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
	AL11911678	A. BUILDING: _____ B. WING _____	02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHPOINTE RETIREMENT COMMUNITY	5100 NORTHPOINTE PARKWAY PENSACOLA, FL 32514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On , an unannounced complaint investigation for allegations contained within Complaint #2021001204, was conducted at Northpointe Retirement Community. A focused control survey was conducted in conjunction. There were deficiencies identified at the time of the visit. The Facility's Census is 71. The following Class I deficiencies were identified on . . . . . at: A0025- Resident Care Supervision. The facility failed to maintain general awareness and whereabouts of 1 of 1 residents (resident #1) sampled for elopement. A0032- Elopement. The facility failed to implement its elopement policy by failing to search the premises for a missing resident and contact law enforcement after learning that the resident was not in the facility for 5:00 PM medication pass and a telephone conversation with the resident's family members, which revealed they had not seen the resident on for 1 of 1 residents sampled for elopment (resident #1). The facility also failed to have a photo identification of an at risk resident on file. Resident#1 was found in the Bay on . . . . and the medical examiner ruled the resident's an accidental drowning. The facility Administrator was notified of concerns with supervision and elopement on . . . . . . The facility Administrator was informed of the Class I deficiency on	A 000		

AHCA Form 3020-0001

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

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A 025	Continued From page 1	A 025		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.	A 025		

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A 025	Continued From page 2 (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain general awareness and whereabouts of 1 of 1 residents (resident #1) sampled for elopement. Resident#1 was found [redacted] in the [redacted] Bay on [redacted], approximately 3 miles away from the facility, and the resident's [redacted] was ruled an accidental drowning by the [redacted] Medical Examiner. The facility's failure to appropriately supervise resident #1 and maintain awareness of the resident's whereabouts resulted in a Class I deficiency. The facility Administrator was notified of concerns with supervision on [redacted]. The facility Administrator was informed of the Class I deficiency on [redacted]. The Facility's Census is 71, 39 of 71 residents	A 025		

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A 025	Continued From page 3 are receiving limited mental health services. The findings included: On . . . . . , an observation of the facility's floor plan revealed the building to be two stories. Resident #1 resided on the 2nd floor. There is an exit to the outside of the building located on the 2nd floor, in which residents may exit by going through the upper courtyard. Residents in the facility could exit the building through the 2nd floor exit without staff's knowledge. The facility's a camera system is currently not operating according to an interview with the Assistant Administrator during a tour of the facility on . . The sign-out/sign-in log is kept at the front desk on the 1st floor, next to the administration office. A record review was conducted of the facility's adverse incident form dated . . . . . at 3:56 PM. The Assistant Administrator (AA) submitted the document on the Agency's website. The report indicated that on , resident #1 came to the office to tell the AA she was going to see family today. The AA did not think anything of it because resident #1 had said this before. Resident #1 was not in the facility for 5:00 PM medication pass on . . . . . . The AA called resident #1's husband and daughter to ask them to come get her medications for when she was visiting with them. The AA reported that she left messages because she did not get an answer from the resident's husband. The AA reported that the daughter called her . . . later that night and informed the AA she had not heard from resident #1 and that her father was in the hospital. Daughter stated resident #1 was probably at a hotel somewhere. The AA reported that resident #1's daughter seemed unconcerned with the AA's phone call.	A 025		

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A 025	Continued From page 4 On . . . . . at 5:30 AM, resident #1's husband called the AA , he stated, resident #1 had done this before and she was probably at a hotel on Davis Highway. Resident#1's husband stated he would let the AA know if he heard from the resident #1. The report indicated the AA made contact with law enforcement on Sunday . . . . . after she heard that a body was found. The incident report indicated that after the detectives left the facility the AA submitted an incident report to the Agency for Healthcare Administration (AHCA) and a couple hours later employees informed the AA that according to the local news the body found in Bay was identified as resident #1. On . . . . . at approximately 3:33 PM, an interview conducted via telephone with resident #1's husband who reported that resident #1 was known for signing in and out at the facility. The husband stated that resident #1 was not supposed to leave the facility, however, the facility was a low impact facility where she could go in and out as she pleased. He stated that resident #1 was admitted to the facility after being discharged from a mental hospital about 2 years ago. Resident #1's husband stated that the resident "was not mentally capable to take care of herself, she was mentally ill, ... , . . . , very convincing and a good con-artist." On at approximately 9:11 AM, an interview with resident #2, roommate to resident #1, reported that the day resident #1 was last seen she did not say where she was going. Resident #2 reported that resident #1 was known for signing out on the log when she left the facility and signing in when returning to the facility because resident #1 knew the rules of the facility.	A 025		

