

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North 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)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39177 Based on observations, interviews, record review, the facility failed to protect the resident's right to be free from neglect as evidence by; Resident #1 a vulnerable resident with exit seeking behaviors who voiced intent to leave the facility and refused to sign an Against Medical Advice (AMA) was not adequately supervised and monitored by the facility's staff who did not see the resident exit the facility. Resident #1 was found decomposed in a locked closet 12 days after the facility documented he left the facility AMA. Refer to F607, F689 and F835 The findings include: Observation on 09/04/24 at 9:36 AM with the [NAME] President of Operations and the Regional Director of Operations of the space within which Resident #1 was found revealed the space was located in the rear dining room that is used for activities located in the J Unit, cameras were observed in the dining area. The door to the closet where Resident # 1 was found had a Key Entry Lever Handle Lock; there were several boxes and a working toilet that had boxes stacked on it. The Regional Director of Operations revealed the room was previously used as a shower room and is now storage closet. A tour of the area outside the dining/activities area revealed the two emergency exit doors had alarms that required a code prior to opening surveillance cameras were noted on the building's exterior. When asked if the cameras were working The [NAME] President of Operations revealed the cameras were not working and were left in place by the previous owner. Review of Resident # 1's admission Records revealed an admitted [DATE]. The contacts information documentation indicated the resident as Self, the emergency contact #1 listed daughter, #2 Granddaughter and contact information listed for two sisters. Review of the clinical records revealed diagnoses that included but not limited to: Altered Mental Status, Cognitive Communication Deficit, Cerebral Infarction, Difficulty in Walking and Diabetes Mellitus. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's August 2024 Physician's Order Sheets and Medication Administration Records revealed the resident was receiving medications that included but not limited to Lorazepam Tablet 0.5 mg 1 tablet by mouth two times a day for anxiety; Seroquel Oral Tablet 100 mg 1 tablet by mouth at bedtime for Agitation related to altered mental status. There was an order for Psych consult for diagnosis of agitation with revision dated 8/18/2024 that according to the Director of Nursing the resident did not receive because he was no longer in the facility. Review of Resident #1' Care Plans initiated 08/20/2024 Revision on: 08/28/2024 revealed Resident #1 is at risk for falls related to Unsteady gait and Vision impairment; Goal: Resident will be free of fall related injuries by next review date. Interventions: .Check at frequent intervals to monitor for unsafe actions and intervene promptly. Focus- risk for further alteration; in neurological functioning related to history of Cardiovascular Attack (Stroke) and Cerebrovascular Disease.; Date Initiated: 08/21/2024. Revision on: 08/28/2024. Risk for complications of abnormal blood sugar related to diagnosis of Diabetes Mellitus date initiated: 08/21/2024, Revision on: 08/28/2024. Review of Resident #1's 5- Day Minimum Data Set (MDS) dated [DATE] indicated the resident vision is impaired, Brief Interview of Mental Status Score (BIMS) documented 12 out of 15 to suggest Resident #1 was moderately impaired cognitively. Had wandering behavior that occurred 1 to 3 days; Required supervision or touching assistance for eating, oral hygiene; substantial/maximal assistance for toileting, lower body dressing; partial/moderate assistance for upper body dressing; Frequently incontinent. The resident was receiving Antipsychotic, Antianxiety and Antiplatelet medications. No wander/elopement alarms used. Review of Resident # 1's Elopement Risk Assessment/Evaluation dated 8/21/24 completed and documented by the DON revealed an at-risk score of 11.0 meaning the resident was a high risk for elopement. Resident #1 was being monitored for behaviors since his admission on 08/14 /24 until; the behavior monitoring sheets documentation revealed on 8/17/24 during the day shift he had behaviors and was given food, on 8/20/24 he had behaviors during the night shift and was given food, he had behaviors during the day shift on 08/22/24 which documented refer to progress note. Review of the progress notes written by Registered Nurse (RN); Staff D dated 08/22/24 time stamped 15:50 documented: Around 1:00 PM resident noted as agitated requesting to leave the facility. When asked why, resident stated that he just did not want to be here anymore. Resident noted as self-responsible, made supervisor aware. Teaching provided regarding a facilitated transfer and supervisor called family but no answer. Resident refused and stated that he was leaving. Teaching provided regarding risks. Presented AMA however resident refused to sign. Resident then left facility alert and oriented in no distress. Will make another attempt to inform family. Review of the Discharge Without Physician's Approval Form Dated 8/22/24 revealed the resident had not signed above the line that indicated Signature of Resident the above the date line was dated 8-22-24. The Licensed Practical Nurse Unit Manager for the 7:00 AM to 3:00 PM shift confirmed it was his signature that was noted below the blank resident signature line. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Narrative Note written by the Assistant Director of Nursing (ADON) revealed; (General) dated 8/22/2024 timestamped 20:20: Call placed to [local community-based agency] for wellness check, spoke to [representative for the community based agency] who stated only local police do wellness checks however would document call. [local police department] was contacted for a wellness check and an address was provided. Review of Narrative note written by the ADON dated 8/23/2024 time stamped 12:44 documented: Resident daughter and granddaughter arrived at the facility, no concerns voiced however stated that the resident does not like to stay in one place for a long period of time and is violent and agitated at times. Family thanked staff for contacting [local community-based agency] and [local law enforcement] for the wellness check. Review of the facility's ABUSE LOG for August 2024 revealed, Resident #1 was listed on the abuse log for neglect on 8/22/24 related to Resident #1 and was unsubstantiated; Date 8/26/24; [Local community-based agency] called-8/22/24; Accepted/Rejected-Rejected; Allegations-Neglect; 5-Day Federal-9/02/24; Comments-Unsubstantiated. The facility's ELOPEMENT INCIDENT LOG for August 2024 had no incidents of elopements. Review of the Agency for Healthcare Administration (AHCA) Immediate Report dated 09/03/2024 included but not limited to: Date of Incident: 08/22/2024 13:10; Type of Incident-Neglect; Notified: Resident representative, Law Enforcement, Abuse Registry; Description of Incident: On 8/26/24 at 11:00 AM, [sister] and her daughter, visited the facility and spoke with [Administrator] and [Director of Nursing], stating they feel Memorial Regional Hospital was negligent for not diagnosing and notifying facility that her brother has dementia. They are upset that resident chose to leave the facility against medical advice on 8/22/2024 and went out into the streets instead of contacting them (written by Licensed Practical Nurse (LPN) Supervisor 8/26/2024 1:24:20 PM). On 8/22/2024, [Resident #1] left the facility against medical advice. Resident was encouraged to stay and complete his stay or to wait for his family to be discharged but refused and said he is fine, doesn't need to be here and that he takes care of himself. Resident was alert and oriented, voiced no safety concerns, complaints, concerns or change in his behavior at the time of his leaving AMA. Resident's family was notified. A call was placed to [local community-based agency] to notify resident left AMA to request a wellness check since resident left facility alone and would not wait for family. [Local community-based agency] stated they would record the call but that only law enforcement does wellness checks. Law enforcement was notified. Law enforcement stated resident was not at his last known address and was not at any area hospital (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/04/24 at 10:46 AM the 7:00 AM to 3:00 PM Licensed Practical Nurse (LPN) Nurse Manager revealed; Resident #1 was sitting in a wheelchair on the day he left. The resident was anxious and restless. He was Creole speaking and spoke a little English. He was assessed and he wanted to leave the facility. We educate the patient and tell him the risks of him leaving. He was still restless, would stand up in the chair and re-directed him. I went to the morning meeting, when I came back I saw the nurse, [Staff D, RN] talking to the resident trying to redirect him. We spoke to him, and he didn't want to accept what we were trying to tell him. I looked in the [computer program] to see if the resident was self-responsible and I noted that he was, I let the DON know. We presented to the resident the AMA documentation, educated him on it and he refused to sign it, and he was anxious. I left him with the nurse. He had anxious behavior the day he left. He would go to different rooms and had exit seeking behaviors. The Nurse Manager was asked if he saw Resident #1 leaving the facility and if anyone escorted the resident from the facility. He stated: I didn't see him walk out the building. When I came to his room, his belongings were still in his room. The nurse [Staff D] didn't tell everybody that the patient went AMA. The staff was asking about the resident. The LPN Nurse Manager was asked to explain the facility's policy and procedure when a resident is being discharged, he explained: When a resident is being discharged and the resident is self-responsible, education is given by the nurse who is in charge. If they leave without medical advice, the medication will not go with them. I am not sure if the family was called when the resident