STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401

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 **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** Based on interview and record review, the facility failed to provide necessary supervision and monitor the effectiveness of interventions for a resident with dementia and known behaviors including wandering, entering other resident rooms, physical aggression, inappropriate behaviors towards female residents, and exit seeking, for 1 of 1 residents (Resident #1) reviewed for an elopement out of 3 residents listed in the facility's Adverse Incident log. The resident was able to elope from the facility on April 11, 2020 and was found by police at a nearby shopping center. Upon return to the facility after an evaluation at the hospital, the resident was observed with swelling to the face and knuckles, abrasions, discoloration, and scratches. He was discharged from the facility on April 16, 2020 related to another incident with a female resident after returning to the secured unit. The facility's failure to adequately address Resident #1's behavior of unsafe wandering and exit seeking, including the provision of needed supervision, resulted in the finding of Immediate Jeopardy, past non-compliance on 04/11/2020. The Immediate Jeopardy was determined to be corrected on 04/20/2020, prior to the survey. The findings included: Review of the facility's policy titled: Abuse Prohibition Policy and Procedure (effective date: March 2015 and revision date: January 2018) showed: Neglect: Neglect is the failure of the center, 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. Review of the facility's policy titled: Risk Management: Elopement Risk (effective date: April 2006 and revision date: March 2016) showed: 1. If the resident is identified as an elopement risk based on the evaluation, a care plan will be developed to reduce elopement risk. Center staff will provide supervision and engage the resident as needed to minimize wandering or exit seeking behavior according to the plan of care. Elopement occurs when a resident who needs supervision leaves a safe area without supervision. Review of Resident #1's clinical record on 04/23/2020 showed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Admission Nursing assessment dated [DATE] showed his behavioral concerns included: Confusion/forgetfulness; [DIAGNOSES REDACTED]. Resident #1 was admitted with an order for [REDACTED]. Review of Resident #1's Quarterly Minimum Data Set assessment dated [DATE] showed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, showing severe cognitive impairment. Review of Resident #1's comprehensive care plans included: -(Resident #1) has Wandering Behavior and is at risk for Elopement related to: history of wandering through hallways. (Date initiated: 11/07/2019) Goal: (Resident #1) will have physical, emotional, and psychological needs met as evidenced by reduction in behaviors or decreased wandering. (Date initiated 11/07/2019) Goal: (Resident #1) will be protected from elopement and unsafe wandering through next review. (Date initiated: 01/24/2020) Interventions: Ensure environment is clutter free (Date initiated 01/24/2020) Ensure resident identifier is in place (Date initiated: 11/17/2019 and Date created: 12/16/2019) Include staff in information processes for observances for cues to behavior (Date initiated: 01/24/2020) Observe for wandering that effects other and redirect as needed. (Date initiated 01/24/2020) Wander guard (Date initiated: 11/17/2019 and Date created: 12/16/2019) -(Resident #1) has impaired cognition as evidenced by: Decision making problem/Short term memory deficit/Long term memory deficit/Problems understanding others. (Date initiated: 10/13/2019) -(Resident #1) is at risk for falls related to: [DIAGNOSES REDACTED]. (Date initiated 01/11/2019) Review of Resident #1's clinical record on 04/23/2020, and a subsequent request made on 04/24/2020 for all of Resident #1's comprehensive care plans, showed no care plans were found addressing exhibited behaviors such as physical aggression, inappropriate behaviors towards female residents, and wandering into other resident rooms. The care plans reviewed did not describe the type or frequency of supervision needed to address Resident #1's wandering, including into other resident rooms while on the secured unit, or show any change in level of supervision needed when he was transferred to the unsecured unit. His care plan for wandering behavior showed an intervention for a wanderguard but was not revised when it was discovered he could remove the wanderguard prior to his elopement. Review of Resident #1's January 2020 Progress Notes showed: -1/18/2020 Resident #1 was found in (room #) without clothes in bed. He was given his clothes and redirected to his room. He refused to leave and became physically abusive to a female resident hitting her on her hand. He stated he will kill staff. -1/18/2020 Resident #1 seen by Dr., new order [MEDICATION NAME]-1/24/2020 Resident #1 was combative, going room to room looking after the woman, all meds given as per ordered, not effective Review of Resident #1's Physican's Orders for January 2020 showed: -1/18/2020 Send resident to hospital for Altered Mental Status. Physical Aggression and Hitting other resident -1/18/[MEDICATION NAME] 5 milligrams give 1 tablet by mouth at bedtime for [MEDICAL CONDITION] -1/24/2020 Resident meets criteria for gated 100 unit Review of Resident #1's Elopement Risk Scale dated 1/24/2020 showed Resident #1 is ambulatory, expresses a desire and plans to leave, has a strong identification with past roles, has 2 or more attempts to leave the facility in last 90 days, has a medical [DIAGNOSES REDACTED]. His score was 17 indicating high risk for elopement. Care planning section showed one intervention marked: include staff in information process for observances for cues to behavior. Review of Resident #1's February 2020 progress notes showed: -2/26/2020 Ambulated up and down the hallway throughout entire 11-7 shift resident redirected, offered fluids, toileted and allowed time to vent. No change in behavior. Review of Resident #1's March 2020 progress notes showed: -3/7/2020 Resident #1 was sitting in the dining room. A female resident came and waved her finger at his face. Resident #1 then kicked the resident's leg. The other resident swung her purse at him. Staff intervened and removed the aggressor. Resident #1 grabbed a wet floor sign and attempted to hit the aggressor. -3/23/2020 Observed pushing and punching another resident on the floor. Biting on staff member. Resident pacing the floor backwards and forward in an aggressive behavior. Awake alert and confused, broken glass in resident room and trying to get out of lock down unit. Recommendation: Send resident to ER intake for psych -3/24/2020 Returned to facility. Interdisciplinary Team meeting with new interventions to include a complete review of resident medications, psych consult, and resident will be removed from unit and placed on the 400 unit with a wanderguard. -3/26/2020 Wandering on floor, shift had to continue to redirect him -3/28/2020 Resident #1 made two attempts to escape floor, with the second nearly ended with resident taking north stair, but stopped by other nurse and aide. After giving some sleeping aids and redirecting back to bed, remained there for the duration of the night. -3/30/2020 Resident wanderguard was not in place Review of the Federal Immediate Report submitted by the facility for the 03/24/2020 incident showed: According to staff reports on 03/24/2020 at approximately 00.15 AM, (Resident #1) and (female resident) were having an altercation; both residents reside in the secured/dementia unit of this facility. They were observed screaming at each other and (Resident #1) attempted to hit (female resident); staff members immediately intervened and separated both residents. (Resident #1) tried to bite and punch staff members when they tried to redirect him. (Resident #1) was sent to the hospital for aggressive behaviors. (Female resident) had a thorough skin assessment performed, no bruises or other injuries noted or reported. Investigation began in facility. Review of the Federal 5 Day Report submitted by the facility showed: (Resident #1) is a [AGE] year old male who was admitted to this facility in

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401