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A 025	Continued From page 5 On . . . . . at approximately 9:41 AM, an interview was conducted with employee F/medication technician (MT) who reported being on duty the day resident #1 was last seen. Employee F reported that she last time saw resident #1 on around 1:30pm going to the laundry room. Employee F reported that resident #1 was known for signing out when leaving the facility and signing . . . in when she returned from the store, Dairy Queen, convenience store and Dollar General. Employee F stated that on that day (Saturday) resident #1 went missing the log showed that she did not sign out. Employee F reported that there was no time frame or rule for when residents must be returned to the facility after signing out. Employee F reported that she nor other staff on duty had knowledge of what time resident #1 left the facility on . . . . On . . . . . at approximately 9:55 AM, an interview was conducted with the Assistant Administrator (AA) and Administrator. They reported that to their knowledge, resident #1 left the facility on Saturday at some point after 1:30PM, as this was the last time employee F reported to have seen the resident. The AA reported that resident #1 has informed her and other residents that she was going to visit family and friends. Staff did not ask resident #1 any questions about who she was going to visit or when she would be leaving the facility. Their interviews revealed resident #1 seemed happy and she was talkative that day. The AA reported that resident #1 was known for signing out when leaving the facility and signing in upon returning. She stated resident #1 would go out with another resident and family. Both, the AA and Administrator reported that they were not aware what time resident #1 left the facility on	A 025		

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A 025	Continued From page 6 . . . . . , nor where they aware if she left via transportation. The AA and Administrator reported to their knowledge, resident #1 was not transported by facility staff away from the facility. At approximately 11:38 AM on , a second interview with the AA revealed that at 5:00 PM on , resident #1 was not able to be located at the facility for medication pass and that she (AA) called the resident's family (husband and daughter) to come to the facility to pick up the resident's medication and neither answered the phone. Resident #1's daughter called the facility about 7:30 PM stating resident #1 had not been with her all day but was probably at a hotel. The AA reported that the facility had no concerns and did not see this as an elopement. The AA reported that resident #1's daughter was not concerned nor was the resident's husband when he returned the facility's call at 5:30 AM on Sunday morning, ... The AA stated that resident #1's husband stated that the resident was probably in a hotel on Davis Highway. The AA reported that the process for resident's that are planning to stay away from the facility overnight was each resident had to notify facility staff, receive medication when leaving, sign out on the log. Staff would ask the resident at that time how long the resident would be gone so the facility could prepare medication for the stay. The AA reported that it has not been the facility's policy to ask residents where they were going but admitted that it is something to consider and document for accountability purposes. The AA reported that between 1:30 PM and 5:00 PM on , neither staff, nor other residents at the facility to include resident #2(roommate to resident#1) could account for the resident's whereabouts. The AA reported that the facility does not have a policy on how often the sign-out	A 025		

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A 025	Continued From page 7 and sign-in logs are checked to determine residents' whereabouts. The AA reported that the front desk receptionist works Monday through Friday from 8:00am-5:00pm. She indicated that during the weekdays, after 5:00 PM there is not a staff member at the front desk to observe who goes in and out because the Nurse aides are working on the floor. The AA reported that following the incident she verbally informed residents about signing out/signing-in during meal times and medication passes, but she did not document this information for the facility's record. The AA revealed there was not updates to the facility's elopement and/or supervision policies. The AA reported that the facility was an open facility, meaning the doors are always unlocked during the day, upstairs and downstairs. She stated that residents could leave the facility from second floor without staff knowledge. On ..... at approximately 10:40 AM, an interview was conducted with the team leader from the agency through which resident #1 receives mental health clinical services. The team leader reported that resident #1 was able to leave and come independently. The team leader stated that resident #1's level of care determined where she could go, meaning she was at an appropriate level of care. The team leader indicated resident #1 did not need to be in a nursing home or memory care unit. The team leader reported that resident #1 walked away from the facility in ..... and was gone for a few days and that staff at their agency were worried about her. The team leader revealed after the ..... elopement resident #1's daughter found the resident living under a bridge located on Davis Highway. Reportedly, resident #1 had stayed in a motel for a few days until she ran out of money. The team leader reported that resident#1's case	A 025		

