STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Luxe at Jupiter Rehabilitation Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Pioneer Road Jupiter, FL 33458	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 39167 Based on interview, observation, and record review, the facility failed to provide appropriate supervision to prevent an elopement, which resulted in two vulnerable residents who were able to leave the facility and travel along a busy roadway with a likelihood of being hurt, killed or lost, for 2 of 3 sampled residents reviewed for an elopement risk (Resident #1 and Resident #2). Due to the likelihood that serious injury, harm and death could've occurred with Resident #1 and #2, a finding of Immediate Jeopardy was identified. The Immediate Jeopardy noncompliance started on 11/07/24 and is determined to be ongoing. The facility's Administrator was notified of Immediate Jeopardy and given the Immediate Jeopardy Template on 11/21/24 at 11:20 AM. The findings included: 1) Clinical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Depression, and Dementia. The admission Minimum Data Set (MDS) assessment dated [DATE], documented Resident #1 with a Brief Interview for Mental Status (BIMS) score of 07, which indicted Resident #1 was severely cognitively impaired. This MDS documented Resident #1 exhibited moods including: Feeling down, depressed, or hopeless; Trouble falling asleep, staying asleep or sleeping too much. Feeling tired or having little energy. Poor appetite or overeating. Trouble concentrating on things such as reading the newspaper or watching TV. Moving or speaking so slow that other people could have noticed. Review of the physician orders dated 10/08/24, 10/09/24, 10/14/24, 10/15/24, and 11/02/24 revealed Resident #1 received the following psychotropic medications including: Donepezil oral Tablet, 5 MG (milligrams), 1 tablet by mouth at bedtime for Dementia. Quetiapine Fumarate Oral Tablet 75 MG by mouth in the evening for Dementia and Psychosis. Sertraline Oral Tablet 25 MG, give 0.5 tablet by mouth one time a day for Dementia. Memantine Oral Tablet 10 MG 1 tablet by mouth two times a day for Dementia. Mirtazapine Tablet 7.5 MG 1 tablet by mouth at bedtime for Poor Appetite secondary to Depression. Depakote Oral Tablet Delayed Release 250 MG, 1 tablet by mouth two times a day for Mood Disorder. Additional review of physician orders dated 11/06/24 documented to monitor (Resident #1) for elopement, as he has been seen in other resident's rooms. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the clinical records, including medication and treatment administration records, and progress notes revealed the physician order to monitor (Resident #1) for elopement had not been transcribed. There was no documentation of monitoring Resident #1 for elopement in the records. Review of the care plans initiated on 10/10/24 documented Resident #1 had impaired cognitive function/impaired thought processes related to a diagnosis of Encephalopathy, diagnosis of Dementia and BIMS less than 12. On 11/07/24 at approximately 11:00 PM, Resident #1 walked from the 2nd floor via the elevator, unlocked the front door and exited the building to an uneven terrain with multiple tripping hazards and a busy 6 lane road. Resident #1 was located by the police approximately 1 mile from the facility on 11/08/24 at 1:02 AM, transported to a Medical Center for evaluation and returned to the facility by transport at 5:00 AM. Review of Staff A's (Licensed Practical Nurse/LPN) written statement documented on 11/07/24 at approximately at 10 PM, Staff A provided Resident #1 with his scheduled nighttime medications. Approximately 10:30 PM, Resident #1 was seen leaving the nursing station headed towards his room. Approximately 11:00 PM, Resident #1 was not actually in his room. A search was started. At approximately 11:30 PM, the police were notified after an unsuccessful search by the staff. Review of Staff B's (Certified Nursing Assistant/CNA) written statement revealed on 11/07/24 at approximately 10:00 PM, Resident #1 was walking the hallway. Staff B told him to sit in the chair at the nursing station, as Staff B was assisting another resident to her bed. At approximately 10:10 PM, Staff B finished up with the resident and proceeded to do rounds and did not see Resident #1. At approximately 10:15 PM, Staff B notified the nurse and began to look for Resident #1. Review of Staff C's (Certified Nursing Assistant/CNA) written statement recorded on 11/07/24 at 9:50 PM revealed, Staff C was sitting in the middle of the hallway and Resident #1 