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 **Residents Affected -** Few	(continued... from page 1) October 2019 for long-term care in the secured unit. He has a history of kidney failure, hypertension, dementia, muscle weakness and [MEDICAL CONDITION]. He is alert with confusion and has a BIMs of 7. Upon investigation, on 3/24/2020 at approximately 00.15 AM both (Resident #1) and (female resident) were observed screaming at each other. Staff tried to redirect both residents, at this time (Resident #1) became aggressive an attempted to hit (female resident) and the staff. Both residents were separated immediately. (Resident #1) was sent to the hospital for aggressive behaviors. (Resident #1) returned to this facility a few hours later. He was moved to another floor and a wanderguard placed on his ankle for monitoring. (Female resident) remained in the secured unit with close supervision. Based upon investigation, chart review and staff interviews; this facility cannot substantiate this incident as abuse. Actions taken by the facility showed: DCF and family notified Residents separated Skin assessment Wanderguard placed on (Resident #1) (Resident #1) moved to another floor Review of Resident #1's physician's orders [REDACTED].#1's April 2020 progress notes showed: -4/2/2020 Confused noted being combative and pushing staff. Writer personally bathed patient for staff protection as patient was covered in dried feces. meds well tolerated patient noted resting for 2 hours before wandering. hourly rounds done due to patient not having wanderguard -4/4/2020 Received resident resting from another room for at least two hours and then wake up. Resident was wandering, redirected him to his room and then resting for the of the night -4/11/2020 Resident was observed on unit most part of the shift. Resident is very agitated/energetic, constantly wandering down the hall. Redirection was given several times/unsuccessfully. Around 2030, the nursing staff became aware of Resident's disappearance by the Nursing Supervisor. -4/11/2020 Change of Condition form. Room search was done after 911 call, alarm was sounding on 400 wing stair exit door. Police notified the facility that resident was walking in the parking lot at (local shopping plaza), awake alert and confused. Police officer had him in the back of squad car, ambulance called, and resident transferred to (hospital) via 911 ambulance for evaluation and treatment. MD and family member notified. -Late Entry for 4/11/2020 (created 04/14/2020) Patient alert with confusion noted. Patient transferred from 400 wing. Patient has abrasion to right shoulder with redness noted and right cheekbone is red and swollen. Right hand swollen/knuckles are bruised with discoloration noted. -4/12/2020 returned from (hospital) Diagnosis: [REDACTED].Resident received with facial raised area/swollen to right cheekbone. Right shoulder abrasion, red with no bleeding present. Right hand swollen, knuckles with discoloration Resident with no wanderguard on, will address in AM. -4/12/2020 Xrays and CT scan reveal no abnormal structures or fractures .resident roamed halls and entered other room. Tried redirecting many times but continued to persist on eloping. Forcibly removed wanderguard. -4/13/2020 Received resident alert but with confusion, wandering hallways and touching exit doors constantly. A bruise was noted just below right eye, same appears to be healing well. Right fingers noted to be swollen with small bruises on same, bruises. scratches noted near left elbow .Resident was seen in (room #) at 21:00 shaking the resident in (room #'s) TV. No picture can be seen on TV when turned on .Resident was medicated as per Medication Administration Record [REDACTED]. -4/14/2020 Resident alert and confused he wanders all over the floor he's in and out of resident's room. He removed his wanderguard. -4/14/2020 Became combative early in the morning. was redirected and wanderguard placed on right ankle. Patient was calm during this time/placing wanderguard on ankle. -4/16/2020 Risk Manager was informed by a female resident that Resident #1 came into her room last night on 4/15/2020 and pulled down his pants .she stated she was going to scream and that is when he left. -4/16/2020 Social Worker informed Resident #1's family member that the facility is no longer able to meet the needs of resident .Resident #1 wanders into other residents' room taking items that do not belong to him -4/16/2020 resident discharged to an assisted living facility Review of the facility's Adverse Incident report to the State related to Resident #1's elopement dated 04/16/2020 showed: (Resident #1) is a [AGE] year-old male who was admitted to this facility in October of 2019 for long-term care in the secured unit. He has a history of kidney failure, hypertension, dementia, muscle weakness and [MEDICAL CONDITION]. He is alert with confusion and has a BIMs of 7. (Resident #1) had engaged in an altercation with a female resident on 3/24/2020 and as a result was referred to the hospital for evaluation of physical aggression and psychotic behaviors. Upon his readmission, he was placed on the short term Covid 19 monitoring unit as required by law for 14 days in an attempt to manage the spread of the Covid 19 pandemic from new hospital admissions and readmissions. After readmission, (Resident #1) presented with no symptoms and was managed on the 400 unit with a wander guard and close supervision away from the secured unit. After the 14 days he was not returned to the secured unit because the victim from the previous altercation still resides there. On (DATE), the facility transferred (Resident #1) to the 200 wing long-term care unit with a wander guard and under close supervision by staff. The resident was stable and was kept engaged through one to one activities with several departments within the facility during the day. On Saturday April 11th, at approximately 2030, the nursing staff became aware that the resident was not on the 200 wing. The supervisor was notified as soon as the resident was noted to be missing. A room search and a facility search were initiated immediately. The search was in progress when the facility received a phone call from the police asking if there was a missing resident. The supervisor verbally identified the resident for the police officer. The officer said the resident was found wandering in a nearby parking lot. The resident was brought to the facility by the officer who requested a face sheet. The face sheet was provided, an ambulance was called, and the resident transferred to (hospital) via 911 for evaluation and treatment. An interview was conducted with Registered Nurse A (RN A), who was familiar with Resident #1 while he resided on the secured unit, on 04/23/2020 at 3:10 PM. RN A stated Resident #1 wandered a lot. On a typical day he is always back and forth and back and forth the halls. He was going to exits and pushing. She stated she works on the locked unit normally the doors alarm. He does this constantly. Wanderguards work everywhere. She stated Resident #1 had a female resident on the locked unit who followed him around. He would go in her room when she was on that side where he was. After that they moved her to the other hall. The locked unit is two halls. She stated staff know him so they watch him closely. She explained we know how he is and he has to always be in someone's sight, nurses and CNAs (Certified Nursing Assistant). An interview was conducted with CNA B on 04/23/2020 at 3:47 PM. CNA B was assigned to Resident #1 the day he eloped. She stated 'everybody on the floor was watching on him'. After he finished eating all his food she went to assist another resident. The remaining staff were watching him. She stated when she finished she did not see him. Staff started checking the building but every door was closed. By the time staff were looking for him the Supervisor called to say the police called. She stated the door in the 400 unit had an alarm but no one was in the 400 unit to hear it. She stated she only worked with Resident #1 after he was transferred to the 200 hall but knew he walked around alot and tried to leave. An interview was conducted with CNA C on 04/23/2020 at 3:53 PM. CNA C was working on the 200 unit when Resident #1 eloped. She stated Resident #1 always walked back and forth and she would redirect him to sit down. She stated staff knows where he is and when she would pass by him she would keep her eyes on him. An interview was conducted with Licensed Practical Nurse D (LPN D) on 04/23/2020 at 4:04 PM. LPN D was listed as the nurse on the 200 unit when Resident #1 eloped. She stated Resident #1 did not stay still and would go up and down the hallway. He would always go into other residents' rooms. She administered his [MEDICATION NAME] at 6 PM. He was still very agitated and it was ineffective. She stated he was always at the doors trying to leave. She stated he ate dinner and by 7:30 PM staff picked up the trays. He was still pacing the halls. At 8 PM staff started looking for him because they realized he wasn't there. He does not stay in his room. Staff always see him