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A 025	Continued From page 8 manager had last seen the resident on , and during the visit resident #1's speech was clear, she was taking medications, had claimed no attempts or voiced , and no . The team leader for resident#1's mental health clinical services revealed there had been discussion about discharging the resident but after the elopement incident in it was determined that resident #1 was not ready to discharge. The team leader reported the resident was left on the caseload due to display of , symptoms. A record review conducted for resident #1's form 1823, dated , completed by certified staff revealed Resident #1 diagnoses to include type (F 25.0). General medical included and or behavioral status included alert and oriented, calm and . Elopement risk checked off as "no". Pose as danger to self or others checked off as "no". Require 24-hour nursing or care checked off as "no". In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical nursing or facility checked off as "yes". The record identified the resident as needing assistance with the following tasks: preparing meals, shopping, handling personal affairs and assistance handling financial affairs. General oversight included observing well-being, observing whereabouts and reminders for important tasks. The resident need assistance with self-administration of medication. A record review of resident #1's community living support plan was completed on by resident #1, the adult targeted case manager, and assistant Administrator. Record review revealed	A 025		

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A 025	Continued From page 9	A 025		

resident's mental health diagnoses included , , type. Recent symptoms/behaviors during last 6 months included: Resident treatment facility medical records indicated resident #1 had a history of depressed , isolating self, and thinking. Services needs included: , , , behavioral and health case management. Other supports included but were not limited to: Frequency and service location included times a year at a local resident treatment facility.

A record review was conducted of the facility's Sign-in and sign-out log. The log indicates that resident #1 signed in and out of the facility on the following dates:

- There is no record of Resident #1 signing in or out on this day, the last day the resident was seen at the facility.
- signed out at 3:05 PM and signed-in at 4:30 PM
- signed out at 2:35 PM and signed-in at 4:50 PM
/ 21- signed out at 9:05 AM and signed-in at 11:06 AM
/2-1 signed out at 3:05 PM and sign-in at 4:06 PM
- signed out at 5:05 PM and sign-in at 5:21 PM
- signed out at 11:42 AM and sign-in at 12:15 PM
- signed out at 3:05 PM and sign-in at 3:42 PM
- signed out at 1:10 PM and sign-in at 2:50 PM
- signed out at 12:03 PM and sign-in {blank}
- signed out at 1:35 PM and sign-in at

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A 025	Continued From page 10 2:05 PM - signed out at 9:05 AM and sign-in at 10:17 AM - signed out at 4:35 PM and sign-in at 5:15 PM - signed out at 1:30 PM and sign-in at 2:00 PM - signed out at 3:55 PM and sign-in at 4:30 PM - signed out at 3:02 PM and sign-in at 3:40 PM - Resident #1 eloped from the facility on this date but there is no record of the resident signing-in or out on this day. The facility implemented their elopement policy by searching the premises, contacting the resident's family, and finally notifying law enforcement. The resident was found 3 days later by her daughter sleeping under a bridge. Following this elopement, resident #1 was and admitted in a behavioral unit for 11 days before returning to the facility. - signed out at 12:30 PM and sign-in at 12:31 PM - signed out at 12:00 PM and sign-in at 12:45 PM Class I	A 025		
A 032 SS=G	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) 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	A 032		

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A 032	Continued From page 11	A 032		

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 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

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A 032	Continued From page 12 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 sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on staff interview, record review, and policy review, the facility failed to implement its elopement policy by failing to search the premises for a missing resident and contact law enforcement after learning that the resident was not in the facility for 5:00 PM medication pass and a telephone conversation with the resident's family members, which revealed they had not seen the resident on for 1 of 1 residents sampled for elopement (resident #1). The facility also failed to have a photo identification of an at risk resident on file. Resident#1 was found . . . . . in the . . . . . Bay approximately 3 miles away from the facility and the resident's . . . . was ruled an accidental drowning by the Medical Examiner. The facility's failure to routinely account for resident whereabouts resulted in the facility being unaware that resident #1 eloped resulting in a Class I deficiency. The facility Administrator was notified of concerns	A 032		

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NORTHPOINTE RETIREMENT COMMUNITY	5100 NORTHPOINTE PARKWAY PENSACOLA, FL 32514