was anxious. According to this resident, he wanted to go home. Vitals were stable. He was given food. He was in a wheelchair, but he could walk. The Administrator was notified by the nurse. I am not sure if the Administrator went to talk to the resident. The Certified Nursing Assistant (CNAs) assigned to the resident was providing care to another resident. We let the doctor know, let the family know, we give them the paperwork. I think the nurse called the doctor. I don't know what the doctor say. He was anxious but not in an aggressive way. I was made aware he went AMA after lunch around 1:00 PM. She didn't tell me [Staff D] right away that the resident went AMA. The Nurse Manager was asked if Resident #1 ate lunch that day and where did the resident usually eat his lunch. The Nurse manager stated: He would eat lunch in his room or in the hallway. The nurse manager was asked how he came to the conclusion that Resident # 1 was AMA if no one saw the resident exit the facility and may just be missing, because his belongings were still in his room. He revealed he did not see the resident leave the facility. During an interview on 09/04/24 at 11:26 AM the Resident # 1's assigned Certified Nursing Assistant (CNA), Staff B on the day of the incident reported he spoke a little bit of English but mostly spoke Creole. On the day of the incident at first he was in bed, afterwards he was cleaned and transferred to the wheelchair. He was in the hallway close to the nurses' station. In the morning during her rounds, he told her he wanted leave wanted to go home. Staff B stated: I expressed to my supervisor, [Staff A]. They went to talk to him [Staff A and Staff D]. I was moving about going to see about my other residents. This was my second time working with him on that day. He was very anxious, he would go from to bed, walking opening doors, by the exit doors. The nurse knew he was going from room to room. He would stand by the exit door right outside of his room. I only work here three days a week. He was combative and would argue with you. I would say to him come back to your room, if I saw him going to another room. Once we let our supervisor know if we see the resident wandering. I wasn't informed that he went AMA. When I left on my shift at 3:00 PM, he was in his wheelchair on the floor. I came back to work on the following Tuesday, I was made aware he was missing. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/04/24 at 1:19 PM the Nursing Home Administrator (NHA) reported after 1:00 PM on 8/22/2024 she was alerted that a resident was missing. We started looking for the resident in the building and out of the building. Some of us went driving around. Code green was called and that means someone is missing. A few minutes after we had gone driving around, [Staff A] called me and told me that he wasn't missing but he left AMA. He was dealing with the nurse and the resident when he said he wanted to leave, and he refused to sign the AMA form. When he told me it wasn't an elopement, and we went back to the building. The weather was bad, and I asked [Staff A] did he say where he was going. The NHA was asked if anyone escorted the resident out of the building. She stated: Nobody escorted him out of the building, and we didn't know which way he went. Since it was bad weather, we called [local community-based agency] to do a wellness check and the family house was nearby. [Local community-based agency] told us they don't do wellness checks anymore and to call [local law enforcement] and we did. [Law enforcement] went to the address (niece), and he wasn't there. When the police went to the house they decided to file a missing person report. Since the facility became aware a missing person report had been filed with the police by the family after the wellness check was completed and the resident was not located. The NHA reported staff checked both inside and outside of the facility and when asked how they were able to confirm all area were checked within the facility she did not provide an answer. The NHA was asked why they did not continue searching in the facility every day and open all doors in the facility, no answer was provided. The NHA stated all hospitals were checked and areas close to the facility. The NHA was asked if they called the police to get any updates an if she was positive all areas were checked and if anyone had considered looking in that closet and asking for a key to open it. She stated she never thought of that. The NHA was asked if no one heard sounds from the closet or smelled anything while activities were being done in that area she said no. The NHA acknowledged she was unable to confirm if a thorough search was completed within the facility on 08/22/2024. We wanted to keep looking for him so some of use kept looking him, driving around the area. The next day on the 23 rd the daughter and the granddaughter came to the building to meet with me, [DON and ADON]. The daughter said he likes to walk the street and live on the street. His usual spot is by [local hospital]. We called the police that we had spoken to and gave them the information so they could look as well . On 8/26/24 the following Monday, the sister and the niece came to the building, asking questions regarding the situation me and (DON). The niece said he had dementia; we checked the chart and there was no documentation in our chart or the hospital chart that he had dementia. She said she was going to talk to the hospital because that was neglectful to not use that as a diagnosis. We did a neglect report on 8/26/24 and we unsubstantiated it. He was alert and oriented times three on our chart and the hospital's chart. I completed the 5-day report on yesterday. On 9/02/24, I got a call from [DON] around 8:30 AM that they found a body in the closet. Somebody was saying that there was a bad odor. The maintenance assistant started looking in the vents and rooms and couldn't find the smell. He had housekeeping come and open the door for him and he found the body was decomposed. [DON] called me, and I came straight over. The cops were here, the area was closed off and we couldn't go back there. At that point, the detective was asking questions and interviewing the staff. The medical examiner took the body and when the detective was done we started cleaning the area. The NHA was asked if she should have been notified that the resident was agitated and wants to leave AMA and be notified of all AMAs, she stated: Sometimes they notify me if a resident leaves AMA. They are supposed to educate the resident about what AMA means. The NHA was as asked if it was unusual for a resident to leave without taking their belongings. She stated: I went in his room and his things were there. We have had some AMAs, and they have left their things because they had too many things. The NHA was asked if she was sure everywhere in the facility was checked including that specific closet. She stated: The DON said he checked that closet, but it was locked. It was an old shower room, and we had been using it as a storage room for boxes and papers. I wasn't aware that it could lock from the inside. When asked why they did not get the keys so the door could be unlocked and checked she did not respond. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/04/24 at 1:49 PM, the Director of Nursing (DON) revealed on the afternoon of the incident someone told him that a resident was missing, he went to look for the resident in the area. When he returned to the facility he was told the resident went out AMA. Late that afternoon, it was about to rain, he asked the Administrator and the ADON, if a wellness check needed to be done. The ADON called [local community-based agency], and they told her they do not do a wellness checks anymore and to call the police. The police was called, and they told the police what happened. The DON reported he went back out to search for the resident and did not find the resident. The police asked should we file a missing person's report, and I said no because he filed an AMA. [Staff A], LPN the Supervisor and [Staff D], RN the nurse for the resident signed on the AMA form. We had procedures in place for elopement and AMA. The DON was asked if he was positive all areas in the facility was checked. He reported everywhere was checked. The DON reported he did not know the resident was agitated and wanted to leave. During an interview via telephone on 09/05/2024 at 1:16 PM, the Medical Director was asked if he was notified of Resident #1 wanting to leave the facility AMA. He stated, I was not notified. I became aware of the incident while I was in the facility on Thursday (08/22/2024) that afternoon around 2:00 PM to 3:00 PM and was told they were looking for a missing resident. He reported, if a resident wishes to leave AMA and is alert the resident will need to sign the AMA form, if the resident is unable to sign and they have a proxy the proxy will need to sign, if the proxy cannot be located to sign a guardian will be appointed to sign. When a Resident is agitated even if they are responsible for themselves, the staff cannot let that resident leave AMA. An agitated resident should be sent to the hospital; and the family or emergency contacts should be notified. Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and Procedure revision date was on 10/2022, the policy documented: The facility will provide a safe resident environment and protect all residents from abuse. Therefore, each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation of any type by anyone. Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A prompt thorough investigation will be conducted by the facility immediately. Review of the facility's policy titled Transfer and Discharge (including AMA. Date Implemented 3/2020 and Date reviewed and revised 6/2023; indicated: Item 13-Discharge Against Medical Advise (AMA). a. The resident and family/legal representative should be informed of risks involved, the benefits of staying at the facility, and alternatives to both. Under no circumstances will the facility force, pressure or intimidate a resident into leaving AMA. b. The physician should be notified of the intended AMA discharge and encourage to speak with the resident to encourage them to stay at the facility. c. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social services designee should document any discussions held with the resident/family in the service services progress notes if present. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on record reviews and interviews, the facility failed to implement their abuse and neglect policy as evidenced by staff failure to provide care and services including adequate supervision for one (Resident number 1) out of three residents sampled during the time of this survey. This deficient practice has the potential to affect all residents residing in the facility. This enabled resident number 1 to go missing from the facility undetected on [DATE]. The resident was not located until 8:30 AM on [DATE] deceased in a locked closet and his body was decomposed. Refer to F600, F689 and F835 The findings included: Record review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and Procedure revision date was on ,d+[DATE], the policy documented: The facility will provide a safe resident environment and protect all residents from abuse. Therefore, each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation of any type by anyone. Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A prompt thorough investigation will be conducted by the facility immediately. Review of the facility's Policies and Procedures titled Missing Resident with dated issued [DATE] indicates: It is the intent of the facility to be aware of its resident's, usual habits and location as reasonably practicable. This is with he intent of not invading privacy but to identify a possible missing resident. Procedure: 1. In the event that any staff member identifies that they cannot find a resident in a place that resident is anticipated to be, the staff member will alert their supervisor for assistance, once affirming that the resident was not signed out on leave. 2. The supervisor would assume control of the search. 3. The supervisor would alert staff of the identity of the resident and direct designated staff to participate in the search. 4. The supervisor in charge of the will not assume that resident has left facility and will: a. Re-affirm if the resident could be out of the facility on authorized leave the facility where reaffirming for resident could be out of the facility on an authorized or pass by reviewing the facility sign on process. b. Determine if it's prudent to call the resident's family or other visitors. If there is a possible concern that resident was taken out potentially they did not sign the resident out. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. If the resident is not authorized to leave facility independently. Initiate a search of the facility and premises by assigning staff to look in various areas. d. If the resident is not located is not located in a reasonable amount of time, the Administrator and Director of Nursing (DON), the resident's representative, the attending physician and law-enforcement official will be notified as indicated . e. If the resident remains unable to be located and or is not authorized to leave the facility independently; Initiate an extensive search of the surrounding areas. 5. When a missing person is not located within the confines of the facility building, then the supervisor in charge would direct designated staff to participate in an outside facility grounds search which may include but is not limited to the roof of the building, the parking lot and any outside parked vehicle, etc. 6. In the event that a staff member observes attempting a resident attempting to leave premises without supervision, and is concerned that the resident would not normally be a be appropriate to do so independently , the staff member will: a. call for assistance then calmly approach the resident (attempting to initiate a friendly chat as possible), and in a courteous manner attempt to redirect or guide the resident back to the facility; b. if the resident is upset or agitated and is not easily redirected or guided, the staff member will continue walking with the resident either next to or behind them to provide support, supervision and safety . Review of the Demographic Face Sheet for Resident number 1 documented the resident was initially admitted on [DATE] with diagnoses that included but not limited to cerebral infarction, difficulty in walking, cognitive communication deficit and altered mental status. Review of the Minimum Data Service (MDS) 5-Day assessment dated [DATE] for Resident number 1 documented the resident's Brief Interview of Mental Status (BIMS) Summary Score was 12, indicating moderate cognitive impairment and able to make his needs known, vision was impaired with no corrective lenses, wandering behavior was noted, required partial/moderate to substantial/maximal assistance for ADLs (activities daily living) and there was no wander/elopement alarms used. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for [DATE] documented the resident was receiving the following medications: Lorazepam tablet 0.5 mg (milligrams) give 1 tablet by mouth two times a day for anxiety; Seroquel oral tablet 100 mg give 1 tablet by mouth at bedtime for agitation related to altered mental status and a psych consult was written for a diagnosis of agitation on [DATE]. The resident did not have an order for a wander elopement alarm bracelet. Review of the Behaviors Monitoring Sheets for [DATE] documented the resident's behaviors were monitored on [DATE]-[DATE] at day, evening and night shift. On [DATE] day shift he had behaviors and was given food (code 7); On [DATE] night shift he had behaviors and was given food (code 7) and on [DATE] day shift he had behaviors and refer to progress note (code 9). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North 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.			
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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of care plan's written [DATE] for Resident number 1 documented the resident had a discharge care plan and had wishes to return/be discharged to community/prior living arrangements and resident had a falls care plan and was at risk for falls related to unsteady gait, vision impairment. The resident did not have a wandering/elopement care plan. Review of the progress notes documented the following: Dated [DATE] time stamped 04:58 Behavior Note: Resident was washed and made comfortable in bed still taking off clothes redirected with food beverage peri care polite conversation. Resident still taken off clothing pass on to ,d+[DATE] shift to follow up; Dated [DATE] time stamped 05:37 Behavior Note: Resident walking in hallway going in other resident rooms and yelling redirected with food beverage peri care and polite conversation. Resident went to bed and resting comfortable, pass on to ,d+[DATE] shift to follow up; Dated [DATE] time stamped 21:16 Narrative Note (General): Overheard a resident yelling Don't hit me. Immediately responded and noted Resident#1 coming out of another resident's room. Resident assessed and complained of pain to left shoulder, back, and head. No open area and no bruising noted. Resident rated pain as a 3 on a ,d+[DATE] pain scale. PRN (as needed) pain medicine given. Resident confused and alert to person. Assisted resident back to his room. Call placed to MD (medical doctor). MD made aware and no new orders given. Call placed to resident's sister; Dated [DATE] time stamped 15:50 Narrative Note (General): Around 1 PM resident noted as agitated requesting to leave the facility. When asked why resident stated that he just did not want to be here anymore. Resident noted as self-responsible, made supervisor aware. Teaching provided regarding a facilitated transfer and supervisor called family but no answer. Resident refused and stated that he was leaving. Teaching provided regarding risks. Presented AMA (against medical advice) however resident refused to sign. Resident then left facility alert and oriented in no distress. Will make another attempt to inform family; Dated [DATE] time stamped 20:20 Narrative Note (General): Call placed to [local community-based agency] for wellness check, spoke to [local community-based agency] who stated only local police do wellness checks however would document call. [Local police] was contacted for a wellness check and an address was provided and dated [DATE] time stamped 12:44 Narrative Note (General): Resident daughter and granddaughter arrived at the facility, no concerns voiced however stated that the resident does not like to stay in one place for a long period of time and is violent and agitated at times. Family thanked staff for contacting [local community-based agency] and [police for the wellness check]. Review of the Elopement Risk Assessment/Evaluation dated [DATE] documented: The resident upon his Admission was not at risk for elopement and a score of three. Review of the Against Medical Advice Form (AMA) for Resident number 1 dated [DATE] documented the resident did not sign the form and two signatures were documented below the resident's signature line. The signatures were the Staff A, Licensed Practical Nurse (LPN), Nurse Unit Manager 7:00 AM to 3:00 PM shift and Staff D, Registered Nurse (RN) 7:00 AM to 3:00 PM shift. The facility's Transfer and Discharge policy indicated in Item 13: Discharge Against Medical Advice (AMA). a. The resident and family/legal representative should be informed of risks involved, the benefits of staying at the facility, and alternatives to both. Under no circumstances will the facility force, pressure or intimidate a resident into leaving AMA. b. The physician should be notified of the intended AMA discharge and encourage to speak with the resident to encourage them to stay at the facility. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social services designee should document any discussions held with the resident/family in the service services progress notes if present. d. Notify Adult Protection Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly. On [DATE] at 10:46 AM, Staff A, Licensed Practical Nurse (LPN), Nurse Unit Manager 7:00 AM to 3:00 PM shift stated, The resident was sitting in a wheelchair on the day he left. He was restless, anxious. He was Creole speaking and a little English. We assessed him. He stated, He wanted to leave the facility. We educate the patient and told him the risks of him leaving. He was still restless, would stand up in the chair and we re-directed him. I went to the morning meeting, when I came back I saw the nurse, [Staff D], RN talking to the resident trying to redirect him. We spoke to him, and he didn't want to accept what we were trying to tell him. I looked in the [computer program] to see if the resident was self-responsible and I noted that he was, I let the DON (Director of Nursing) know. We presented to the resident the AMA (against medical advice) documentation, educated him on it and he refused to sign it, and he was anxious. I left him with the nurse. He had anxious behavior the day he left. He would go to different rooms and had exit seeking behaviors. I didn't see him walk out the building. When I came to his room, his belongings were still in his room. The nurse [Staff D], RN didn't tell everybody that the patient went AMA. The staff was asking about the resident. The procedure when a resident being discharged we present the resident is self-responsible to self, education is given by the nurse, who is in charge with the nurse. If they leave without medical advice, the medication will not go with them. I am not sure if the family was called when the resident was anxious. According to this resident, he wanted to go home. Vitals were stable. He was given food. He was in a wheelchair, but he could walk. The Administrator was notified by the nurse. I am not sure if the Administrator went to talk to the resident. The Certified Nursing Assistant (CNA) assigned to the resident was providing care to another resident. We let the doctor know, let the family know, we give them the paperwork. I think the nurse called the doctor. I don't know what the doctor say. He was anxious but not in an aggressive way. I was made aware; he went AMA after lunch around 1:00 PM. She didn't tell me [Staff D], RN right away the resident went AMA. He would eat lunch in his room or in the hallway. On [DATE] at 11:26 AM, Staff B, Certified Nursing Assistant (CNA) 7:00 AM to 3:00 PM shift stated, I was assigned to him. I made rounds, he was alert and talkative. He spoke a little bit of English but spoke mostly Creole. At first he was in bed, afterwards he was cleaned and transferred to the wheelchair. He was in the hallway close to the nurses' station. In the morning when I did rounds, he was telling me he wanted to leave. I asked him why he said he wanted to go home. I expressed to my supervisor, [Staff A], LPN. They went to talk to him [Staff A, LPN] and Staff D, RN. I was moving about going to see about my other residents. My second time working with him on that day. He was very anxious, he would go from bed to bed, walking and opening doors, stand by the exit doors. The nurse knew he was going from room to room. He would stand by the exit door right outside of his room. I only work here three days a week. He was combative and would argue with you. I would say to him come back to your room, if I saw him going to another room. We would let our supervisor know if we see the resident wandering. I wasn't informed that he went AMA. When I left on my shift at 3:00 PM, he was in his wheelchair on the floor. I came back to work on the following Tuesday, I was made aware he was missing. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:19 PM with the Administrator/Risk Manager stated, Somebody had alerted me that there was a missing resident on [DATE] after 1:00 PM. We started looking for the resident in the building and out of the building. Some of us went driving around. Code green was called and that means someone is missing. A few minutes after we had gone driving around, [Staff A], LPN the Supervisor called me and told me that he wasn't missing but he left AMA. He was dealing with the nurse and the resident when he said he wanted to leave, and he refused to sign the AMA form. When he told me that I said it wasn't an elopement and we went back to the building. The weather was bad, and I asked [Staff A], LPN did he say where he was going. Nobody escorted him out of the building, and we didn't know which way he went. Since it was bad weather, we called [local agency] to do a wellness check, and the family house was nearby. [local community-based agency] told us they don't do wellness checks anymore and to call local law enforcement and we did. Law enforcement went to the address (the resident's niece), and he wasn't there. When the police went to the house they decided to file a missing person report. We wanted to keep looking for him so some of us, kept looking for him. We were driving around the area looking for him. The next day on the 23 rd the daughter and the granddaughter came to the building to meet with me, the DON (director of nursing) and the ADON (Assistant Director of Nursing). The daughter said he likes to walk the street and live on the street. His usual spot is by [local hospital]. We called the police that we had spoken to and gave them the information so they could look as well. On [DATE] the following Monday, the sister and the niece came to the building, asking questions regarding the situation to me and [DON]. The niece said he had dementia. We checked the chart and there was no documentation in our chart or the hospital chart that he had dementia. She said she was going to talk to the hospital because that was neglectful to not use that as a diagnosis. We did a neglect report on [DATE] and we unsubstantiated it. He was alert and oriented times three on our chart and the hospital's chart. I completed the 5-day report on yesterday. On [DATE], I get a call from [the DON] around 8:30 AM that they found a body in the closet. Somebody was saying that there was a bad odor. The maintenance assistant started looking in the vents and rooms and couldn't find the smell. He had housekeeping come and open the door for him and he found the body was decomposed. [DON] called me, and I came straight over. The cops were here, the area was closed off and we couldn't go back there. At that point, the detective was asking questions and interviewing the staff. The medical examiner took the body and when the detective was done we started cleaning the area Sometimes they notify me if a resident leaves AMA. On [DATE] at 1:49 PM, the Director of Nursing (DON) stated, On that day, somebody told me in the afternoon that a resident was missing. I went out and looked for the resident. I looked around and I came back. I was informed the resident went out AMA. Late that afternoon, it was about to rain, I asked the Administrator and the ADON, do you think we need to do a wellness check. ADON called the [local community-based agency], and they said they don't do a wellness check anymore and to call the police. We called the police, explained to the police what happened. I went back out and drove around to look for him. I went all the way to the [local hospital] and I didn't see him. I couldn't find the resident. The police asked should we file a missing person's report, and I said no because he filed an AMA. [Staff A], LPN the Supervisor and [Staff D], RN the nurse for the resident signed on the AMA form. We had procedures in place for elopement and AMA which is a part of the education plan. I don't know if he had a psych consult. Subsequent interview with the DON on [DATE] at 3:18 PM. He stated, The resident never received a psych consult. He was gone by the time the psychiatrist came to see him. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:08 PM with the Maintenance Assistant via Spanish translator he revealed the nurses called him because of the bad smell. He checked the attic in J wing, the AC duct. He went to the dining room because the smell was strong. The door was locked, housekeeping opened the door. When he opened the door he found the body. Only saw the legs and he left quickly. He called another staff member and he came and looked. On [DATE] at 7:24 AM Staff E, Registered Nurse (RN) 11:00 PM to 7:00 AM shift stated, He had the behaviors of wandering. He would go into other patients room and the patients would get mad. He was very mean and angry. I gave him a choice to go to his room. Sometimes he would go and if not I would have him take a chair and sit down. He spoke a little bit of English. On [DATE] at 9:35 AM via telephone Staff D, Registered Nurse (RN) 7:00 AM to 3:00 PM shift stated, He was my patient, and I was in the hallways. At 11:22 AM, I gave him his medication. I moved on to my next patient. The CNA around 1:00 PM or 2:00 PM and she said to me he wanted to leave. I went to talk to the supervisor [Staff A], LPN. I tell him the CNA report to me that the patient wanted to leave. He said we have to talk to the patient. He cannot leave. He would have to sign a paper, AMA form. He refused to sign the form. If he want to leave, he had to sign the paper. When he refused to sign the paper, [Staff A], LPN said that two people have to sign the form before the patient can leave. [Staff A], LPN signed the paper first and I signed the paper next. I left and took care of my other patients. I didn't see the resident after that. The procedure for AMA give them the paper to sign and they can go. I did not call the doctor. Once I left the supervisor [Staff A], LPN he said he would take care of it. He was alert and oriented times three. That morning, he did not have any wandering behavior. Sometimes I would see him wandering into other patients room. I would talk to him in Creole don't go in the room he would come back around. He would walk around and go everywhere. I would have to say yes [Staff A], LPN told the social services. I don't know if she came to see him.