because he is near the nurse's station. He removed his wanderguard. The doors have alarms but the alarm to the 400 unit exit door was not heard all the way in the 200 unit. He has a steady gait. She stated there were no problems between Resident #1 and any residents on the 200 unit except he did wander into other residents' rooms and some may yell. She stated she was aware of his behaviors and that he doesn't stay still. Normally they do not have that type of resident in the 200 unit. An interview was conducted with the Executive Director, Director of Clinical Services, Risk Manager, and Assistant Executive Director on 04/23/2020 at 4:18 PM. The Director of Clinical Services explained that Resident #1 was on the locked unit at first but because he had the altercation he was transferred to the other unit. She stated Resident #1 and (female resident) had a little thing going but staff thought it was okay. The attraction became more aggression. Staff have seen them argue with each other but they let it slide. It was noted the interactions became more aggressive. (Female resident) would approach him and hit him with her purse. The facility reported the March 23 incident as resident-to-resident. The doctor re-evaluated him and sent him to the hospital. He was not kept and when he came back he was placed on the mandatory 14 day quarantine on the 400 unit. He was kept busy and a wanderguard placed. Staff knew he was a risk but he had never actually eloped. She stated staff found they could keep him busy with a broom because of his former job in a factory. Resident #1 and (female resident) were kept on separate areas. Resident #1 was sent to the 200 unit to separate him because they did know what would happen if he returned to the locked unit. The 400 unit was empty and staff never could have surmised that he would find his way all the way to the 400 hall. Everyone was aware of behaviors and redirected him with wanderguard on. The Risk Manager stated at some point he took his wanderguard off. The Director of Clinical Services stated they decided to put him back on the secured unit after his elopement. Resident #1 was discharged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	**300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401**

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 **Residents Affected -** Few	(continued... from page 2) from the facility for another behavior. She stated when he eloped the police called to advise the facility they had Resident #1 while staff were still searching the building. The Risk Manager stated the police did not return Resident #1 to the facility but took him directly to the hospital and did not tell the facility why. She stated he did not have injuries prior to eloping. The Director of Clinical Services explained the facility allocated the 400 unit for a 14 day quarantine after returning from the hospital. There were other residents on the unit at the time Resident #1 was there. Since that time the 400 unit was closed to consolidate staff and residents. She stated Resident #1 is fast and steady on his feet. The Risk Manager stated the only time they noticed the wanderguard was not on him was when he eloped. The Director of Clinical Services stated Resident #1 was transferred from the facility after an incident with another female resident. She stated staff previously found Resident #1 in bed with (female resident) a few times and separated them. Nothing happened and he was fully clothed at the time. She stated initially she thought they were just holding hands but when it became aggressive then staff moved the residents to opposite halls. They would find each other in the morning and hold hands. But then it became aggressive. The Risk Manager stated Resident #1 had taken off his wanderguard the day he eloped. The alarm to the door went off but because it was so far away the staff did not hear it until they searched for him. Resident #1 walked from the 200 wing where he was admitted and walked to the 400 wing where he previously stayed. He found the back exit and went out to the parking lot. He was about 5 minutes away, 2 blocks in a straight line. She stated during their investigation Administrative staff re-enacted the steps. The staff on the unit that day did not see him walking to the 400. They said he was at the nurses station to be monitored. The CNA went to give care and when she came out she did not see him. The Director of Clinical Services stated since his elopement they put an alarm on the double doors on the 400 unit and a plastic zippered curtain at the entrance to the hall. She stated the facility was trying to keep both safe and both in the facility, Resident #1 and (female resident). He did not have the wanderguard while on the locked unit because he did not need it. She stated the doors throughout the facility have wanderguard alarms. She stated staff just had close supervision and tried to engage him in activities during the day time. He did well on 400 hall. He liked to clean. He was not on the 200 unit long. He was on the 400 unit for a longer period of time. He had done excellent on 400. He was happier on the 400. He wanted to sleep and clean. Review of Resident #1's progress notes and April 2020 MAR indicated [REDACTED]. He was documented as being able to remove it. Review of the Police Report on 04/28/2020 showed a call was made to the Police Department on 04/11/2020 around 08:49 PM from a nearby residence. Upon arrival, police observed Resident #1 on the sidewalk where he had been for approximately 10 minutes. Resident #1 was observed with a knot on his head and was described as confused and possibly lost. Emergency Services was called but Resident #1 began walking away towards the shopping plaza. Police also noted a hand injury. Emergency Services was called again. The Facility's actions to remove the Immediate Jeopardy included: 1) Resident #1 was placed back on the secured unit upon return from the hospital on [DATE]. A full body assessment was completed for Resident #1 upon return from the hospital. 2) All current residents with a [DIAGNOSES REDACTED]. No other residents were identified as an elopement risk except the residents currently on the secured unit. 3) An elopement drill was conducted with staff on 04/13/2020. 4) All exit door maglocks were inspected on 04/13/2020 to ensure proper functioning. 5) An additional alarm was placed on the double doors leading to the closed unit to make the alarm sound more audible on 04/13/2020. Nursing Supervisors were inserviced on 04/13/2020 regarding the new alarm on the double doors. 6) A zippered plastic partition was placed in the hallway of the closed unit as an additional barrier. 7) An ad hoc QAPI meeting was conducted on 04/13/2020 that included the Executive Director, the Director of Clinical Services, the Medical Director, the Assistant Executive Director, the Director of Quality Assurance, and other department heads. A Performance Improvement Plan was established. The corrective actions included: 1) Follow-up QAPI/Risk Management meetings were conducted on 04/16/2020 and 04/20/2020. 2) Residents with behaviors towards other residents were identified and interventions reviewed and revised beginning on 04/13/2020. 3) Administration completed daily checks of the newly installed door alarm. 4) Additional staff on Leave of Absence (LOA) or in quarantine were educated on elopement procedures via telephone and additional staff onsite beginning 04/14/2020 through 04/16/2020. As of 04/16/2020 the following portion of the facility's staff were educated about elopement procedures: 50 out of 77 CNAs, 25 out of 28 LPNs, 28 out of 38 RNs, 19 out of 23 staff listed under Administration, 11 out of 18 Environmental Services staff, 7 out of 20 culinary staff, and 12 rehabilitation staff. 4) New employee orientation packets for certified nursing assistants include information and quizzes regarding dementia care and elopement. Random staff interviews conducted by Surveyor confirmed knowledge of elopement procedures. Interviews conducted in person and via phone were conducted as follows: On 04/29/2020 from 02:25 PM until 04:06 PM, 2 CNAs and 2 RNs. On 04/30/2020 beginning at 01:31 PM, 1 Respiratory Therapist, 1 Social Services staff, 1 Medical Records staff, 1 Housekeeping staff, 1 Administrative staff, 4 RNs, 1 LPN, and 2 CNAs. An initial tour conducted on 04/23/2020 revealed the alarm to the double doors was in place leading to the closed unit and the zippered plastic partition was also in place further down the hall. A subsequent tour on 04/30/2020 revealed the alarm and barrier remained in place. No residents were observed actively exit seeking on 04/23/2020 or on 04/30/2020. Immediate Jeopardy was determined to be past non-compliance, corrected on 04/20/2020.
