STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105985	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palm Bay	5405 Babcock St NE Palm Bay, FL 32905

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** 46665 Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 of 3 residents reviewed for elopement, of a total sample of 3 residents, (#1). Review of the medical record revealed resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on 10/18/23 with diagnoses that included Traumatic Brain Injury (TBI), psychosis, persistent mood disorders, cognitive impairment, lack of coordination, and difficulty in walking. The most recent Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 7/25/24 noted during the look back periods, resident #1 had impaired vision and he scored 8 out of 15 on the Brief Interview for Mental Status that indicated he was moderately cognitively impaired. The assessment showed there were no behaviors towards himself or others, signs or symptoms of delirium, rejections of evaluations or care, or wandering, and he scored 0 out of 27 on the resident mood interview that indicated no depression. Resident #1 was able to walk independently and did not have any falls since the prior assessment. The assessment indicated an active discharge plan with community referrals was in place. Resident #1 had a care plan for self-care ADL performance deficits related to cognitive deficits, TBI, psychosis, and mood disorder, and for history of behaviors related to wandering in rooms, removing wander alarm device, agitation, destruction of facility equipment, refusal of medications, and setting off fire alarms with a history of 1-to-1 supervision. Interventions included electronic wander alarm device and 1-to-1 supervision. Additional care plans included trouble concentrating related to depression, TBI, right visual impairment, and impaired cognition/thought processes/short term memory loss. Interventions included to cue, re-orient, and supervise as needed. A Statement of Incapacity signed by Medical Doctor (MD) L on 11/22/23 and MD M on 1/03/24 documented the resident was incapable of making his own decisions. (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	On 8/25/24 at 8:20 AM, resident #1 was observed in his room, sitting on the bed, eating breakfast. RN E was nearby, sitting in a chair and said he was assigned to 1-to-1 supervision of the resident. The resident said he wasn't from the area, and his mother lived about 2 hours away, but he thought he had been at the facility for about a year. The next day on 8/26/24 at 12:32 PM, resident #1 was observed walking independently out of his bathroom toward his bed. He sat down on the bed in his room and picked up his cell phone to correctly demonstrate his ability to use the phone to call his mother and 911. The resident stated, I won't go out the window again; wherever I have to be is where I have to be. In a telephone interview on 8/25/24 at 3:44 PM, resident #1's mother recalled that on 8/04/24 at approximately 6:00 AM, she received a call from the facility that her son was missing, and it looked like he climbed out of the window in his room. She said her son was supposed to be transferred to an Assisted Living Facility (ALF) a few days prior and he was very upset when it didn't happen. She explained, she was very worried, even though he was physically able to get around. Resident #1's mother said she tried to call her son, but he didn't answer, and after a couple hours, she decided to drive herself over and try to find him. She said her son called her back while she was driving, and she was able to safely locate him by his descriptions of a parking lot near the facility. She said she convinced him to go with her and transported him back to the facility, about a half mile down the road. Resident #1's mother was upset when she explained she believed facility staff didn't check on him enough because he was physically independent. She stated, They pretty much left him alone other than when they went to give him his medications; he would always be somewhere else in the facility. Review of the Family Medicine Progress Note dated 7/02/24 read, He is doing well, history of traumatic brain injury and is unable to care for himself . requires close safety monitoring and help with ADLs . Eating and sleeping well at night, mood and behavior stable . nurse denies any issues or concerns . Awake and oriented x 1. The Admission/Readmission Data Collection assessment dated [DATE] noted the resident was cognitively impaired, independently mobile, had poor decision making skills, and was at risk for elopement. The Elopement Risk Evaluations dated 12/30/24, 1/08/24, and 5/30/24 documented the resident was not at risk for elopement and not oblivious to safety needs. The Elopement Risk Evaluation dated 8/04/24, after the elopement indicated the resident was at risk for elopement, and he was oblivious to safety needs. On 8/26/24 at 9:14 AM, the Social Services Director explained that after a failed discharge to an ALF on 8/01/24, resident #1 was disappointed and upset. She said the transfer didn't occur because of insurance issues. She said the resident received psychiatric services, and after the elopement incident, 1-to-1 supervision was implemented. She recalled during a facility stand down meeting approximately 3 months prior, the resident had damaged the television and the wall in his room. She said she contacted his mother, and she apologized. She stated, When the discharge didn't happen the behaviors got worse because he was upset and furious. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 9:54 AM, the Maintenance Director recalled resident #1's television was found to have cracks and appeared to have been purposefully damaged. He said the wall was also damaged and it looked like it had been punched. He said the resident denied responsibility for the damage however, there wasn't a roommate, and no one witnessed how it happened. The Maintenance Director said the window in resident #1's room had a small, removable, security screw-type device to prevent the window from being opened all the way which was in place at the top of the window when the resident eloped on 8/04/24. The single screw was removed by resident #1 using force and he was able to open the window enough to climb out and exit the facility. The Maintenance Director demonstrated the facility had since installed similar, but more secure devices at the top and bottom of all the windows to prevent the windows from being opened as easily to allow exit. In a telephone interview on 8/27/24 at 12:12 PM, Certified Nursing Assistant (CNA) D recalled he worked the 11:00 PM to 7:00 AM shift on 8/04/24, and resident #1 was included in his assignment. The CNA explained he last saw the resident in his room lying in bed sleeping at approximately 11:00 PM when he did his rounds. He said he was very familiar with the resident, and explained resident #1 did not like to be disturbed during the night, and was able to use the bathroom without assistance. He recalled, at approximately 6:00 AM, the nurse went to the room to check on the resident and found the window open with the screen missing. He said when staff checked further, they found the resident's belongings were scattered about the room and outside the window. He explained they searched the facility but were unable to locate the resident anywhere inside nor outside, and the police were called. The CNA conveyed he normally checked on all residents as much as possible, and understood the expectations were that staff were supposed to check on residents at least every 2 hours. In a telephone interview with Registered Nurse (RN) A, she recalled on 8/03/24 she worked the 7:00 PM to 7:00 AM shift, and had resident #1 on her assignment. The RN said she last saw the resident around 10:00 PM when she administered medications. She said around 6:00 AM, she went into the resident's room, saw the open window without a screen, and realized the resident wasn't there. She said she immediately asked CNA D if he knew where the resident was, and he said he last saw him between 11:00 PM and 12:00 AM. She conveyed, nurses expect CNAs to check on all residents even if they're independent and stated, They are supposed to check more than that. On 8/27/24 at 11:52 AM, the 100 Hall Unit Manager recalled around 6:00 AM on 8/04/24, staff notified her by phone that resident #1 could not be located. She explained, three days prior, the resident was upset after an unsuccessful transfer to an ALF. She said staff told her the resident wanted the door closed during the night and stated, They should at least open the door and look in. In an interview with the Regional Director of Clinical Services, Nursing Home Administrator (NHA), and Director of Nursing (DON) on 8/26/24 at 2:09 PM, the NHA conveyed the facility investigated the incident and determined that staff failed to conduct regular rounds throughout the night to ensure the resident remained sleeping in his room. She explained, the facility re-educated their staff after the incident and stated, Even if people are independent, we still need to check on them. The DON stated, They should have checked on him at least. The Regional Director of Clinical Services stated, They're supposed to check every 2 hours. Review of the facility's standards and guidelines dated 8/01/20 and titled Elopement/Wandering Risk Guideline read, . If a patient/resident is identified as being at risk complete an Elopement Risk Alert and obtain a photograph. Initiate individualized interventions in the patient/resident Care Plan and Kardex . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Assessment Tool dated 3/18/24 read, . you may accept residents with, or your residents may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management: . Psychosis . impaired cognition, mental disorder, depression, . Behavior that Needs interventions . Traumatic Brain Injuries . Using our facility admission evaluation process, residents are carefully evaluated preadmission to ensure that we can meet their needs and have the required competencies and training to do so. The facility will adjust staff as needed based on the acuity level of care needed to meet the needs of the following: 1-1 supervision . Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (Post Traumatic Stress Disorder), other psychiatric diagnoses, intellectual or developmental disabilities.