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A 032	Continued From page 13 with elopement on ..... . The facility Administrator was informed of the Class I deficiency on ..... . The Facility's Census is 71. The findings included: On ..... , an observation of the facility's floor plan revealed the building to be two stories. Resident #1 resided on the 2nd floor. There is an exit to the outside of the building located on the 2nd floor, in which residents may exit by going through the upper courtyard. Residents in the facility could exit the building through the 2nd floor exit without staff's knowledge. The facility's camera system is currently not working. The sign-out/sign-in log is kept at the front desk on the 1st floor, next to the administration office. Record review of facility's Elopement Policy titled: Missing Person, effective date unknown, revealed when staff are concerned that a resident is missing, they should contact the Administrator immediately. After contacting the administrator, the following procedures are outlined for staff to follow if a resident is missing. 1. A thorough search will be made of each building. 2. Unoccupied rooms will be checked. 3. The grounds surrounding each building will be checked. 4. An employee will take a car and search the surrounding neighborhood. 5. The police will be notified by the Administration. 6. The police will require the following information: name, age, physical description, clothing description, name and address of family member	A 032		

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A 032	Continued From page 14 7. Family will be notified by Administration A record review of documentation of a previous elopement for resident #1 was conducted. On [redacted], resident #1 eloped from the facility after telling an employee she felt she couldn't stay at the facility any longer because she owed too many people money and that she could not afford to pay everyone anymore. The employee reinforced to resident #1 that she lives at the facility and does not owe any money. The employee said she should return to her room and speak with the Assistant Administrator in the morning. The employee said that resident #1 agreed to talk with management in the morning and went up the elevator toward her room. At 8:10 PM, when employee A went to resident #1's room to assist with her PM medication, resident #1 was not in her room. Staff immediately conducted a search around the inner an outer premises of the facility and when resident #1 could not be located at the facility and surround neighborhood, law enforcement was notified. A missing resident report was filed by law enforcement. Resident #1 was found 3 days after her elopement by the resident's daughter living under a bridge. After being found, the resident was admitted to a local behavioral health facility for 11 days before returning to the facility. The facility did not document in their analysis of the incident interventions put into place for resident #1 following her elopement and return the facility. There was also no mention policies and procedures updates, elopement drill, or education provided to staff and other residents. Resident #1 had an updated form 1823 conducted on . The form documents the resident's diagnoses to include [redacted] type (F 25.0), [redacted]	A 032		

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A 032	Continued From page 15 , and . The elopement risk section of the form was checked off as "No", meaning the resident was not considered an elopement risk following her elopement in which she was missing from the facility for 3 days before being located. The section regarding "Pose as danger to self or others" was checked off as "No". The form indicated resident#1's needs could be met in an assisted living facility, which was not a medical nursing or facility. The form documents that the resident required assistance with preparing meals, shopping, handling personal affairs, and handling financial affairs. The form also documents resident #1 requires general oversight to include observing the resident's well-being, observing the resident whereabouts and reminders for important tasks. It also indicates that the resident was assistance with self-administration of medication. Record review of facility's adverse incident form dated at 3:56 PM, submitted by the Assistant Administrator (AA), documents that on , resident #1 came to the office to tell the AA she was going to see family today. The AA did not think anything of it because resident #1 had said this before and resident #1's daughter had come to see her. Resident #1 was not in the facility for 5:00 PM medications on , as a result, the AA called her husband and daughter to ask them to come get her medications for when she was with them. The AA left messages. The daughter called the AA later that night and informed the AA she had not heard from resident #1 and that her father was in the hospital. Resident #1's Daughter stated resident #1 was probably at a hotel somewhere. She seemed unconcerned with the AA's phone call. On at 5:30 AM, resident #1's husband called AA	A 032		