F 0657 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor the effectiveness of interventions and revise a resident's comprehensive care plans for a resident with dementia and known behaviors including wandering, entering other resident rooms, physical aggression, inappropriate behaviors towards female residents, and exit seeking, for 1 of 1 residents (Resident #1) reviewed for an elopement out of 3 residents listed in the facility's Adverse Incident log. The resident was able to elope from the facility on April 11, 2020 and was found by police at a nearby shopping center. Upon return to the facility after an evaluation at the hospital, the resident was observed with swelling to the face and knuckles, abrasions, discoloration, and scratches. He was discharged from the facility on April 16, 2020 related to another incident with a female resident after returning to the secured unit. The facility's failure to adequately address Resident #1's behavior of unsafe wandering and exit seeking resulted in the finding of Immediate Jeopardy, past non-compliance on 04/11/2020. The Immediate Jeopardy was determined to be corrected on 04/20/2020, prior to the survey. The findings included: Review of the facility's policy titled: Risk Management: Elopement Risk (effective date: April 2006 and revision date: March 2016) showed: 1. If the resident is identified as an elopement risk based on the evaluation, a care plan will be developed to reduce elopement risk. Center staff will provide supervision and engage the resident as needed to minimize wandering or exit seeking behavior according to the plan of care. Elopement occurs when a resident who needs supervision leaves a safe area without supervision. Review of Resident #1's clinical record on 04/23/2020 showed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Admission Nursing assessment dated [DATE] showed his behavioral concerns included: Confusion/forgetfulness; [DIAGNOSES REDACTED]. Resident #1 was also admitted with an order for [REDACTED]. Review of Resident #1's comprehensive care plans included: -(Resident #1) has Wandering Behavior and is at risk for Elopement related to: history of wandering through hallways. (Date initiated: 11/07/2019) Goal: (Resident #1) will have physical, emotional, and psychological needs met as evidenced by reduction in behaviors or decreased wandering. (Date initiated 11/07/2019) Goal: (Resident #1) will be protected from elopement and unsafe wandering through next review. (Date initiated: 01/24/2020) Interventions: Ensure environment is clutter free (Date initiated 01/24/2020) Ensure resident identifier is in place (Date initiated: 11/17/2019 and Date created: 12/16/2019) Include staff in information processes for observances for cues to behavior (Date initiated: 01/24/2020) Observe for wandering that effects other and redirect as needed. (Date initiated 01/24/2020) Wander guard (Date initiated: 11/17/2019 and Date created: 12/16/2019) -(Resident #1) has impaired cognition as evidenced by: Decision making problem/Short term memory deficit/Long term memory deficit/Problems understanding others. (Date initiated: 10/13/2019) -(Resident #1) is at risk for falls related to: [DIAGNOSES REDACTED]. (Date initiated 01/11/2019) Review of Resident #1's clinical record on 04/23/2020, and a subsequent request made on 04/24/2020 for all of Resident #1's comprehensive care plans, showed no care plans were found addressing exhibited behaviors such as physical aggression, inappropriate behaviors towards female residents, and wandering into other resident rooms. The care plans reviewed did not describe the type or frequency of supervision needed to address Resident #1's wandering, including into other resident rooms while on the secured unit, or show any change in level of supervision needed when he was transferred to the unsecured unit. His care plan for wandering behavior showed an intervention for a wanderguard but was not revised when it was discovered he could remove the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	**300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401**

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 0657 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) wanderguard prior to his elopement. Review of Resident #1's January 2020 Progress Notes showed: -1/18/2020 Resident #1 was found in (room #) without clothes in bed. He was given his clothes and redirected to his room. He refused to leave and became physically abusive to a female resident hitting her on her hand. He stated he will kill staff. -1/18/2020 Resident #1 seen by Dr., new order [MEDICATION NAME]-1/24/2020 Resident #1 was combative, going room to room looking after the woman, all meds given as per ordered, not effective Review of Resident #1's physician's orders [REDACTED]. Physical Aggression and Hitting other resident -1/18/[MEDICATION NAME] 5 milligrams give 1 tablet by mouth at bedtime for [MEDICAL CONDITION] -1/24/2020 Resident meets criteria for gated 100 unit Review of Resident #1's Elopement Risk Scale dated 1/24/2020 showed: -Resident #1 is ambulatory, expresses a desire and plans to leave, has a strong identification with past roles, has 2 or more attempts to leave the facility in last 90 days, has a medical [DIAGNOSES REDACTED]. -His score was 17 indicating high risk for elopement. -The care planning section showed one intervention marked: include staff in information process for observances for cues to behavior. Review of Resident #1's February 2020 progress notes showed: -2/26/2020 Ambulated up and down the hallway throughout entire 11-7 shift resident redirected, offered fluids, toileted and allowed time to vent. No change in behavior Review of Resident #1's March 2020 progress notes showed: -3/7/2020 Resident #1 was sitting in the dining room. A female resident came and waved her finger at his face. Resident #1 then kicked the resident's leg. The other resident swung her purse at him. Staff intervened and removed the aggressor. Resident #1 grabbed a wet floor sign and attempted to hit the aggressor. -3/23/2020 Observed pushing and punching another resident on the floor. Biting on staff member. Resident pacing the floor backwards and forward in an aggressive behavior. Awake alert and confused, broken glass in resident room and trying to get out of lock down unit. Recommendation: Send resident to ER intake for psych -3/24/2020 Returned to facility. Interdisciplinary Team meeting with new interventions to include a complete review of resident medications, psych consult, and resident will be removed from unit and placed on the 400 unit with a wanderguard. -3/26/2020 Wandering on floor, shift had to continue to redirect him -3/28/2020 Resident #1 made two attempts to escape floor, with the second nearly ended with resident taking north stair, but stopped by other nurse and aide. After giving some sleeping aids and redirecting back to bed, remained there for the duration of the night. -3/30/2020 Resident wanderguard was not in place Review of the Federal Immediate Report submitted by the facility for the 03/24/2020 incident showed: According to staff reports on 03/24/2020 at approximately 00.15 AM, (Resident #1) and (female resident) were having an altercation; both residents reside in the secured/dementia unit of this facility. They were observed screaming at each other and (Resident #1) attempted to hit (female resident); staff members immediately intervened and separated both residents. (Resident #1) tried to bite and punch staff members when they tried to redirect him. (Resident #1) was sent to the hospital for aggressive behaviors. (Female resident) had a thorough skin assessment performed, no bruises or other injuries noted or reported. Investigation began in facility. Review of the Federal 5 Day Report submitted by the facility showed: (Resident #1) is a [AGE] year old male who was admitted to this facility in October 2019 for long-term care in the secured unit. He has a history of kidney failure, hypertension, dementia, muscle weakness and [MEDICAL CONDITION]. He is alert with confusion and has a BIMs of 7. Upon investigation, on 3/24/2020 at approximately 00.15 AM both (Resident #1) and (female resident) were observed screaming at each other. Staff tried to redirect both residents, at this time (Resident #1) became aggressive an attempted to hit (female resident) and the staff. Both residents were separated immediately. (Resident #1) was sent to the hospital for aggressive behaviors. (Resident #1) returned to this facility a few hours later. He was moved to another floor and a wanderguard placed on his ankle for monitoring. (Female resident) remained in the secured unit with close supervision. Based upon investigation, chart review and staff interviews; this facility cannot substantiate this incident as abuse. Actions taken by the facility showed: DCF and family notified Residents separated Skin assessment Wanderguard placed on (Resident #1) (Resident #1) moved to another floor Review of Resident #1's physician's orders [REDACTED].