STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106089	A. BUILDING _____ B. WING _____	**04/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KEY WEST HEALTH AND REHABILITATION CENTER	**5860 W JUNIOR COLLEGE RD KEY WEST, FL 33040**

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 -** Some	**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 observation, interview, and record review the facility failed to identify the hazard of leaving the second floor windows of the facility accessible as a secondary means of egress (an unobstructed way to get in or out of any occupied portion of a building) for fifty five residents residing in the second floor of the facility. The residents residing on the second floor included those with dementia and psychological issues. The residents in danger of falling out of a window included those residents with a history of attempted suicide (Resident #1, #5, and #6) and residents identified as an elopement risk (Resident #2, #3, and #4). On [DATE] at approximately 8:30 p.m., Resident #1 fell from a fully opened window in his room on the second floor of the facility. The facility failed to implement interventions to prevent a similar adverse incident from occurring and reoccurring. Due to the lack of facility action, residents residing on the second floor were at risk of injury or death from falling out a window. This noncompliance was identified as Immediate Jeopardy. The Administrator was informed of this Immediate Jeopardy on [DATE] at 7:30 p.m., after the facility initiated a plan to secure all the second floor windows so that they could not be opened to allow a resident to exit the window. The findings included: Cross reference to F689 and F921. Resident #1 was readmitted to the facility on [DATE]. His original admitted was on [DATE]. Resident #1 was a [AGE] year old man with a history of chronic pain related to [MEDICAL CONDITION]. A quarterly Minimum Data Set ((MDS) dated [DATE] showed the resident had a Brief Interview Mental Status score of 13, which meant that he was cognitively intact . The MDS showed Resident #1 did not ambulate in the hall and he was a one person stand by assist with transferring. The resident's Medication Administration Record [REDACTED]. He also took an anti anxiety medication ([MEDICATION NAME]) daily. A psychologist's note dated [DATE] showed Resident #1 had attempted to commit suicide by overdosing on [MEDICATION NAME] (a medication used for anxiety and sedation). The resident's [MEDICAL CONDITION] drug care plan, which was last updated on [DATE], documented that Resident #1 had made statements to staff at the facility about killing himself. On [DATE] at 8:55 a.m., LPN Staff B said Resident #1 was able to open the window and fall out. She said the resident had been interviewable but was confused at times. At the time of the interview, the window in Resident #1's room was observed to have easy, unrestricted egress. The window opened by turning a thumb screw on a small clamp attached to the widow frame approximately of a turn to the left and removing the clamp. The two locks on the inside of the window could be easily lifted off and the window could be easily fully opened 2 to 3 feet wide without any difficulty. Staff B said there had been no changes to prevent the window from being opened by a resident since the incident had occurred. The staff member said she did not feel the windows being able to fully open was safe for any of the residents on the second floor. On [DATE] at 9:10 a.m., the surveyor checked 5 more additional resident rooms windows with Licensed Practical Nurse (LPN) Staff A. The five rooms were checked at both ends of the facility. All 5 room windows were easily opened in the same manner as Resident #1's room. The windows had screens . On [DATE] at 6:30 p.m., Licensed Practical Nurse Staff A stated she was the nurse assigned to Resident #1 on [DATE]. She said she went to give the resident his medication at 8:30 p.m., and could not find the resident. After a short search she said she saw the window was open and Resident #1's walker was next to the opened window. Staff A said she used the flashlight on her mobile phone and looked out the fully opened window and saw the resident lying on his back on the ground outside the window. Staff A said she immediately called 911 and yelled for other staff in the building to assist the resident. Staff A said the resident was declared to be deceased by E[CONDITION] shortly thereafter. The facility census list documented that as of [DATE] there were 55 residents who reside on the second floor. Review of the resident census and condition report revealed: 3 residents on the second floor have been assessed to be at risk for elopement: Resident #2, Resident #3 and Resident #4. 