approached Staff C and stated that he wanted to see a show. Staff C told Resident #1 to return to his room. Staff C called the nurse, and the nurse brought him back to his room. At 10:20 PM, another CNA informed Staff C that Resident #1 was not in his room, and the staff started searching each room and outside of the facility. On 11/19/24 at 11:30 AM, an interview was held with the Nursing Home Administrator (NHA) and an inquiry was made regarding Resident #1's elopement. The NHA explained, it was believed that Resident #1 forcefully opened the facility front door, he walked out to the sidewalk, and made a right, which leads to a small street that goes to the SWA (Solid Waste Authority). Resident #1 then made a right turn that led towards a 6-lane road. The NHA further explained the front door was locked at night after the receptionist leaves. At this time, the sensor is turned off and the sensor will not open the door, once the door is approached. One must unlock the door and physically pry the door open. On 11/19/24 at 2:20 PM, an interview was held with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). An inquiry was made regarding how the staff monitored Resident #1 for elopement, and where the monitoring for the elopement was documented. The DON voiced the staff did not see the monitor for elopement order until 11/07/24 at 7 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/19/24 at 2:33 PM, a phone interview was completed with Staff A. She voiced that she was the nurse on duty. The last time she saw Resident #1 was around 10:20 PM, in which he was at the nursing station. She further explained that typically Resident #1 comes out his room, asks for tea, then wanders to other resident's rooms. Staff A stated she kept him at the nursing station to keep an eye on him. However, at approximately 10:25 PM, she left him alone at the nursing station and went to pass medications for her other residents. The pathway Resident #1 allegedly took was walked by the Surveyor on 11/20/24 at 10:20 AM, accompanied with the NHA for approximately 3/4 of a mile and stopped at the corner of two major roads where Resident #1 allegedly turned and went further southbound. The police picked Resident #1 up between this location and a diner approximately a quarter mile up the road, located on a local six-lane road, which is a three lane each direction and very busy. During this walk with the NHA, it was noted that the path was all even sidewalks with an occasional crosswalk that sloped down slightly where it entered the road and then back up to the sidewalk. Along the sidewalk, there were mostly wooded areas and office buildings. Review of the Interdisciplinary Team (IDT) notes dated 11/08/2024 at 5:22 AM (after the resident eloped and was returned to the facility), indicated on 11/07/24 at approximately 11:00 PM, Resident #1 was not observed in his room. The local law enforcement located Resident #1, had him transported to the emergency room for evaluation, and was Resident #1 returned to the facility on [DATE] at 5:00 AM. 2) A review of Resident #2's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included: Non-Alzheimer's Dementia, Anxiety disorder, Depression, and Psychotic disorder. According to progress notes dated 11/18/24 at 7:18 PM, Resident #2 was alert with intermittent confusion. The quarterly MDS assessment, with a reference date of 10/14/24, recorded a BIMS score of 06, indicating severe cognitive impairment. Review of care plans initiated on 07/12/2024 recorded Resident #2 had a communication problem related to impairment in cognitive status, Language Barrier. She required an interpreter. Resident #2 had a diagnosis of Dementia, and further decline was expected with the progression of disease processes. On 11/16/24 at 12:45 AM, Resident #2 walked and walked down 3 flights of stairs via stairwell and exited to a sidewalk with uneven terrain with multiple tripping hazards. The resident was located across the street at a Rehabilitation Hospital at 1:33 AM (this is a small street with a crosswalk between facilities, which is not on the same property) and returned to the facility by the police at 1:33 AM. Review of Resident #2's progress notes, dated 11/16/24 revealed the following: -Evening shift - resident was seen in room periodically throughout the evening. No concerns were noted. No exit seeking behaviors. -12:00 AM - Resident was toileted and returned to bed. -12:30 AM - Resident was in bed with eyes closed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe at Jupiter Rehabilitation Center (the)	674 Pioneer Road Jupiter, FL 33458