#1's April 2020 progress notes showed: -4/2/2020 Confused noted being combative and pushing staff. Writer personally bathed patient for staff protection as patient was covered in dried feces. meds well tolerated patient noted resting for 2 hours before wandering. hourly rounds done due to patient not having wanderguard -4/4/2020 Received resident resting from another room for at least two hours and then wake up. Resident was wandering, redirected him to his room and then resting for the of the night -4/11/2020 Resident was observed on unit most part of the shift. Resident is very agitated/energetic, constantly wandering down the hall. Redirection was given several times/unsuccessfully. Around 2030, the nursing staff became aware of Resident's disappearance by the Nursing Supervisor. -4/11/2020 Change of Condition form. Room search was done after 911 call, alarm was sounding on 400 wing stair exit door. Police notified the facility that resident was walking in the parking lot at (local shopping plaza), awake alert and confused. Police officer had him in the back of squad car, ambulance called, and resident transferred to (hospital) via 911 ambulance for evaluation and treatment. MD and family member notified. -Late Entry for 4/11/2020 (created 04/14/2020) Patient alert with confusion noted. Patient transferred from 400 wing. Patient has abrasion to right shoulder with redness noted and right cheekbone is red and swollen. Right hand swollen/knuckles are bruised with discoloration noted. -4/12/2020 returned from (hospital) Diagnosis: [REDACTED].Resident received with facial raised area/swollen to right cheekbone. Right shoulder abrasion, red with no bleeding present. Right hand swollen, knuckles with discoloration Resident with no wanderguard on, will address in AM. -4/12/2020 Xrays and CT scan reveal no abnormal structures or fractures .resident roamed halls and entered other room. Tried redirecting many times but continued to persist on eloping. Forcibly removed wanderguard. -4/13/2020 Received resident alert but with confusion, wandering hallways and touching exit doors constantly. A bruise was noted just below right eye, same appears to be healing well. Right fingers noted to be swollen with small bruises on same, bruises. scratches noted near left elbow .Resident was seen in (room #) at 21:00 shaking the resident in (room #'s) TV. No picture can be seen on TV when turned on .Resident was medicated as per Medication Administration Record [REDACTED]. -4/14/2020 Resident alert and confused he wanders all over the floor he's in and out of resident's room. He removed his wanderguard. -4/14/2020 Became combative early in the morning. was redirected and wanderguard placed on right ankle. Patient was calm during this time/placing wanderguard on ankle. -4/16/2020 Risk Manager was informed by a female resident that Resident #1 came into her room last night on 4/15/2020 and pulled down his pants .she stated she was going to scream and that is when he left. -4/16/2020 Social Worker informed Resident #1's family member that the facility is no longer able to meet the needs of resident .Resident #1 wanders into other residents' room taking items that do not belong to him -4/16/2020 resident discharged to an assisted living facility Review of the facility's Adverse Incident report to the State related to Resident #1's elopement dated 04/16/2020 showed: (Resident #1) is a [AGE] year-old male who was admitted to this facility in October of 2019 for long-term care in the secured unit. He has a history of kidney failure, hypertension, dementia, muscle weakness and [MEDICAL CONDITION]. He is alert with confusion and has a BIMs of 7. (Resident #1) had engaged in an altercation with a female resident on 3/24/2020 and as a result was referred to the hospital for evaluation of physical aggression and psychotic behaviors. Upon his readmission, he was placed on the short term Covid 19 monitoring unit as required by law for 14 days in an attempt to manage the spread of the Covid 19 pandemic from new hospital admissions and readmissions. After readmission, (Resident #1) presented with no symptoms and was managed on the 400 unit with a wander guard and close supervision away from the secured unit. After the 14 days he was not returned to the secured unit because the victim from the previous altercation still resides there. On (DATE), the facility transferred (Resident #1) to the 200 wing long-term care unit with a wander guard and under close supervision by staff. The resident was stable and was kept engaged through one to one activities with several departments within the facility during the day. On Saturday April 11th, at approximately 2030, the nursing staff became aware that the resident was not on the 200 wing. The supervisor was notified as soon as the resident was noted to be missing. A room search and a facility search were initiated immediately. The search was in progress when the facility received a phone call from the police asking if there was a missing resident. The supervisor verbally identified the resident for the police officer. The officer said the resident was found wandering in a nearby parking lot. The resident was brought to the facility by the officer who requested a face sheet. The face sheet was provided, an ambulance was called, and the resident transferred to (hospital) via 911 for evaluation and treatment. An interview was conducted with Registered Nurse A (RN A), who was familiar with Resident #1 while he resided on the secured unit, on 04/23/2020 at 3:10 PM. RN A stated Resident #1 wandered a lot. On a typical day he is always back and forth and back and forth the halls. He was going to exits and pushing. She stated she works on the locked unit normally the doors alarm. He does this constantly. Wanderguards work everywhere. She stated Resident #1 had a female resident on the locked unit who followed him around. He would go in her room when she was on that side where he was. After that they moved her to the other hall. The locked unit is two halls. She stated staff know him so they watch him closely. She explained 'we know how he is and he has to always be in someone's sight, nurses and CNAs (Certified Nursing Assistant)'. An interview was conducted with CNA B on 04/23/2020 at 3:47 PM. CNA B was assigned to Resident #1 the day he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	**300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401**

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 0657 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 4) eloped. She stated 'everybody on the floor was watching on him'. After he finished eating all his food she went to assist another resident. The remaining staff were watching him. She stated when she finished she did not see him. Staff started checking the building but every door was closed. By the time staff were looking for him the Supervisor called to say the police called. She stated the door in the 400 unit had an alarm but no one was in the 400 unit to hear it. She stated she only worked with Resident #1 after he was transferred to the 200 hall but knew he walked around alot and tried to leave. An interview was conducted with CNA C on 04/23/2020 at 3:53 PM. CNA C was working on the 200 unit when Resident #1 eloped. She stated Resident #1 always walked back and forth and she would redirect him to sit down. She stated staff knows where he is and when she would pass by him she would keep her eyes on him. An interview was conducted with Licensed Practical Nurse D (LPN D) on 04/23/2020 at 4:04 PM. LPN D was listed as the nurse on the 200 unit when Resident #1 eloped. She stated Resident #1 did not stay still and would go up and down the hallway. He would always go into other residents' rooms. She administered his [MEDICATION NAME] at 6 PM. He was still very agitated and it was ineffective. She stated he was always at the doors trying to leave. She stated he ate dinner and by 7:30 PM staff picked up the trays. He was still pacing the halls. At 8 PM staff started looking for him because they realized he wasn't there. He does not stay in his room. Staff always see him because he is near the nurse's station. He removed his wanderguard. The doors have alarms but the alarm to the 400 unit exit door was not heard all the way in the 200 unit. He has a steady gait. She stated there were no problems between Resident #1 and any residents on the 200 unit except he did wander into other residents' rooms and some may yell. She stated she was aware of his behaviors and that he doesn't stay still. Normally they do not have that type of resident in the 200 unit. An interview was conducted with the Executive Director, Director of Clinical Services, Risk Manager, and Assistant Executive Director on 04/23/2020 at 4:18 PM. The Director of Clinical Services explained that Resident #1 was on the locked unit at first but because he had the altercation he was transferred to the other unit. She stated Resident #1 and (female resident) had a little thing going but staff thought it was okay. The attraction became more aggression. Staff have seen them argue with each other but they let it slide. It was noted the interactions became more aggressive. (Female resident) would approach him and hit him with her purse. The facility reported the March 23 incident as resident-to-resident. The doctor re-evaluated him and sent him to the hospital. He was not kept and when he came back he was placed on the mandatory 14 day quarantine on the 400 unit. He was kept busy and a wanderguard placed. Staff knew he was a risk but he had never actually eloped. She stated staff found they could keep him busy with a broom because of his former job in a factory. Resident #1 and (female resident) were kept on separate areas. Resident #1 was sent to the 200 unit to separate him because they did know what would happen if he returned to the locked unit. The 400 unit was empty and staff never could have surmised that he would find his way all the way to the 400 hall. Everyone was aware of behaviors and redirected him with wanderguard on. The Risk Manager stated at some point he took his wanderguard off. The Director of Clinical Services stated they decided to put him back on the secured unit after his elopement. Resident #1 was discharged from the facility for another behavior. She stated when he eloped the police called to advise the facility they had Resident #1 while staff were still searching the building. The Risk Manager stated the police did not return Resident #1 to the facility but took him directly to the hospital and did not tell the facility why. She stated he did not have injuries prior to eloping. The Director of Clinical Services explained the facility allocated the 400 unit for a 14 day quarantine after returning from the hospital. There were other residents on the unit at the time Resident #1 was there. Since that time the 400 unit was closed to consolidate staff and residents. She stated Resident #1 is fast and steady on his feet. The Risk Manager stated the only time they noticed the wanderguard was not on him was when he eloped. The