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 39177 Based on observations, interviews, record review, the facility failed to ensure the facility's environment was safe and residents were adequately supervised, as evidenced by one (Resident #1) out of three vulnerable resident sampled with exit seeking behaviors voice his intent to leave the facility refused to sign an Against Medical Advice (AMA). was not adequately supervised and monitored by the facility's staff who did not see the resident exit the facility The facility had an unsecured closet that was being used for storage that Resident #1 entered undetected. Resident #1 decomposed body was found for 12 days after staff reported the resident left the facility AMA. Refer to F600, F607 and F835 The findings include: Observation on 09/04/24 at 9:36 AM with the [NAME] President of Operations and the Regional Director of Operations of the space within which Resident #1 was found revealed the space was located in the rear dining room that is used for activities located in the J Unit, cameras were observed the dining area which the facility's administrative staff said were nonfunctional cameras. The door to the closet where Resident # 1 was found had a Key Entry Lever Handle Lock; there were several boxes and a working toilet that had boxes stacked on it. The Regional Director of Operations revealed the room was previously used as a shower room and is now storage closet. A tour of the area outside the dining/activities area revealed the two emergency exit doors had alarms that required a code prior to opening surveillance cameras were also noted on the building's exterior. When asked if the cameras were working The [NAME] President of Operations revealed the cameras were not working and were left in place by the previous owner. Review of Resident # 1's admission Records revealed an admitted [DATE]. The contacts information documentation indicated the resident as Self, the emergency contact #1 listed daughter #2 Granddaughter and contact information listed for two sisters. Review of the clinical records revealed diagnoses that included but not limited to: Altered Mental Status, Cognitive Communication Deficit, Cerebral Infarction, Difficulty in Walking and Diabetes Mellitus. Review of Resident #1's August 2024 Physician's Order Sheets and Medication Administration Records revealed the resident was receiving medications that included but not limited to Lorazepam Tablet 0.5 mg 1 tablet by mouth two times a day for anxiety; Seroquel Oral Tablet 100 mg 1 tablet by mouth at bedtime for Agitation related to altered mental status. There was an order for -Psych consult for diagnosis of agitation with revision dated 8/18/2024 that according to the Director of Nursing the resident did not receive because he was no longer in the facility. Review of Resident #1 admission care plans dated 8/15/24 revealed The resident resident had a falls care plan (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and was at risk for falls related to unsteady gait, had vision impairment and no care plan for wandering/elopement vision impairment. Care Plans initiated 08/20/2024 Revision on: 08/28/2024 revealed Resident #1 is at risk for falls related to Unsteady gait and Vision impairment. Goal: Resident will be free of fall related injuries by next review date. Interventions: .Check at frequent intervals to monitor for unsafe actions and intervene promptly. Focus ;risk for further alteration; in neurological functioning related to history of Cardiovascular Attack (Stroke) and Cerebrovascular Disease.; Date Initiated: 08/21/2024. Revision on: 08/28/2024. Risk for complications of abnormal blood sugar related to diagnosis of Diabetes Mellitus date initiated: 08/21/2024, Revision on: 08/28/2024. Review of Resident #1's 5- Day Minimum Data Set (MDS) dated [DATE] indicated the resident vision is impaired, was moderately impaired cognitively and had wandering behaviors that occurred 1 to 3 days. and there was no wander/elopement alarms used. Review of Resident # 1's ELOPEMENT RISK ASSESSMENT/EVALUATION dated 8/21/24 completed and documented by the DON revealed an at-risk score of 11.0 meaning the resident was a high risk for elopement Resident #1 was being monitored for behaviors since his admission on 08/14 /24 until; the behavior monitoring sheets documentation revealed on 8/17/24 during the day shift he had behaviors and was given food, on 8/20/24 he had behaviors during the night shift and was given food, he had behaviors during the day shift (date of the incident) which documented refer to progress note. Review of the progress notes written by Registered Nurse (RN); Staff D dated 08/22/24 time stamped 15:50 documented: Around 1:00 PM resident noted as agitated requesting to leave the facility. When asked why, resident stated that he just did not want to be here anymore. Resident noted as self-responsible, made supervisor aware. Teaching provided regarding a facilitated transfer and supervisor called family but no answer. Resident refused and stated that he was leaving. Teaching provided regarding risks. Presented AMA however resident refused to sign. Resident then left facility alert and oriented in no distress. Will make another attempt to inform family. Review of the Discharge Without Physician's Approval Form Dated 8/22/24 revealed the resident had not signed above the line that indicated Signature of Resident the above the date line was dated 8-22-24. A signature belonging to the Licensed Practical Nurse Unit Manager (Staff A) was noted below the blank resident signature line. Review of Narrative Note written by the Assistant Director of Nursing (ADON) revealed; (General) dated 8/22/2024 timestamped 20:20: Call placed to [local community-based agency] for wellness check, spoke to [local community based agency staff] who stated only local police do wellness checks however would document call. [Local police department] was contacted for a wellness check and an address was provided. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Narrative note written by the ADON dated 8/23/2024 time stamped 12:44 documented: Resident daughter and granddaughter arrived at the facility, no concerns voiced however stated that the resident does not like to stay in one place for a long period of time and is violent and agitated at times. Family thanked staff for contacting [local community-based agency] and [local law enforcement] for the wellness check. Review of the facility's ABUSE LOG: Dated August 2024 revealed, Resident #1 was listed on the abuse log for neglect on 8/22/24 and was unsubstantiated; Date 8/26/24; [Local community-based agency] called-8/22/24; Accepted/Rejected-Rejected; Allegations-Neglect; 5-Day Federal-9/02/24; Comments-Unsubstantiated. The facility's ELOPEMENT INCIDENT LOG for August 2024 had no incidents of elopements. During an interview on 9/04/24 at 10:46 AM the 7:00 AM to 3:00 PM Licensed Practical Nurse (LPN) Nurse Manager revealed; Resident #1 was sitting in a wheelchair on the day he left. The resident was anxious was restless and anxious. He was Creole speaking and spoke a little English. He was assessed and he wanted to leave the facility. We educate the patient and tell him the risks of him leaving. He was still restless, would stand up in the chair and re-directed him. I went to the morning meeting, when I came back I saw the nurse, [Staff D, RN] talking to the resident trying to redirect him. We spoke to him, and he didn't want to accept what we were trying to tell him. I looked in the [computer program] to see if the resident was self-responsible and I noted that he was, I let the DON know. We presented to the resident the AMA documentation, educated him on it and he refused to sign it, and he was anxious. I left him with the nurse. He had anxious behavior the day he left. He would go to different rooms and had exit seeking behaviors. The Nurse Manager was asked if he saw Resident #1 leaving the facility and if anyone escorted the resident from the facility. He stated: I didn't see him walk out the building. When I came to his room, his belongings were still in his room. The nurse [Staff D] didn't tell everybody that the patient went AMA. The staff was asking about the resident. The LPN Nurse Manager explained the facility's policy and procedure when a resident is being discharged, he explained when a resident is being discharged and the resident is self-responsible, education is given by the nurse, who is in charge with the nurse. If they leave without medical advice, the medication will not go with them. I am not sure if the family was called when the resident was anxious. According to this resident, he wanted to go home. Vitals were stable. He was given food. He was in a wheelchair, but he could walk. The Administrator was notified by the nurse. I am not sure if the Administrator went to talk to the resident. The Certified Nursing Assistant (CNAs) assigned to the resident was providing care to another resident. We let the doctor know, let the family know, we give them the paperwork. I think the nurse called the doctor. I don't know what the doctor say. He was anxious but not in an aggressive way. I was made aware he went AMA after lunch around 1:00 PM. She didn't tell me [Staff D] right away that the resident went AMA. The Nurse Manager was asked if Resident #1 ate lunch that day and where did the resident usually eat his lunch. The Nurse manager stated, He would eat lunch in his room or in the hallway. The nurse manager was asked how he came to the conclusion that Resident # 1 was AMA if no one saw the resident exit the facility and may just be missing. and may have possibly be missing because his belongings were still in his room. He revealed he did not see the resident leave the facility. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/04/24 at 11:26 AM the Resident # 1's assigned Certified Nursing Assistant (CNA), Staff B on the day of the incident reported he spoke a little bit of English but mostly spoke Creole. On the day of the incident at first he was in bed, afterwards he was cleaned and transferred to the wheelchair. He was in the hallway close to the nurses' station. In the morning during her rounds, he told her he wanted leave wanted to go home. Staff B stated: I expressed to my supervisor, [Staff A]. They went to talk to him (Staff A and Staff D). I was moving about going to see about my other residents. This was my second time working with him on that day. He was very anxious, he would go from to bed, walking opening doors, by the exit doors. The nurse knew he was going from room to room. He would stand by the exit door right outside of his room. I only work here three days a week. He was combative and would argue with you. I would say to him come back to your room, if I saw him going to another room. Once we let our supervisor know if we see the resident wandering. I wasn't informed that he went AMA. When I left on my shift at 3:00 PM, he was in his wheelchair on the floor. I came back to work on the following Tuesday, I was made aware he was missing. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North Miami, FL 33161	