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

-12:45 AM - Resident was not in her room.

-1:00 AM-Resident was not in her room, wheelchair near bed, walker at the foot of her bed.

-1:14 AM-Nurse went outside in front of the center and informed [the Receptionist] that the resident was missing. Immediately started searching all rooms and informed co-workers.

-1:16 AM-Code orange announced. Elopement search initiated.

-1:19 AM-Texted DON (Director of Nursing).

-1:25 AM-911 called by the receptionist at the Rehab Hospital. She had found the resident outside the front doors and called the nurse manager at the facility. (No police report because the resident was brought right back).

-1:30 AM - Provided police with resident's face sheet.

-1:33 AM - Police confirmed they had the resident and drove her back to the center. The resident was calm and smiling. Two officers helped her out of the police car and walked her to the front door. The resident was wearing pajamas and wrapped in a blanket.

-1:35 AM - Nurse escorted the resident to her room via wheelchair. She was pleasant and calm. Assessment completed, no skin impairments or pain noted.

-1:40 AM-Thorough investigation was initiated, including interviews, reenactment, resident assessment, and a review of employee files and resident's medical record.

Review of a psychiatric note dated 11/17/2024 at 00:00 (midnight), documented [Resident #2] was alert and oriented times one, on/off confused. Resident #2 reported that last night she was walking by herself and got out the facility by the stairs. Reported she just wanted to walk as usual around the facility because she walks every day with caregiver.

An interview was held with the NHA on 11/19/24 at 3:11 PM, who reported that after the elopement involving Resident #1, the facility conducted full house elopement risk assessments on all residents. During the assessment there were two residents identified, and they were relocated to reside on the third floor. He further stated that Resident #2 has been in the facility since July 2024 and she likes to wander and because of her lower BIMS score, the facility moved her to the 3rd floor. He added that a lot of changes have occurred with Resident #2. She had a change in environment, she had a memory deficit, the psychiatrist has changed her medications, her daughter visited from [another state] they took her out, so that created a lot of stimulation for her. She was able to walk, she was doing better in therapy, she went out looking for her niece. When the facility interviewed her regarding the elopement incident, she said she took the stairs from the 3rd floor to elope. It was revealed that the staff called the NHA around 12 AM, reported they were looking for Resident #2, and she was later found at the post-acute rehab across from the facility. The NHA stated, Resident #2 did not elope through the front door, she went out through the side doors. He explained that if the side doors are pushed for 15 seconds, they will automatically open. He further added that after the elopement involving Resident #1, screamer alarms were added to the exit doors of the facility to alert staff when the doors are opened.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/22/24 beginning at 10:47 AM, a tour of the entire facility was conducted with the Maintenance Director, checking on all exit doors in the facility starting from the 3rd floor. At 11:06 AM, the Maintenance Director accompanied the two surveyors to the exit door at the stair well in the back of the building on the 3rd floor, near the elevator, and it was checked. When the Maintenance Director pushed on the door, the screamers sounded very loud, and the alarms went off. No staff responded to the sound of the alarms. Despite corrections were put in place after the elopements, the staff failed to respond to the sound of the exit alarms. On 11/22/24 at 11:10 AM, the stairwell where Resident #2 allegedly eloped was checked. Director. When the Maintenance Director pushed on the door after 15 seconds, the screamers went off, sounded very loud. No staff responded to the sound of the alarm. Despite corrections were put in place after the elopements, the staff failed to respond to the sound of the exit alarms. On 11/22/24 at 11:21 AM, the exit door/stairwell at the second floor was checked. The Maintenance Director pushed on the door; the alarms sounded. Despite corrections were put in place after the elopements, the staff failed to respond to the sound of the exit alarms. On 11/22/24 at 11:26 AM, the exit door/stairwell was checked at the second floor. The Maintenance Director pushed on the door; the alarms sounded. Despite corrections were put in place after the elopements, the staff failed to respond to the sound of the exit alarms. On 11/22/24 at 11:29 AM, a tour began at the first floor to check the exit doors at the stairwell. When the Maintenance Director pushed on the first exit door, the alarm sounded. Despite corrections were put in place after the elopements, the staff failed to respond to the sound of the exit alarms. On 11/22/24 at 11:33 AM, an observation was made of the alarmed door that led into the kitchen. This alarmed door was observed propped wide open. Further observation revealed there was a dietary office located inside of the kitchen that had a door leading to the outside of the facility, which was not alarmed. The main kitchen exit door leading to the outside exterior grounds of the facility was also not alarmed. It was noted that during this observation, there were no kitchen staff present, which would have allowed any resident to exit the building unnoticed. On 11/22/24 at 11:38 AM, the exit door that led to the parking lot was checked at the first floor. When the Maintenance Director pushed on the door, the alarms went off. Despite corrections were put in place after the elopements, the staff failed to respond to the sound of the exit alarms. On 11/22/24 at 11:42 AM, during the tour, an inquiry was made regarding the lack of response by the staff when the alarms sounded. The Maintenance Director confirmed this concern and stated that he would need to conduct additional in-services, regarding the staff's lack of response to the door alarms. On 11/22/24 at 2:34 PM, another observation of the exit door that led to the kitchen was conducted. This door was still wide open after it was brought to the Maintenance Director's attention at the time of the tour.