Director of Clinical Services stated Resident #1 was transferred from the facility after an incident with another female resident. She stated staff previously found Resident #1 in bed with (female resident) a few times and separated them. Nothing happened and he was fully clothed at the time. She stated initially she thought they were just holding hands but when it became aggressive then staff moved the residents to opposite halls. They would find each other in the morning and hold hands. But then it became aggressive. The Risk Manager stated Resident #1 had taken off his wanderguard the day he eloped. The alarm to the door went off but because it was so far away the staff did not hear it until they searched for him. Resident #1 walked from the 200 wing where he was admitted and walked to the 400 wing where he previously stayed. He found the back exit and went out to the parking lot. He was about 5 minutes away, 2 blocks in a straight line. She stated during their investigation Administrative staff re-enacted the steps. The staff on the unit that day did not see him walking to the 400. They said he was at the nurses station to be monitored. The CNA went to give care and when she came out she did not see him. The Director of Clinical Services stated since his elopement they put an alarm on the double doors on the 400 unit and a plastic zippered curtain at the entrance to the hall. She stated the facility was trying to keep both safe and both in the facility, Resident #1 and (female resident). He did not have the wanderguard while on the locked unit because he did not need it. She stated the doors throughout the facility have wanderguard alarms. She stated staff just had close supervision and tried to engage him in activities during the day time. He did well on 400 hall. He liked to clean. He was not on the 200 unit long. He was on the 400 unit for a longer period of time. He had done excellent on 400. He was happier on the 400. He wanted to sleep and clean. Review of Resident #1's progress notes and April 2020 MAR indicated [REDACTED]. He was documented as being able to remove it. Review of the Police Report on 04/28/2020 showed a call was made to the Police Department on 04/11/2020 around 08:49 PM from a nearby residence. Upon arrival, police observed Resident #1 on the sidewalk where he had been for approximately 10 minutes. Resident #1 was observed with a knot on his head and was described as confused and possibly lost. Emergency Services was called but Resident #1 began walking away towards the shopping plaza. Police also noted a hand injury. Emergency Services was called again. Review of Resident #1's Quarterly Minimum Data Set assessment dated [DATE] showed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, showing severe cognitive impairment. The Facility's actions to remove the Immediate Jeopardy included: 1) Resident #1 was placed back on the secured unit upon return from the hospital on [DATE]. A full body assessment was completed for Resident #1 upon return from the hospital. 2) All current residents with a [DIAGNOSES REDACTED]. No other residents were identified as an elopement risk except the residents currently on the secured unit. 3) An elopement drill was conducted with staff on 04/13/2020. 4) All exit door maglocks were inspected on 04/13/2020 to ensure proper functioning. 5) An additional alarm was placed on the double doors leading to the closed unit to make the alarm sound more audible on 04/13/2020. Nursing Supervisors were inserviced on 04/13/2020 regarding the new alarm on the double doors. 6) A zippered plastic partition was placed in the hallway of the closed unit as an additional barrier. 7) An ad hoc QAPI meeting was conducted on 04/13/2020 that included the Executive Director, the Director of Clinical Services, the Medical Director, the Assistant Executive Director, the Director of Quality Assurance, and other department heads. A Performance Improvement Plan was established. The corrective actions included: 1) Follow-up QAPI/Risk Management meetings were conducted on 04/16/2020 and 04/20/2020. 2) Residents with behaviors towards other residents were identified and interventions reviewed and revised beginning on 04/13/2020. 3) Administration completed daily checks of the newly installed door alarm. 4) Additional staff on Leave of Absence (LOA) or in quarantine were educated on elopement procedures via telephone and additional staff onsite beginning 04/14/2020 through 04/16/2020. As of 04/16/2020 the following portion of the facility's staff were educated about elopement procedures: 50 out of 77 CNAs, 25 out of 28 LPNs, 28 out of 38 RNs, 19 out of 23 staff listed under Administration, 11 out of 18 Environmental Services staff, 7 out of 20 culinary staff, and 12 rehabilitation staff. 4) New employee orientation packets for certified nursing assistants include information and quizzes regarding dementia care and elopement. Random staff interviews conducted by Surveyor confirmed knowledge of elopement procedures. Interviews conducted in person and via phone were conducted as follows: On 04/29/2020 from 02:25 PM until 04:06 PM, 2 CNAs and 2 RNs. On 04/30/2020 beginning at 01:31 PM, 1 Respiratory Therapist, 1 Social Services staff, 1 Medical Records staff, 1 Housekeeping staff, 1 Administrative staff, 4 RNs, 1 LPN, and 2 CNAs. An initial tour conducted on 04/23/2020 revealed the alarm to the double doors was in place leading to the closed unit and the zippered plastic partition was also in place further down the hall. A subsequent tour on 04/30/2020 revealed the alarm and barrier remained in place. No residents were observed actively exit seeking on 04/23/2020 or on 04/30/2020. Immediate Jeopardy was determined to be past non-compliance, corrected on 04/20/2020.
F 0689 **Level of harm** - Immediate jeopardy **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** Based on interview and record review, the facility failed to provide the supervision necessary to prevent an elopement for a resident with dementia and known behaviors including wandering, entering other resident rooms, physical aggression,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	**300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401**

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 **Residents Affected -** Few	(continued... from page 5) inappropriate behaviors towards female residents, and exit seeking, for 1 of 1 residents (Resident #1) reviewed for an elopement out of 3 residents listed in the facility's Adverse Incident log. The resident eloped from the facility on April 11, 2020 and was found by police at a nearby shopping center. The Plaza is approximately 0.4 miles from the facility. The sidewalk is set back approximately 2-3 feet (grass easement) from a car-parking lane (approximately 4-5 feet) from the one-direction street, that leads to the plaza. Upon return to the facility after an evaluation at the hospital, the resident was observed with swelling to the face and knuckles, abrasions, discoloration, and scratches. He was discharged from the facility on April 16, 2020 related to another incident with a female resident after returning to the secured unit. The facility's failure to adequately supervise Resident #1, who was previously identified as a high risk for elopement, resulted in the finding of Immediate Jeopardy, past non-compliance on 04/11/2020. The Immediate Jeopardy was determined to be corrected on 04/20/2020, prior to the survey. The findings included: Review of the facility's policy titled: Risk Management: Elopement Risk (effective date: April 2006 and revision date: March 2016) showed: 1. If the resident is identified as an elopement risk based on the evaluation, a care plan will be developed to reduce elopement risk. Center staff will provide supervision and engage the resident as needed to minimize wandering or exit seeking behaivor according to the plan of care. Elopement occurs when a resident who needs supervision leaves a safe area without supervision. Review of the facility's Adverse Incident report to the State related to Resident #1's elopement dated 04/16/2020 showed: (Resident #1) is a [AGE] year-old male who was admitted to this facility in October of 2019 for long-term care in the secured unit. He has a history of kidney failure, hypertension, dementia, muscle weakness and [MEDICAL CONDITION]. He is alert with confusion and has a BIMs of 7. (Resident #1) had engaged in an altercation with a female resident on 3/24/2020 and as a result was referred to the hospital for evaluation of physical aggression and psychotic behaviors. Upon his readmission, he was placed on the short term Covid 19 monitoring unit as required by law for 14 days in an attempt to manage the spread of the Covid 19 pandemic from new hospital admissions and readmissions. After readmission, (Resident #1) presented with no symptoms and was managed on the 400 unit with a wander guard and close supervision away from the secured unit. After the 14 days he was not returned to the secured unit because the victim from the previous altercation still resides there. On (DATE), the facility transferred (Resident #1) to the 200 wing long-term care unit with a wander guard and under close supervision by staff. The resident was stable and was kept engaged through one to one activities with several departments within the facility during the day. On Saturday April 11th, at approximately 2030, the nursing staff became aware that the resident was not on the 200 wing. The supervisor was notified as soon as the resident was noted to be missing. A room search and a facility search were initiated immediately. The search was in progress when the facility received a phone call from the police asking if there was a missing resident. The supervisor verbally identified the resident for the police officer. The officer said the resident was found wandering in a nearby parking lot. The resident was brought to the facility by the officer who requested a face sheet. The face sheet was provided, an ambulance was called, and the resident transferred