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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/04/24 at 1:19 PM the Nursing Home Administrator (NHA) reported after 1:00 PM on 8/22/2024 she was alerted that a resident was missing. We started looking for the resident in the building and out of the building. Some of us went driving around. Code green was called and that means someone is missing. A few minutes after we had gone driving around, [Staff A] called me and told me that he wasn't missing but he left AMA. He was dealing with the nurse and the resident when he said he wanted to leave, and he refused to sign the AMA form. When he told me it wasn't an elopement, and we went back to the building. The weather was bad, and I asked [Staff A] did he say where he was going. The NHA was asked if anyone escorted the resident out of the building. She stated: Nobody escorted him out of the building, and we didn't know which way he went. Since it was bad weather, we called [local community-based agency] to do a wellness check and the family house was nearby. [Local community-based agency] told us they don't do wellness checks anymore and to call local law enforcement and we did. Law enforcement went to the address (niece), and he wasn't there. When the police went to the house they decided to file a missing person report. (Since the facility became aware a missing person report had been filed with the police by the family after the wellness check was completed and the resident was not located. The NHA reported staff checked both inside and outside of the facility and when asked how they were able to confirm all area were checked within the facility she did not provide an answer. The NHA was asked why they did not continue searching in the facility every day and open all doors in the facility, no answer was provided the NHA stated all hospitals were checked and areas close to the facility the NHA was asked if they called the police to get any updates. The NHA was asked if they are positive all areas were checked and if anyone had considered looking in that closet and asking for a key to open it she stated she never thought of that. The NHA was asked if no one heard sounds from the closet or smelled anything while activities were being done in that area she said no. the NHA acknowledged she was unable to confirm if a thorough search was completed within the facility on 08/22/2024). We wanted to keep looking for him so some of use kept looking him. Driving around the area. The next day on the 23 rd the daughter and the granddaughter came to the building to meet with me, [DON and ADON]. The daughter said he likes to walk the street and live on the street. His usual spot is by [local hospital]. We called the police that we had spoken to and gave them the information so they could look as well . On 8/26/24 the following Monday, the sister and the niece came to the building, asking questions regarding the situation me and (DON). The niece said he had dementia; we checked the chart and there was no documentation in our chart or the hospital chart that he had dementia. She said she was going to talk to the hospital because that was neglectful to not use that as a diagnosis. We did a neglect report on 8/26/24 and we unsubstantiated it. He was alert and oriented times three on our chart and the hospital's chart. I completed the 5-day report on yesterday. On 9/02/24, I got a call from [DON] around 8:30 AM that they found a body in the closet. Somebody was saying that there was a bad odor. The maintenance assistant started looking in the vents and rooms and couldn't find the smell. He had housekeeping come and open the door for him and he found the body was decomposed. [DON] called me, and I came straight over. The cops were here, the area was closed off and we couldn't go back there. At that point, the detective was asking questions and interviewing the staff. The medical examiner took the body and when the detective was done we started cleaning the area. The NHA was asked if she should have been notified that the resident was agitated and wants to leave AMA and also be notified of all AMAs, she stated: Sometimes they notify me if a resident leaves AMA. They are supposed to educate the resident about what AMA means. The NHA was as asked if it was unusual for a resident to leave without taking their belongings. She stated: I went in his room and his things were there. We have had some AMAs, and they have left their things because they had too many things. The NHA was asked if she was sure everywhere in the facility was checked including that specific closet. She stated: The DON said he checked that closet, but it was locked. It was an old shower room, and we had been using it as a storage room for boxes and papers. I wasn't aware that it could lock from the inside. When asked why they did not get the keys so the door could be unlocked and checked she did not respond. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/04/24 at 1:49 PM, the Director of Nursing (DON) revealed on the afternoon of the incident someone told him that a resident was missing, he went to look for the resident in the area. When he returned to the facility he was told the resident went out AMA. Late that afternoon, it was about to rain, he asked the Administrator and the ADON, if a wellness check needed to be done. The ADON called [local community-based agency], and they told her they do not do a wellness checks anymore and to call the police. The police was called, and they told the police what happened. The DON reported he went back out to search for the resident and did not find the resident. The police asked should we file a missing person's report, and I said no because he filed an AMA. [Staff A], LPN the Supervisor and [Staff D], RN the nurse for the resident signed on the AMA form. We had procedures in place for elopement and AMA. The DON was asked if he was positive all areas in the facility was checked. He reported everywhere was checked. The DON reported he did not know the resident was agitated and wanted to leave. During an interview via telephone on 09/05/2024 at 1:16 PM, the Medical Director was asked if he was notified of Resident #1 wanting to leave the facility AMA. He stated, I was not notified. I became aware of the incident while I was in the facility on Thursday (08/22/2024) that afternoon around 2:00 PM to 3:00 PM and was told they were looking for a missing resident. He reported, if a resident wishes to leave AMA and is alert the resident will need to sign the AMA form, if the resident is unable to sign and they have a proxy the proxy will need to sign, if the proxy cannot be located to sign a guardian will be appointed to sign. When a Resident is agitated even if they are responsible for themselves, the staff cannot let that resident leave AMA. An agitated resident should be sent to the hospital; and the family or emergency contacts should be notified. Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and Procedure revision date was on 10/2022, the policy documented: The facility will provide a safe resident environment and protect all residents from abuse. Therefore, each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation of any type by anyone. Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A prompt thorough investigation will be conducted by the facility immediately. Review of the facility's policy titled Transfer and Discharge (including AMA. Item 13-Discharge Against Medical Advise (AMA) Date Implemented 3/2020 and Date reviewed and revised 6/2023; indicated: a. The resident and family/legal representative should be informed of risks involved, the benefits of staying at the facility, and alternatives to both. Under no circumstances will the facility force, pressure or intimidate a resident into leaving AMA. b. The physician should be notified of the intended AMA discharge and encourage to speak with the resident to encourage them to stay at the facility. c. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social services designee should document any discussions held with the resident/family in the service services progress notes if present. d. Notify Adult Protection Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly.		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on record reviews and interviews the facility's administrative staff failed to ensure staff implemented a safe AMA discharge process by failing to monitor/escort a resident leaving the facility; failed to communicate and ensure efficient preventative measures to prevent the neglect of one resident (Resident number 1) out of three sampled residents who displayed exit seeking behaviors. As evidenced by failure by staff to implement assigned level of supervision for resident number 1 who was at risk for elopement, had exit seeking behaviors, wandered the unit and near exit doors and voiced his intent to leave the facility. These deficient practices enabled Resident number 1 to go missing from the facility undetected on [DATE]. The resident was not located until 8:30 AM on [DATE] deceased and decomposing in a locked closet. Refer to F600, F607 and F689 The findings included: Review of the Job Description for the Nursing Home Administrator documented: The Administrator is responsible for developing, managing and supervising the overall functions of the facility in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is responsible for providing a positive, caring and homelike environment for the residents. Review of the Job Description for the Director of Nursing documented: The Director of Nursing is responsible for planning, organizing, developing and directing the day-to-day functions of the nursing department in accordance with current Federal, state and local standards and established nursing policies and procedures. He/she is responsible for providing a positive, caring and homelike environment for the residents. Review of the Job Description for the Assistant Director of Nursing documented: The Assistant Director of Nursing is responsible for supervising the day-to-day nursing activities in accordance with current Federal, state and local standards and established nursing policies and procedures. In the absence of the Director of Nursing Services, he/she is charged with carrying out the resident care policies. He/she is responsible for providing a positive, caring and homelike environment for the residents. Review of the Job Description for the Director of Social Services documented: The primary purpose is to plan, organize, develop and direct the overall operation of the facility social services department in accordance with current federal, state and local standard guidelines and regulations and to assure that the facility is maintained in a clean, safe and comfortable manner. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy and Procedure revision date was on ,d+[DATE], the policy documented: The facility will provide a safe resident environment and protect all residents from abuse. Therefore, each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation of any type by anyone. Neglect means failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. A prompt thorough investigation will be conducted by the facility immediately. Review of the facility's policy titled, Residents at Risk for Elopement Policy and Procedure issued [DATE] documented: Policy Guidelines: The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission and conduct a coordinated resident search in the event of a missing resident. II Definitions: Wandering refers to a cognitively impaired resident's ability to move about inside the facility aimlessly, but often with purpose and without an appreciation of personal safety needs and who may enter a dangerous situation. III Procedural Components: A. Assessment: 2) An elopement risk evaluation is completed on all residents on admission and with a change in condition or mental status; 4) g. iv. Exit-seeking (the resident is intent on leaving the unit or facility, looking for exits and hovering at exits waiting for the opportunity to leave with someone or pushing on a door); B. Risk Reduction Measures: 1) Interventions that may be used for residents identified as high risk for elopement include: b) Room placement close to common areas such as the nurses' station and away from exits and f) Transfer to a more suitable or more secured unit. Review of the facility's policy titled, Missing Resident Policy and Procedure issued [DATE] documented: Policy: It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practicable. Procedure: 1) In the event that any staff member identifies that they cannot find a resident in a place that the resident is anticipated to be, the staff member will alert their supervisor for assistance once affirming that the resident was not signed out on leave; 2) The supervisor would assume control of the search; 3) The supervisor would alert staff of the identity of the resident and direct designated staff to participate in the search; 4) The supervisor in charge of the search will not assume that the resident has left the facility and will: b) Determine if it is prudent to call the Residents family or other visitors if there is a possible concern that the resident was taken out and potentially they did not sign the resident out; c) If the resident is not authorized to leave the facility independently, initiate a search of the facility and premises by assigning staff to look in various areas; d) If the resident is not located in a reasonable amount of time, the Administrator and the Director of Nursing (DON), the resident's representative, the Attending Physician and law enforcement officials will be notified as indicated and e) If the resident remains unable to be located and or is not authorized to leave the facility independently, initiate an extensive search of the surrounding area. Review of the Demographic Face Sheet for Resident #1 documented the resident was initially admitted on [DATE] with diagnoses that included but not limited to cerebral infarction, difficulty in walking, cognitive communication deficit and altered mental status. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Minimum Data Service (MDS) 5-Day assessment dated [DATE] for Resident #1 documented the resident's Brief Interview of Mental Status (BIMS) Summary Score was 12, indicating moderate cognitive impairment and able to make his needs known Review of care plan's written [DATE] for Resident #1 documented the resident had a discharge care plan and had wishes to return/be discharged to community/prior living arrangements and resident had a falls care plan and was at risk for falls related to unsteady gait, vision impairment. The resident did not have a wandering/elopement care plan. Review of the Elopement Risk Assessment/Evaluation dated [DATE] documented: The resident upon his Admission was not at risk for elopement and a score of three. Review of Resident # 1's Elopement Risk Assessment/Evaluation dated [DATE] completed and documented by the DON revealed an at-risk score of 11.0 meaning the resident was a high risk for elopement Review of the Against Medical Advice Form (AMA) for Resident #1 dated [DATE] documented the resident did not sign the form and two signatures were documented below the resident's signature line. The signatures were the Staff A, Licensed Practical Nurse (LPN), Nurse Unit Manager 7:00 AM to 3:00 PM shift and Staff D, Registered Nurse (RN) 7:00 AM to 3:00 PM shift. On [DATE] at 1:19 PM during an interview the Administrator/Risk Manager stated, Somebody had alerted me that there was a missing resident on [DATE] after 1:00 PM. We started looking for the resident in the building and out of the building. Some of us went driving around. Code green was called and that means someone is missing. A few minutes after we had gone driving around, [Staff A], LPN the Supervisor called me and told me that he wasn't missing but he left AMA. He was dealing with the nurse and the resident when he said he wanted to leave, and he refused to sign the AMA form. When he told me that I said it wasn't an elopement and we went back to the building. The weather was bad, and I asked [Staff A], LPN did he say where he was going. Nobody escorted him out of the building, and we didn't know which way he went. Since it was bad weather, we called [local agency] to do a wellness check, and the family house was nearby. [local community-based agency] told us they don't do wellness checks anymore and to call local law enforcement and we did. Law enforcement went to the address (the resident's niece), and he wasn't there. When the police went to the house they decided to file a missing person report. We wanted to keep looking for him so some of us, kept looking for him. We were driving around the area looking for him. The next day on the 23rd the daughter and the granddaughter came to the building to meet with me, the DON (director of nursing) and the ADON (Assistant Director of Nursing). The daughter said he likes to walk the street and live on the street. His usual spot is by [local hospital]. We called the police that we had spoken to and gave them the information so they could look as well. On [DATE] the following Monday, the sister and the niece came to the building, asking questions regarding the situation to me and [DON]. The niece said he had dementia. We checked the chart and there was no documentation in our chart or the hospital chart that he had dementia. She said she was going to talk to the hospital because that was neglectful to not use that as a diagnosis. We did a neglect report on [DATE] and we unsubstantiated it. He was alert and oriented times three on our chart and the hospital's chart. I completed the 5-day report on yesterday. On [DATE], I get a call from [the DON] around 8:30 AM that they found a body in the closet. [DON] called me, and I came straight over. The cops were here, the area was closed off and we couldn't go back there. At that point, the detective was asking questions and interviewing the staff. The NHA was asked about the protocol when a resident is leaving AMA and if she is notified; the NHA stated: Sometimes they notify me if a resident leaves AMA.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31581 Based on observation record review and interviews the facility failed to ensure residents' medical records are accurate in accordance with accepted professional standards and practices for two (Resident #1 and Resident #3) out of three residents sampled, as evidenced by an Elopement Risk Assessment information for Resident#1 was struck out by the Director of Nursing (DON) when written by the Assistant Director of Nursing (ADON); and a progress note for Resident #1 that indicated Resident #1 left Against Medical Advice (AMA) without staff observation of Resident #1 exiting the facility and an Elopement Care Plan for Resident #3 noted with interventions that included a monthly [wander management system] check inconsistent with an attestation from the facility stating [wander management systems] are not used, These practices has the potential to affect any of the residents residing in the facility. 1) Review of the Demographic Face Sheet for Resident #1 documented the resident was initially admitted on [DATE] with diagnoses that included but not limited to cerebral infarction, difficulty in walking, cognitive communication deficit and altered mental status. Review of the Minimum Data Service (MDS) 5-Day assessment dated [DATE] for Resident number 1 documented the resident's Brief Interview of Mental Status (BIMS) Summary Score was 12, indicating moderate cognitive impairment and able to make his needs known, vision was impaired with no corrective lenses, wandering behavior was noted, required partial/moderate to substantial/maximal assistance for ADLs (activities daily living) and there was no wander/elopement alarms used. Review of the Physician's Order Sheets (POS) and Medication Administration Records (MAR) for August 2024 documented the resident was receiving the following medications: Lorazepam 1 tablet by mouth two times a day for anxiety; Seroquel oral tablet at bedtime for agitation related to altered mental status and a psych consult was written for a diagnosis of agitation on 8/18/2024. Review of the Behaviors Monitoring Sheets for August 2024 documented the resident's behaviors were monitored on 8/14/24-8/22/24 at day, evening and night shift. On 8/17/24 day shift he had behaviors and was given food (code 7); On 8/20/24 night shift he had behaviors and was given food (code 7) and on 8/22/24 day shift he had behaviors and refer to progress note (code 9). Review of care plan's written 8/15/24 for Resident number 1 documented the resident had a discharge care plan and had wishes to return/be discharged to community/prior living arrangements and resident had a falls care plan and was at risk for falls related to unsteady gait, vision impairment. The resident did not have a wandering/elopement care plan. Review of the Elopement Risk Assessment/Evaluation for Resident number 1 dated 8/21/24 documented the resident was at risk with a score of 11.0. He was described as independently ambulatory, very confused, comatose, combative, depressed, or psychotic and impulsive behavior. The evaluation was documented by the Assistant Director of Nursing. On 8/22/24 time stamped 16:07 by the Director of Nursing (DON) documented the Elopement Risk Assessment/Evaluation was incomplete and the documentation was incorrect. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/04/24 at 1:49 PM during an interview the Director of Nursing (DON) stated, [Assistant Director of Nursing] (ADON) made a statement, and the elopement evaluation was struck out. On 9/04/24 at 2:49 PM the ADON stated, I did the elopement risk evaluation on 8/21/24. It was done on the wrong person. It was supposed to be for [another resident]. On 8/21/24, I placed the elopement risk in the wrong chart as I was working in two charts at once. As I was going to conduct an interview with [Resident #1], I noted another resident with exit seeking behavior in which I redirected then documented. I then went to talk to the staff to closely monitor him. I then went to clinical meeting and accidentally placed the elopement risk in [Resident #1's] chart as it was still open. The elopement risk was then struck out. [Resident #1's] Elopement Risk was done on 8/15/24 upon his admission and he was not at risk for elopement. He had a score of three. Review of the statement written concerning Elopement Risk Assessment/Evaluation documented: On 8/21/24, I placed the elopement risk in the wrong chart as I was working in two charts at once. As I was going to conduct an interview with [Resident #1], I noted another resident with exit seeking behavior in which I redirected then documented. I then went to talk to the staff to closely monitor him. I then went to clinical meeting and accidentally placed the elopement risk in [Resident #1's] chart as it was still open. The elopement risk was then struck out. Review of the Elopement Risk Assessment/Evaluation dated 8/15/24 documented: The resident upon his admission was not at risk for elopement and a score of three. 39177 Review of the progress notes written by Registered Nurse (RN); Staff D dated 08/22/24 time stamped 15:50 documented: Around 1:00 PM resident noted as agitated requesting to leave the facility. When asked why, resident stated that he just did not want to be here anymore. Resident noted as self-responsible, made supervisor aware. Teaching provided regarding a facilitated transfer and supervisor called family but no answer. Resident refused and stated that he was leaving. Teaching provided regarding risks. Presented AMA however resident refused to sign. Resident then left facility alert and oriented in no distress. Will make another attempt to inform family. On 09/04/24 at 11:49 AM surveyor on the team attempted to contact Staff D and a voice message left with call back number. Record review of Policy and Procedure: Documentation in Medical record Date implemented: 4/2020 Date Reviewed/Revised: 10/2023 Policy: Each resident 's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident 's progress through complete, accurate, and timely documentation. Policy Explanation and Guidelines: 6. Corrections to a medical record shall be made to clarify inaccurate information. a. Only the individual who made the original entry shall correct the entry. 48906 2) On 9/4/24 at 10:10 AM Resident #3 was observed seated on the bed eating lunch. An identification bracelet with the resident's name was observed on the wheelchair next to Resident #3. Resident #3 stated, I placed the name bracelet on my wheelchair to keep it safe. (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a list provided by facility of all residents at risk for Elopement revealed Resident #3 was at risk for Elopement. Record review of demographic sheet for Resident #3 revealed an admitted [DATE] and readmitted [DATE] with diagnosis that included Schizophrenia. Record review of the Quarterly Minimum Data Set (MDS) with reference date 6/20/24, Section C (Cognitive status) revealed a Brief Interview for Mental Status score of 12 out of 15 indicating moderate cognitive impairment. Section E (Behaviors) revealed Resident #3 had not exhibited wandering behaviors and Section P (restraints) revealed none were used. Record review of Care Plan initiated on 04/30/24 and revised on 6/1/24 revealed Resident #3 had behaviors of wandering with no purpose and a goal of Resident #3 will not have complications related to wandering behaviors thru next review with interventions that included: Maintenance to do monthly [wander management system] system check. Record review of the physician's order sheet revealed an order dated 6/6/24 for Risperidone oral tablet one milligram direction give one tablet by mouth two times a day for Schizophrenia, monitor behavior, mood, sleep, and appetite and an order dated 6/7/24 for Behavior Code 1: Agitated directions document # of times behavior occurred each shift every shift. Record review of Electronic Health record revealed an assessment of Elopement Risk dated 4/30/24 with a total score of 11, indicating a risk for Elopement. On 9/4/24 at 2:10 PM Staff G, Licensed Practical Nurse (LPN) stated: I am the nurse for [Resident #3] today. I am not aware if [Resident #3] is at risk for elopement, but we have an Elopement Book that is kept at the nursing station. the nurse showed surveyor the Elopement Book, Resident #3 was listed, and a picture provided. Staff G further stated: We have interventions in place to monitor residents who are at risk for elopement and [Resident #3] does not have a [wander management system]. On 9/4/24 at 3:10 PM; when asked about the wander systems check; the Maintenance Director stated, We do not do [wander management system] checks. Record review of Attestation from Facility revealed the facility does not use a [wander management system].		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER North Dade Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 NE 135th Street North 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)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48906 Based on interview and record review, the facility's quality assurance and assessment committee failed to identify quality concerns to implement effective plans of action related to adequate supervision resulting in repeated deficient practice. The facility's history includes deficient practice for failing to supervise residents and was cited for Free of Accident Hazards, Supervision, Devices and Quality Assurance and Assessment (QA&A).during survey with Event ID # 4HN11, exit date [DATE] with noncompliance cited at a scope and severity (S/S) of No actual harm with potential for more than minimal harm that is not immediate jeopardy (D). Additional during survey Event ID # 8CDC11, exit date [DATE] QA&A with noncompliance cited at a S/S of D. During survey Event ID # 4E6811, exit date [DATE] Administration was cited at S/S of Actual harm that is not immediate jeopardy (G). On [DATE], the facility was negligent and failed to provide adequate supervision and effective services to prevent harm resulting in the death of one (Resident #1) out of three sampled residents with exit seeking behaviors, resulting in Resident #1 being found deceased in a locked room in the rear of the building after twelve days of being unaccounted for. These repeated deficient practices has the potential to affect any of the residents residing in the facility. Refer to F607, F689 and F835 The findings included: Record review of the facility's Quality Assurance Performance Improvement (QAPI) Program Policy and Procedure (revised [DATE]) documented the following: Policy-It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Policy Explanation and Compliance Guidelines: 3. The QAPI plan will address the following elements: f. Process to ensure care and services delivered meet accepted standards of quality. Review of the Quality Assurance and Performance Improvement (QAPI) Committee Meeting Sign-in Sheets dated [DATE], [DATE] and [DATE] documented the facility had a QAA Committee meeting monthly. Attendees included: Administrator/Risk Manager, Human Resources Manager, Rehab Director, Business Office Manager, Infection Control and Prevention Officer, Housekeeping Director, Social Services Director, Dietitian, MDS (Minimum Data Set) Coordinator, Medical Director, Activities Director, Food Service Director, and Regional Clinical Director, Director of Nursing (DON), and Assistant Director of Nursing (ADON). (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:50 PM, the Administrator/Risk Manager/QAA stated, The QAA Committee meets every month on the second Thursday of the month. The committee consist of the Medical Director, Administrator, DON and all interdisciplinary team members and sometimes the pharmacy and a CNA. The purpose of QAA is to review systems that are in place and review the reports of each department head to see where we can improve. We prioritize our Plans of Improvement by what mostly affect residents 'safety. We report to our corporate officers. We are currently working on Elopements, AMA and QAPI. We have a system for tracking adverse incidents by keeping a log and go over it the morning meetings and we do root causes analysis and the five whys to determine the causes of the event. Staff communicate concerns to the QAA committee by coming directly to myself or attending a monthly town hall meeting that includes an open forum. We have done audits on previous AMAs for last 90 days to make sure all steps were followed and if an error is found we know to educate. .		