/lost resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview via telephone on 05/29/25 at 9:10 AM, Staff A, LPN stated: I was assigned to the resident in the evening of 03/03/25, when I started my shift the resident expressed that he wanted to go home, I called and spoke to the resident's wife, and told her the resident was really agitated and wanted to go home, she stated she was going to send her daughter to pick him up, after speaking with the resident's wife I went to go look for the resident, I could not find him. I called the RN supervisor (Staff B) on duty and told her I could not find the resident, [Staff B] called a code silver alert, and we started looking for the resident everywhere in all the rooms in the facility,outside of the facility and in the neighborhood; 20 minutes later the resident's daughter called the facility, spoke with [Staff B] and stated,my dad is home. A a few minutes later the daughter came to the facility and collected his belongings and signed the resident out AMA. The resident and his family live close to the facility in the neighborhood. I then wrote up my notes of what happened. Interview on 05/29/25 at 9:23 AM, RN Supervisor (Staff B) stated: On 03/03/25 around 8:00 PM the LPN (Staff A) came to me in the office and reported that [Resident #1] was missing, the wife called him and stated the resident called her and stated he wanted to leave the facility because he did not want to stay and did not think he belonged at the facility. After [Staff A] spoke to the resident's wife he went to look for the resident and could not find him on the unit. I immediately called Code Silver through the entire building, all the staff started looking for [Resident #1]. During the search, I called the resident's wife to let her know [Resident #1] was missing, the wife stated she already called her daughter to come pick the resident up. I notified the DON and the police department. When I was on the phone with the police department, the daughter arrived at the facility and stated her father was at home. The daughter arrived at the facility approximately 20 minutes after we started looking for the resident. The daughter stated she was at the facility to pick up the resident's belongings and sign the AMA paperwork. I spoke with the resident's daughter about arranging home health and rehabilitation services, she stated we can talk in the morning about that. The next day I called the resident's wife to see how the resident was doing and discuss the services that he would need, she did not answer the phone. Interview on 05/29/25 at 9:53 AM via telephone with Spanish translator, Certified Nursing Assistant CNA (Staff C) stated: I was the CNA assigned to [Resident # 1] on 03/03/25 in the evening, I gave the resident a bath then left him in the room, I went to take care of another resident, later as I was walking by the room, the resident was standing in the room on the phone, I heard him saying he did not want to be at the facility, later I went back to the resident's room he was still standing talking on the phone and I ask him to please sit down in his chair. Later during my shift, I saw the LPN (Staff A) coming out of the resident's room and he asked me if I had seen the resident, I stated no and started to help look for the resident all over the building. As we were looking for the resident, after 20 minutes the resident's daughter came to the facility and stated, the resident was home, and she is here to pick up his stuff. We were all relieved that the resident was safe. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/29/25 at 10:20 AM, the Administrator (NHA) stated: On 03/03/25 I was informed about a missing resident at the facility, I was at home on medical leave, I checked the facility's camera and was able to establish a timeline of the resident leaving the facility. The camera showed the resident's room door was closed at 17:52:29 (5:52:29 PM), at 19:30 (7:30 PM) resident's exits his room, closed the door, wearing white T-shirt and [NAME] shorts, [indwelling urinary catheter] clipped to shorts at the right side of waist, wearing sneakers, holding phone in left hand, walks to north unit on second floor, stops in the middle of hallway, turns around and goes to the other direction while talking on the phone, goes back and forth north to south unit, 19:55 (7:55 PM) arrives at elevator lobby, walks into elevator with visitor, walks out of the elevator on the first floor with the visitor talking to the phone and the visitor. Visitor waves at the receptionist to open door, resident walks out of the front door with the visitor, at the time other visitors were checking in at the receptionist's desk. At 19:58:25 (7:58:25 PM) on 03/03/25, [Staff A] hangs up the phone at 2nd floor south station, at 19:58:32 (7:58:32 PM) [Staff A] knocks on resident's closed door, enters the room, 19:58:43 (7:58:43 PM) [Staff A] leaves resident's room, goes to north unit on 2nd floor, then center stairwell, other staff starts looking for the resident. 19:55 (7:55 PM) wife called to let us know the resident wanted to leave, the resident walked out of the facility 30 seconds before the call. The resident walked home; he lives a few blocks from the facility in the neighborhood. He lives on 19 Street and the facility is located on 8th Street. We received a report from the family that the resident was home safe. We now make visitors check in and out on the camera system. The resident was assessed for elopement risk upon admission, he was not exit seeking, there was no way for us to know that he was going to leave. The nursing staff checked on residents at least every two hours. This facility is not a lockdown facility; we do have a [wander alert system] for residents that are at risk for elopement.