to (hospital) via 911 for evaluation and treatment. Review of the Police Report on 04/28/2020 showed a call was made to the Police Department on 04/11/2020 around 08:49 PM from a nearby residence. Upon arrival, police observed Resident #1 on the sidewalk where he had been for approximately 10 minutes. Resident #1 was observed with a knot on his head and was described as confused and possibly lost. Emergency Services was called but Resident #1 began walking away towards the shopping plaza. Police also noted a hand injury. Emergency Services was called again. Review of Resident #1's clinical record on 04/23/2020 showed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Admission Nursing assessment dated [DATE] showed his behavioral concerns included: Confusion/forgetfulness; [DIAGNOSES REDACTED]. Resident #1 was also admitted with an order for [REDACTED]. Review of Resident #1's Quarterly Minimum Data Set assessment dated [DATE] showed Resident #1 had a BIMS score of 7, showing severe cognitive impairment. Review of Resident #1's comprehensive care plans included: -(Resident #1) has Wandering Behavior and is at risk for Elopement related to: history of wandering through hallways. (Date initiated: 11/07/2019) Goal: (Resident #1) will have physical, emotional, and psychological needs met as evidenced by reduction in behaviors or decreased wandering. (Date initiated 11/07/2019) Goal: (Resident #1) will be protected from elopement and unsafe wandering through next review. (Date initiated: 01/24/2020) Interventions: Ensure environment is clutter free (Date initiated 01/24/2020) Ensure resident identifier is in place (Date initiated: 11/17/2019 and Date created: 12/16/2019) Include staff in information processes for observances for cues to behavior (Date initiated: 01/24/2020) Observe for wandering that effects other and redirect as needed. (Date initiated 01/24/2020) Wander guard (Date initiated: 11/17/2019 and Date created: 12/16/2019) -(Resident #1) has impaired cognition as evidenced by: Decision making problem/Short term memory deficit/Long term memory deficit/Problems understanding others. (Date initiated: 10/13/2019) -(Resident #1) is at risk for falls related to: [DIAGNOSES REDACTED]. (Date initiated 01/11/2019) Review of Resident #1's clinical record on 04/23/2020, and a subsequent request made on 04/24/2020 for all of Resident #1's comprehensive care plans, showed no care plans were found addressing exhibited behaviors such as physical aggression, inappropriate behaviors towards female residents, and wandering into other resident rooms. The care plans reviewed did not describe the type or frequency of supervision needed to address Resident #1's wandering, including into other resident rooms while on the secured unit, or show any change in level of supervision needed when he was transferred to the unsecured unit. His care plan for wandering behavior showed an intervention for a wanderguard but was not revised when it was discovered he could remove the wanderguard prior to his elopement. Review of Resident #1's Elopement Risk Scale dated 1/24/2020 showed: -Resident #1 is ambulatory, expresses a desire and plans to leave, has a strong identification with past roles, has 2 or more attempts to leave the facility in last 90 days, has a medical [DIAGNOSES REDACTED]. -His score was 17 indicating high risk for elopement. -The care planning section showed one intervention marked: include staff in information process for observances for cues to behavior. Review of Resident #1's Progress Notes showed: January 2020 -1/18/2020 Resident #1 was found in (room #) without clothes in bed. He was given his clothes and redirected to his room. He refused to leave and became physically abusive to a female resident hitting her on her hand. He stated he will kill staff. -1/18/2020 Resident #1 seen by Dr., new order [MEDICATION NAME]-1/24/2020 Resident #1 was combative, going room to room looking after the woman, all meds given as per ordered, not effective February 2020 -2/26/2020 Ambulated up and down the hallway throughout entire 11-7 shift resident redirected, offered fluids, toileted and allowed time to vent. No change in behavior March 2020 -3/7/2020 Resident #1 was sitting in the dining room. A female resident came and waved her finger at his face. Resident #1 then kicked the resident's leg. The other resident swung her purse at him. Staff intervened and removed the aggressor. Resident #1 grabbed a wet floor sign and attempted to hit the aggressor. -3/23/2020 Observed pushing and punching another resident on the floor. Biting on staff member. Resident pacing the floor backwards and forward in an aggressive behavior. Awake alert and confused, broken glass in resident room and trying to get out of lock down unit. Recommendation: Send resident to ER intake for psych -3/24/2020 Returned to facility. Interdisciplinary Team meeting with new interventions to include a complete review of resident medications, psych consult, and resident will be removed from unit and placed on the 400 unit with a wanderguard. -3/26/2020 Wandering on floor, shift had to continue to redirect him -3/28/2020 Resident #1 made two attempts to escape floor, with the second nearly ended with resident taking north stair, but stopped by other nurse and aide. After giving some sleeping aids and redirecting back to bed, remained there for the duration of the night. -3/30/2020 Resident wanderguard was not in place April 2020 -4/2/2020 Confused noted being combative and pushing staff. Writer personally bathed patient for staff protection as patient was covered in dried feces. meds well tolerated patient noted resting for 2 hours before wandering. hourly rounds done due to patient not having wanderguard -4/4/2020 Received resident resting from another room for at least two hours and then wake up. Resident was wandering, redirected him to his room and then resting for the of the night -4/11/2020 Resident was observed on unit most part of the shift. Resident is very agitated/energetic, constantly wandering down the hall. Redirection was given several times/unsuccessfully. Around 2030, the nursing staff became aware of Resident's disappearance by the Nursing Supervisor. -4/11/2020 Change of Condition form. Room search was done after 911 call, alarm was sounding on 400 wing stair exit door. Police notified the facility that resident was walking in the parking lot at (local shopping plaza), awake alert and confused. Police officer had him in the back of squad car, ambulance called, and resident transferred to (hospital) via 911 ambulance for evaluation and treatment. MD and family member notified. -Late Entry for 4/11/2020 (created 04/14/2020) Patient alert with confusion noted. Patient transferred from 400 wing. Patient has abrasion to right shoulder with redness noted and right cheekbone is red and swollen. Right hand swollen/knuckles are bruised with discoloration noted. -4/12/2020 returned from (hospital) Diagnosis: [REDACTED].Resident received with facial raised area/swollen to right cheekbone. Right shoulder abrasion, red with no bleeding present. Right hand swollen, knuckles with discoloration Resident with no wanderguard on, will address in AM. -4/12/2020 Xrays and CT scan reveal no abnormal structures or fractures .resident roamed halls and entered other room. Tried redirecting many times but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	**300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401**

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 **Residents Affected -** Few	(continued... from page 6) continued to persist on eloping. Forcibly removed wanderguard. -4/13/2020 Received resident alert but with confusion, wandering hallways and touching exit doors constantly. A bruise was noted just below right eye, same appears to be healing well. Right fingers noted to be swollen with small bruises on same, bruises. scratches noted near left elbow .Resident was seen in (room #) at 21:00 shaking the resident in (room #'s) TV. No picture can be seen on TV when turned on .Resident was medicated as per Medication Administration Record [REDACTED]. -4/14/2020 Resident alert and confused he wanders all over the floor he's in and out of resident's room. He removed his wanderguard. -4/14/2020 Became combative early in the morning. was redirected and wanderguard placed on right ankle. Patient was calm during this time/placing wanderguard on ankle. -4/16/2020 Risk Manager was informed by a female resident that Resident #1 came into her room last night on 4/15/2020 and pulled down his pants .she stated she was going to scream and that is when he left. -4/16/2020 Social Worker informed Resident #1's family member that the facility is no longer able to meet the needs of resident .Resident #1 wanders into other residents' room taking items that do not belong to him -4/16/2020 resident discharged to an assisted living facility Review of Resident #1's physician's orders [REDACTED]. Physical Aggression and Hitting other resident -1/24/2020 Resident meets criteria for gated 100 unit -3/24/2020 Send resident to ER for aggression and hitting other resident -3/25/2020 Check wanderguard placement every shift -3/25/2020 Check wanderguard every shift to ensure its functioning properly An interview was conducted with Registered Nurse A (RN A), who was familiar with Resident #1 while he resided on the secured unit, on 04/23/2020 at 3:10 PM. RN A stated Resident #1 wandered a lot. On a typical day he is always back and forth and back and forth the on the halls. He was going to exits and pushing. She stated she works on the locked unit normally the doors alarm. He does this constantly. Wanderguards work everywhere. She stated Resident #1 had a female resident on the locked unit who followed him around. He would go in her room when she was on that side where he was. After that they moved her to the other hall. The locked unit is two halls. She stated staff know him so they watch him closely. She explained 'we know how he is and he has to always be in someone's sight, nurses and CNAs (Certified Nursing