2 residents on the second floor have a history of attempted suicide: Resident #5, and Resident #6. Resident #6 was Resident #1's roommate. There were 22 residents with [DIAGNOSES REDACTED]. On [DATE] at 10:58 a.m., the Director of Maintenance said on [DATE] U.S. Department of Housing and Urban Development (HUD) had dinged him during a survey because the window clamps stopping the windows from fully being opened were too tight. He said he was told the thumb screws attached to the window panes had to be able to be removed by hand so residents could open the windows and firemen had access in case of a fire. The Maintenance Director said on the night the incident occurred, he had audited all the windows on the second floor to ensure the clamps were in place and they were able to be removed by hand so the windows could open easily. An e-mail dated [DATE] from HUD verified the facility received the inspection report. The HUD report dated [DATE] listed rooms [ROOM NUMBERS]. The report regarding these two rooms stated, Bedroom Window will not open all the way. Installed mechanical stop blocks only secondary egress from floor area. Emergency/Fire Exits (applies only on third or lower floors) - Blocked - Inoperable Window. On [DATE] at 11:00 a.m., the Maintenance Director said he had called the local Fire Marshall on [DATE] and was told he could secure the windows on the second floor because there were stairs at each end of the second floor and the building had a sprinkler system. The Maintenance Director stated after he contacted with the Fire Marshal, that he did not change the second floor bedroom windows. These remained easily opened by hand turning a thumb screw and lifting two levers on the inside. On [DATE] the Fire Marshal faxed the Fire Safety Code to the facility on [DATE]. The Fire Safety Code stated, It shall be recognized that, in buildings housing certain patients, it might be necessary to lock doors and bar windows to confine and protect inhabitants. On [DATE] at 10:55 a.m., the Administrator said he had spoken with the staff the night of the incident and audits were done of the windows on the second floor. The night of the incident the clamps stopping the windows from fully being opened were snug enough and we did not need to make any adjustments on the windows. The Administrator stated he had been aware of the [DATE] HUD inspection and that the thumb screws on the metal clamps had to be loose enough to allow egress out of the windows on the second floor in case of a fire. He said he had been aware of this since he had started working at the facility in September of 2019. The Administrator was informed of this Immediate Jeopardy on [DATE] at 7:30 p.m. On [DATE] at 4:00 p.m., the Administrator was informed the immediate jeopardy was removed after confirmation the facility corrective actions were implemented lowering the scope and severity to E. ***Photographic evidence obtained***
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility Administration failed to use its resources effectively to ensure a safe environment for 6 residents (Resident #1, #2, #3, #4, #5, and #6). The Administrator failed to address the ability of residents to open the second floor windows. The Administrator failed to contact the Agency for Health Care Agency (AHCA), the Florida state survey agency or the local Fire Marshal to assist and advise on the resident room windows

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

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.

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) that could be fully opened. On [DATE]2/20 Resident #1 fell to his death from an open window in his room. The Administrator failed to assess the residents' safety on the second floor after the incident on [DATE]2/20. The administration failed to identify the second floor resident room windows were a safety risk for 3 residents (Resident #2, #3, #4) who had been assessed as an elopement risk and 2 residents (Resident #5, and #6) with a past history of suicide attempts. The facility administrator failed to act to secure the windows on the second floor. The facility administration failed to arrange neded psychological services for residents after the psychologist ceased services at the facility in November of 2019. Due to the facility's actions, residents