Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911749	A. BUILDING: _____ B. WING _____	09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESERVE AT PALM AIRE (THE)	3701 W MCNAB ROAD POMPANO BEACH, FL 33069

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A 000	Initial Comments An unannounced Complaint (#2026006134) and Generator Monitoring survey, was conducted at Preserve At Palm Aire (The) on and . A deficiency related to the complaint was identified at the time of survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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A 032	Continued From page 1 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record reviews, interviews, and observations, it was determined that the facility failed to provide appropriate supervision to prevent elopement for 2 of 2 residents sampled who resided in the secured memory care unit (Residents # 1 and #2). The findings included:	A 032		

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A 032	Continued From page 2 A review of the facility's policy and procedures for elopement provided by the Administrator with an effective date of ,and revised on documented the following: Purpose: To ensure that Residents who may be , are kept safe while retaining their ability to be as independent as possible. Policy: The Community will ensure Residents are assessed prior to admission to Community and periodically throughout their residency according to procedures, for risk factors that increase the likelihood of elopement from the community. These include a history of attempted elopement, tendencies, restlessness, agitation, and a diagnosis of . In the event of a missing Resident, the Community will promptly initiate the missing Resident procedure. Elopement: When a resident leaves the premises or a safe area without authorization, necessary supervision and /or following Community sign out protocol. Missing Resident: A Resident is missing whole whereabouts are unknown. Resident at-risk for elopement will be listed in the Community's communication systems. Elopement risk will also be recorded on the service plan.	A 032		

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A 032	Continued From page 3 The Executive Director (or designee) will ensure that all staff are trained in the elopement and missing Resident procedures, communication systems, and ◡ alert system (if used). Elopement drills will be held four times per year per shift, or additional to meet regulatory requirements. If the Community has a ◡ alert system: Staff will be trained in the system. The Executive Director (or designee) will ensure the ◡ alert system is discussed with Residents and the authorized Responsible Party. Use of the system will be documented on the Resident's Service Plan A review of the facility investigation documentation revealed the following: a) On at approximately 7:20 AM , Resident # 1 was last seen by the Medtech (Staff F), who stated that Resident #1 was ◡ in the hallway and put her to bed. At 8:20 AM, maintenance staff found Resident # 1 outside and contacted staff. Medtech (Staff F) received a call from the front desk staff that Resident #1 was in the parking lot outside of the Memory area. At 8:21 AM Staff F went outside with staff and 911 was notified on nurse's cell round 8:43 AM. At 8:45 AM Nurse on duty arrived in the parking lot to assess the Resident. Resident #1 was transferred to {name of the hospital}Hospital. Medtech notified physician. Nurse on duty and the Assistant Executive Director notified Resident # 1 son (POA). b) On at approximately 11:00 PM Resident # 2 was calm in the common area. At	A 032		

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A 032	Continued From page 4 12:00 AM Resident # 2 was agitated and medicated with , which is ordered by the Physician as needed. At 12:20 AM the Resident Associate (Staff M), stated she was sitting with Resident # 2 and went to get her charger and on return heard the door alarm go off and Resident # 2 was outside the door. She attempted to redirect him, he became more agitated and combative and she called the nurse. Security officer on duty stated that she could not get the Resident #2 to return to the neighborhood (memory care) and he was agitated so she called the police for assistance. At 12:58 AM, Nurse stated she overheard the Resident Associate (Staff M), calling over the radio and found Resident # 2 sitting in the lobby. Resident #2 stated he is being held hostage and is going home. The Nurse was able to redirect Resident # 2 and walk him into the secured unit. Nurse on duty stated that she informed the police that everything was under control and the police left. Review of Resident #1 and #2's file, revealed both residents suffered from , and required supervision to ensure there safety and well-being. Further review confirmed both resided in the secured Memory Care unit , in which entrance and exit into the building by an individual required the authorization of staff through code. Record review of the files' revealed the following: a)Record review of Resident# 1's file revealed the following. Resident was admitted to the facility on . Review of Resident # 1's Health Assessment (Form 1823) dated , revealed diagnoses of , , , ( ), ( ), ( ), and , , ( ).	A 032		