Assistant)'. An interview was conducted with CNA B on 04/23/2020 at 3:47 PM. CNA B was assigned to Resident #1 the day he eloped. She stated 'everybody on the floor was watching on him'. After he finished eating all his food she went to assist another resident. The remaining staff were watching him. She stated when she finished she did not see him. Staff started checking the building but every door was closed. By the time staff were looking for him the Supervisor called to say the police called. She stated the door in the 400 unit had an alarm but no one was in the 400 unit to hear it. She stated she only worked with Resident #1 after he was transferred to the 200 hall but knew he walked around alot and tried to leave. An interview was conducted with CNA C on 04/23/2020 at 3:53 PM. CNA C was working on the 200 unit when Resident #1 eloped. She stated Resident #1 always walked back and forth and she would redirect him to sit down. She stated staff knows where he is and when she would pass by him she would keep her eyes on him. An interview was conducted with Licensed Practical Nurse D (LPN D) on 04/23/2020 at 4:04 PM. LPN D was listed as the nurse on the 200 unit when Resident #1 eloped. She stated Resident #1 did not stay still and would go up and down the hallway. He would always go into other residents' rooms. She administered his [MEDICATION NAME] at 6 PM. He was still very agitated, and it was ineffective. She stated he was always at the doors trying to leave. She stated he ate dinner and by 7:30 PM staff picked up the trays. He was still pacing the halls. At 8 PM staff started looking for him because they realized he wasn't there. He does not stay in his room. Staff always see him because he is near the nurse's station. He removed his wanderguard. The doors have alarms but the alarm to the 400 unit exit door was not heard all the way in the 200 unit. He has a steady gait. She stated there were no problems between Resident #1 and any residents on the 200 unit except he did wander into other residents' rooms and some may yell. She stated she was aware of his behaviors and that he doesn't stay still. Normally they do not have that type of resident in the 200 unit. An interview was conducted with the Executive Director, Director of Clinical Services, Risk Manager, and Assistant Executive Director on 04/23/2020 at 4:18 PM. The Director of Clinical Services explained that Resident #1 was on the locked unit at first but because he had the altercation he was transferred to the other unit. She stated Resident #1 and (female resident) had a little thing going but staff thought it was okay. The attraction became more aggression. Staff have seen them argue with each other but they let it slide. It was noted the interactions became more aggressive. (Female resident) would approach him and hit him with her purse. The facility reported the March 23 incident as resident-to-resident. The doctor re-evaluated him and sent him to the hospital. He was not kept and when he came back he was placed on the mandatory 14 day quarantine on the 400 unit. He was kept busy and a wanderguard placed. Staff knew he was a risk but he had never actually eloped. She stated staff found they could keep him busy with a broom because of his former job in a factory. Resident #1 and (female resident) were kept on separate areas. Resident #1 was sent to the 200 unit to separate him because they did know what would happen if he returned to the locked unit. The 400 unit was empty and staff never could have surmised that he would find his way all the way to the 400 hall. Everyone was aware of behaviors and redirected him with wanderguard on. The Risk Manager stated at some point he took his wanderguard off. The Director of Clinical Services stated they decided to put him back on the secured unit after his elopement. Resident #1 was discharged from the facility for another behavior. She stated when he eloped the police called to advise the facility they had Resident #1 while staff were still searching the building. The Risk Manager stated the police did not return Resident #1 to the facility but took him directly to the hospital and did not tell the facility why. She stated he did not have injuries prior to eloping. The Director of Clinical Services explained the facility allocated the 400 unit for a 14 day quarantine after returning from the hospital. There were other residents on the unit at the time Resident #1 was there. Since that time the 400 unit was closed to consolidate staff and residents. She stated Resident #1 is fast and steady on his feet. The Risk Manager stated the only time they noticed the wanderguard was not on him was when he eloped. The Director of Clinical Services stated Resident #1 was transferred from the facility after an incident with another female resident. She stated staff previously found Resident #1 in bed with (female resident) a few times and separated them. Nothing happened and he was fully clothed at the time. She stated initially she thought they were just holding hands but when it became aggressive then staff moved the residents to opposite halls. They would find each other in the morning and hold hands. But then it became aggressive. The Risk Manager stated Resident #1 had taken off his wanderguard the day he eloped. The alarm to the door went off but because it was so far away the staff did not hear it until they searched for him. Resident #1 walked from the 200 wing where he was admitted and walked to the 400 wing where he previously stayed. He found the back exit and went out to the parking lot. He was about 5 minutes away, 2 blocks in a straight line. She stated during their investigation Administrative staff re-enacted the steps. The staff on the unit that day did not see him walking to the 400. They said he was at the nurses station to be monitored. The CNA went to give care and when she came out she did not see him. The Director of Clinical Services stated since his elopement they put an alarm on the double doors on the 400 unit and a plastic zippered curtain at the entrance to the hall. She stated the facility was trying to keep both safe and both in the facility, Resident #1 and (female resident). He did not have the wanderguard while on the locked unit because he did not need it. She stated the doors throughout the facility have wanderguard alarms. She stated staff just had close supervision and tried to engage him in activities during the day time. He did well on 400 hall. He liked to clean. He was not on the 200 unit long. He was on the 400 unit for a longer period of time. He had done excellent on 400. He was happier on the 400. He wanted to sleep and clean. Review of Resident #1's progress notes and April 2020 MAR indicated [REDACTED]. He was documented as being able to remove it. The Facility's actions to remove the Immediate Jeopardy included: 1) Resident #1 was placed back on the secured unit upon return from the hospital on [DATE]. A full body assessment was completed for Resident #1 upon return from the hospital. 2) All current residents with a [DIAGNOSES REDACTED]. No other residents were identified as an elopement risk except the residents currently on the secured unit. 3) An elopement drill was conducted with staff on 04/13/2020. 4) All exit door maglocks were inspected on 04/13/2020 to ensure proper functioning. 5) An additional alarm was placed on the double doors leading to the closed unit to make the alarm sound more audible on 04/13/2020. Nursing Supervisors were inserviced on 04/13/2020 regarding the new alarm on the double doors. 6) A zippered plastic partition was placed in the hallway of the closed unit as an additional barrier. 7) An ad hoc QAPI meeting was conducted on 04/13/2020 that included the Executive Director, the Director of Clinical Services, the Medical Director, the Assistant Executive Director, the Director of Quality Assurance, and other department heads. A Performance Improvement Plan was established. The corrective actions included: 1) Follow-up QAPI/Risk Management meetings were conducted on 04/16/2020 and 04/20/2020. 2) Residents with behaviors towards other residents were identified and interventions reviewed and revised beginning on 04/13/2020. 3) Administration completed daily checks of the newly installed door alarm. 4) Additional staff on Leave of Absence (LOA) or in quarantine were educated on elopement procedures via telephone and additional staff onsite beginning 04/14/2020 through 04/16/2020. As of 04/16/2020 the following portion of the facility's staff were educated about elopement procedures: 50 out of 77 CNAs, 25 out of 28 LPNs, 28 out of 38 RNs, 19 out of 23 staff listed under Administration, 11 out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105607	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GARDEN OF WEST PALM BEACH	**300 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401**

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 **Residents Affected -** Few	(continued... from page 7) of 18 Environmental Services staff, 7 out of 20 culinary staff, and 12 rehabilitation staff. 4) New employee orientation packets for certified nursing assistants include information and quizzes regarding dementia care and elopement. Random staff interviews conducted by Surveyor confirmed knowledge of elopement procedures. Interviews conducted in person and via phone were conducted as follows: On 04/29/2020 from 02:25 PM until 04:06 PM, 2 CNAs and 2 RNs. On 04/30/2020 beginning at 01:31 PM, 1 Respiratory Therapist, 1 Social Services staff, 1 Medical Records staff, 1 Housekeeping staff, 1 Administrative staff, 4 RNs, 1 LPN, and 2 CNAs. An initial tour conducted on 04/23/2020 revealed the alarm to the double doors was in place leading to the closed unit and the zippered plastic partition was also in place further down the hall. A subsequent tour on 04/30/2020 revealed the alarm and barrier remained in place. No residents were observed actively exit seeking on 04/23/2020 or on 04/30/2020. Immediate Jeopardy was determined to be past non-compliance, corrected on 04/20/2020.