residing on the second floor were at risk of injury or death from falling out of a window. This noncompliance was identified as Immediate Jeopardy. The Administrator was informed of this Immediate Jeaopardy on 4/28/20 at 7:30 p.m. The Immediate Jeopardy was removed on 4/29/20 at 4:00 p.m., after the facility initiated a plan to secure all the second floor windows so that they could not be opened to allow a resident to exit through the window. The findings included: Cross reference to F689 and F921. Interviews and documented statements from staff revealed Resident #1 fell to his death from the open window of his second floor room on [DATE]2/20 at approximately 8:30 p.m. Resident #1 was a [AGE] year-old man with a history of attempted suicide. On 4/27/20 at approximately 10:00 a.m., during an interview the DON reviewed the last psychological visits reports for residents and said many of the residents did not have any documented follow-ups visits since the psychologist stopped services at the facility in November of 2019. The DON said he could not provide any documentation the lack of psychological services was identified as a concern and discussed in any Quality Assurance meetings. The DON verified he could not provide documentation Resident #1 had any follow up with psychological services after 5/3/19. Residents who remain at high risk to exit the facility through an open window of the second floor included: Three residents assessed to be at risk for elopement: Resident #2 Resident #3 Resident #4 Two residents with a history of attempted suicide: Resident #5, and Resident #6. On 4/27/20 at approximately 4:30 p.m., the windows on the second floor were observed to be easily opened by removing the metal clip, lifting two levers on the side of the windows. The Maintenance Director stated the second-floor bedroom windows remained easily opened by hand turning a thumb screw and lifting two levers on the inside. He said on 2/14/20 he had informed the Business Manager of the Fire Marshal's statements. On 4/26/20 at 11:05 a.m., the Business Manager said she had spoken with the Administrator regarding the Fire Marshal informing the facility they could secure the windows on the second floor. The Business Manager provided regulations the Fire Marshal had faxed to the facility on [DATE]. These regulations indicated some residents with dementia being housed in the building could have doors and windows secured to keep the residents safe. The Business Manager said she and the Administrator had spoken about securing the windows but decided not to secure the windows. The Fire Marshal faxed the Fire Safety Code to the facility on [DATE] that stated, It shall be recognized that, in buildings housing certain patients, it might be necessary to lock doors and bar windows to confine and protect inhabitants. The faclity presented an an e-mail dated [DATE]8/18 that included the date the facility had an inspection report by HUD. The report dated 8/10/17 listed rooms [ROOM NUMBERS]. The report regarding these two rooms stated, Bedroom Window will not open all the way. Installed mechanical stop blocks only secondary egress from floor area. Emergency/Fire Exits (applies only on third or lower floors) - Blocked - Inoperable Window. On 4/27/20 at 10:55 a.m., the Administrator said he had spoken with the staff the night of the incident and audits were done of the windows on the second floor. The Administrator said he had told the Maintenance Director to contact the Fire Marshal regarding the second-floor windows. The Administrator said he had determined on the night of the incident the clamps stopping the windows from fully being opened were snug enough and he did not need to make any adjustments on the windows. The Administrator stated he had been aware of the 8/10/17 HUD inspection and that the thumb screws on the metal clamps had to be loose enough to allow egress out of the windows on the second floor in case of a fire. He said he had been aware of this since he had started working at the facility in September of 2019. The Administrator said he did not feel any residents were in danger with the windows being a secondary egress. The Administrator said on [DATE]4/20 at 11:15 a.m., the Fire Marshal told the facility they could secure the windows if they wanted to. The Administrator provided notes from an ad hoc (as needed) Quality Assurance (QA) meeting he held the evening of 4/26/20. He said the facility decided the windows at this facility did not need to be secured any more than they were prior to the incident.