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A 032	Continued From page 5 The resident's ب status was documented as memory loss; however, Resident #1 was not identified as an elopement risk. Further review revealed that Resident # 1 required supervision with ambulation but required assistance with bathing, ب, eating, and grooming. The sections ب toileting and transferring were left blank by the healthcare provider. b) Record review of Resident# 2's file revealed the following. Resident was admitted to the facility on . Review of Resident # 2's Health Assessment (Form1823) dated revealed diagnoses of ( ), (HLD), ب prostatic hyperplasia ( ), history of transient ( ), and unsteady gait. The resident's ب status was documented as ; however, Resident # 2 was not identified as an elopement risk. Further review revealed that Resident # 2 required supervision with ambulation, bathing, ب, and grooming. Further review revealed that Resident #2 was independent with eating, toileting and transferring. During an interview conducted on at 9:34 AM with the Administrator , she stated that Resident # 2 eloped from the memory care unit (MCU) on . She stated that Resident # 2 was agitated and that the staff member assigned to him walked away to retrieve her phone charger. She stated that Resident # 2 was found outside of the MCU. She further stated that she submitted an AIRS report to the Agency. During an interview conducted on at 9:56 AM with the Director of the memory care unit (MCU), she stated that no residents wore wristbands identifying them as being at risk for	A 032		

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A 032	Continued From page 6 elopement. She further stated that the residents had ripped the wristbands off. During an interview conducted on at 12:35 PM with the Maintenance Director, he stated that on , a contract familiar with the properly notified him that Resident # 1 was in the parking lot outside of the memory care unit (MCU). Further, he stated that on the day of the elopement the alarm on the door through which Resident # 1 exited had been turned off and had not been reset. During an interview conducted on at 1:08 PM, she stated that all residents in the memory care unit (MCU) were at risk for elopement and that this was the reason they resided in the unit. The Administrator also provided the surveyor a census identifying all 33 residents as being at risk for elopement. During an interview conducted on at 12:18 PM with the receptionist (Staff H), she stated that a vendor approached to the front desk and reported that Resident # 1 had , but that he was unsure of the resident's identity. Staff H further stated that Resident # 1 had exited through the door of the memory care unit (MCU) into the courtyard near the parking lot. She stated that the vendor might have left the gate open. During an interview conducted on at 1:37 PM with a medication technician (Staff I), she stated that she was present the day that Resident # 1 eloped. She further stated that no one was certain how the elopement occurred. She reported that the door alarm had always worked well and that a new resident was moving into the facility through the door that day. In	A 032		

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A 032	Continued From page 7 addition, Staff I stated that no training was provided following the elopement. During an interview conducted on at 1:55 PM with the vendor (painter), he stated that he always used the door when performing work at the facility. During an interview conducted on at 1:55 PM with the vendor (painter), he stated that he always used the door to perform work for the facility. The vendor refused to provide his name to the surveyor. During an interview conducted on at 3:22 PM with a medication technician (Staff J) , she stated that she had worked at the facility for 22 years. She stated that the facility procedures required vendors to enter through the door and one staff member to remain at the door until the vendor finishes. She stated that the southwest door is where the vendors entered the facility. During an interview conducted on at 3:40 PM with a housekeeping (Staff K), she stated that she had worked at the facility for six years. She stated that the facility had used the emergency exit doors as entrances for vendors. She stated that a lake was near the building . During a confidential interview conducted on at 3:44 PM, it was revealed that the residents could still open the emergency exit doors despite the doors being equipped with alarms. It was also revealed that Resident #1's family member still do not understand how the elopement had occurred. Additionally, it was revealed that the family did not received a call from management and that the screen on	A 032		

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A 032	Continued From page 8 Resident #1's porch was torn at the time of the incident. On at 9:51 AM , the surveyor observe that the facility's memory care unit, known as " The Bridges," was located on the first floor of the assisted living facility. The memory care unit had 7 doors. The main entrance , identified as Door #1 was located on the southeast side. Door # 2 was located on the southwest side, and Door #3 was located on the northwest side. Doors # 2 and #3 were emergency exits, however, these three doors were the most frequently used and were equipped with alarm systems. On at 12:19 PM, the surveyor observed Resident #1 eating lunch in the dining room without any staff assistance. On from 9:50 AM to 5:00 PM, the surveyor observed five staff members in the memory care unit, which had a census of 33 residents. On from 9: 50 AM to 5:00 Pm, the surveyor observed residents seeking the facility's exit doors. On at 1:55 PM, the surveyor observed a vendor requesting that a staff member open the emergency door # 2. On at 4:30 PM , the surveyor observed that the lake was approximately 10 from Door #2 and Door # 3. On at 4:45 PM, the surveyor observed another vendor exiting the memory care unit through Door # 3.	A 032		

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A 032	Continued From page 9 During the exit conference on at 5:00 PM with the Administrator and the Director of the memory care unit (The Bridges), stated that the facility had not provided staff with elopement in-service training following the elopements of both residents. Both acknowledged the findings. Class III	A 032		