F 0921 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify having windows that could open on the second floor were not safe. There were 55 residents living on the second floor. The 2nd floor environment presented the highest safety risk for injury or death due to falling out of a window for 2 residents with a history of attemped suicide (Residents #5, and #6) and 3 residents identified as an elopement risk (Resident #2, #3, and #4). On [DATE] at approximately 8:30 p.m., Resident #1 fell from a fully opened window in his room on the second floor of facility. Resident #1 was found lying on his back, unresponsive, and pulseless on the ground outside the opened window. According to the police report filed by the officer on scene, Emergency Medical Services (E[CONDITION]) pronounced Resident #1 deceased at 8:57 p.m. The facility failed to implement interventions to prevent a similar adverse incident from occuring and reoccurring. This noncompliance was identified as Immediate Jeopardy. The Administrator was informed of this Immediate Jeopardy on [DATE] at 7:30 p.m. The Immediate Jeopardy was removed on [DATE] at 4:00 p.m., after the facility initiated a plan to secure all the second floor windows so that they could not be opened to allow a resident to exit the window. The findings included: Resident #1 was readmitted to the facility on [DATE]. His original admitted was on [DATE]. A quarterly MDS (Minimum Data Set) dated [DATE] showed the resident had a Brief Interview Mental Status (BI[CONDITION]) of 13 (good cognition). The resident's medical record showed he had a history of [REDACTED]. He also took an anti-anxiety medication ([MEDICATION NAME]) daily. A psychologist's note dated [DATE] showed Resident #1 had attempted to commit suicide by overdosing on [MEDICATION NAME]. A [MEDICAL CONDITION] drug care plan, which was last updated on [DATE], showed Resident #1 had made statements to staff at the facility about killing himself. On [DATE] at 8:55 a.m., LPN (Licensed Practical Nurse) Staff B said Resident #1 was able to open the window and fall out. She said the resident had been interviewable but was confused at times. At the time of the interview, the window in room [ROOM NUMBER] was observed to have easy, unrestricted egress. The window could be opened by turning a thumb screw on a small clamp attached to the widow frame approximately of a turn to the left and removing the clamp. The two locks on the inside could be easily lifted off and the window could be easily fully opened 2 to 3 feet wide without any difficulty. LPN Staff B said there had been no changes to prevent the window from being opened by a resident since the incident had occurred. LPN Staff B said she did not feel the windows being able to be fully opened were safe for any of the residents on the second floor. On [DATE] at 9:10 a.m., 5 more room windows were observed with LPN Staff A. All 5 room windows were easily opened in the same manner as room [ROOM NUMBER]. On [DATE] at 6:30 p.m., LPN Staff A said she was the nurse assigned to Resident #1 on [DATE]. She said she went to give the resident his medication at 8:30 p.m., and could not find the resident. After a short search LPN Staff A said she saw the window to the resident's room was open and his walker was next to the opened window. Staff A said she used the flashlight and looked through the fully opened window. She observed Resident #1 lying on his back on the ground outside the window. Staff A said she immediately called 911 and yelled for other staff in the building to assist the resident. As of [DATE] there were 55 residents residing on the second floor. Record review revealed there were residents on the second floor at high risk to fall out a window. Three residents on the second floor had been assessed to be at risk for elopement: Resident #2 Resident #3 Resident #4 Two residents on the second floor had a history of [REDACTED].#5, and Resident #6. There were 22 residents with [DIAGNOSES REDACTED]. There were 13 residents with a [DIAGNOSES REDACTED]. There were 25 residents with a history of depression on the second floor. On [DATE] at 10:58 a.m., the Director of Maintenance said on [DATE] the U.S. Department of Housing and Urban Development (HUD) had cited the facility because the window clamps stopping the windows from fully being opened were too tight. He said he was told the thumb screws attached to the windowpanes had to be able to be removed by hand so residents could open the windows and allow access to the firemen in case of a fire. The Maintenance Director said on the night the incident occurred, he had audited all the windows on the second floor to ensure the clamps were in place and that they were able to be removed by hand. The Maintenance Director said he had called the local Fire Marshall on [DATE] and was told he could secure the windows on the second floor because there were stairs at each end of the second floor and the building had a sprinkler system. On [DATE] the second-floor bedroom windows remained easily opened by hand turning a thumb screw and lifting two levers on the inside. The Fire Safety Code faxed to the facility by the Fire Marshal

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F 0921 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) on [DATE] documented, It shall be recognized that, in buildings housing certain patients, it might be necessary to lock doors and bar windows to confine and protect inhabitants. On [DATE] at 10:55 a.m., the Administrator said he had spoken with the staff the night of the incident and audits were done of the windows on the second floor. The night of the incident the clamps stopping the windows from fully being opened were snug enough. The administrator said the facility did not need to make any adjustments on the windows. The Administrator stated he had been aware of the [DATE] HUD inspection stating the thumb screws on the metal clamps had to be loose enough to allow egress out of the windows on the second floor in case of a fire. He said he had been aware of this since he had started working at the facility in September of 2019.