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A 032	Continued From page 16 . . . . , he stated, "resident #1 does this and I bet resident #1 was at a hotel on Davis Highway. Resident #1's husband stated he would let the AA know if he heard from resident #1. The incident report continued that on . . . . . , at 1:00 AM, the AA received a call from the facility that a sheriff's deputy was at facility to see resident #1's file. The deputy stated that a photograph of resident #1 was posted on their Facebook page . . . in when she went missing. He came to gather information. On . . . . . at 11:15 AM two detectives came to facility and wanted more information on resident #1. The detectives spoke with resident #1's roommate, staff members and other residents. The incident report indicated that the AA reported to the officers that there was a body found in the . . . . . Bay which they did not think matched resident's #1 description. The AA told them on Sunday, ... after she heard that a body was found, she called 911 to inquire if it was male or female. The Incident report indicated that after the detectives left the facility the 24-hour incident report was submitted to the Agency for Healthcare Administration. A couple hours later, employees informed the AA that according to the local news the body that was found in . . . . . Bay was identified as resident #1. On at approximately 9:55 AM, an interview with Assistant Administrator (AA) and Administrator revealed that to their knowledge, resident #1 left the facility on Saturday, time unknown, and was last seen around 1:30 PM by employee F who saw resident #1 going to laundry the room to do laundry. The AA reported that resident #1 had informed her and other residents that she was going to visit family and friends. She did not answer any questions about who she was going to visit or when she would be leaving the	A 032		

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A 032	Continued From page 17	A 032		

facility. She seemed happy and she was talkative that day. The AA reported that resident #1 was known for signing out when leaving the facility and signing in upon returning. Resident #1 would go out with another resident and family. The AA reported that on at 5:00 PM medication pass resident #1 was not in the facility for medication, so the AA called family members (husband and daughter) asking that they come to the facility to pick up medication so that when resident#1 was with them she would have her medications. The AA reported that the family members did not answer their phone and so she left message on both the husband and daughter. The AA reported that the daughter called a few hours later and informed the AA that resident #1 was not with them, but probably at hotel which she had done before. The AA reported that resident #1 had done this once before in . The AA reported that on Sunday morning at approximately 5:30 AM, resident #1's husband returned the AA's call saying resident #1 probably was at hotel on Davis Highway. The AA reported that resident #1 would keep all her , , , , , , with mental health facility. The AA reported that the last report she received was from an investigator or law enforcement on Monday late afternoon who reported he was waiting for autopsy to come . After the incident elopement training was provided to staff verbally but facility had no documentation. The AA reported that elopement training is done on hire, every six months with elopement drills. The AA reported that residents are monitored at mealtime and medication pass. The AA and Administrator reported that they were not aware when resident #1 left the facility on . The AA and the Administrator indicated they were unable to determine if the resident left via transportation and to their knowledge no

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A 032	Continued From page 18 facility staff transported resident #1 away from the facility. At approximately 11:38 AM on , a second interview with the AA who reported again that at 5:00 PM on , resident #1 was not at the facility for medication pass and the AA called resident #'1 family (husband and daughter) to get come pick the resident's medication up but neither of them answered the phone, so the AA left messages. Resident #1's daughter call . . . about 7:30 PM stating that resident #1 was not with her but was probably at a hotel. The AA reported that the facility has no concerns and did not see this as an elopement. The AA reported that the resident's daughter was not concerned nor was her husband, when he returned a call at 5:30 AM on Sunday morning . Both the daughter and husband indicated that resident#1 was probably in a hotel on Davis Highway. AA reported that . . . in . . . . . , when resident #1 eloped, she did not notify the facility that she was going out and did not notify that she was going out with family or friends or anyone. On Saturday . . . . . , when resident #1 reported that she was going out with family and friends, the facility did not implement the elopement policy because they did not feel it was an elopement because she had informed assistant administrator and other residents that she was going to visit family and friends. The AA reported that the process for resident's that are planning to stay away from the facility overnight was each resident had to notify facility staff, receive medication when leaving, sign out on the log. Staff would ask the resident at that time how long the resident would be away from the facility so the facility could prepare medication for the stay. The AA confirmed resident had not made preparations to stay out overnight. The AA reported that it has	A 032		

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A 032	Continued From page 19	A 032		

not been the facility's policy to ask residents where they were going but admitted that it is something to consider and write down for accountability purposes. AA reported that resident #1 did not sign in and out on the log for the elopement and did not sign out on Saturday . The AA reported that between 1:30 PM and 5:00 PM on staff or other residents at the facility to include resident #2(roommate to resident#1) could account resident#1's whereabouts. The AA indicated it was not until 5:00 PM on when resident #1 missed medication pass that she contacted the resident's family (spouse and daughter) about the resident missing medication, so they needed to come pick medications up so they could provide to resident #1 while she was with them. The AA indicated that the facility did not have pictures of residents but will implement pictures and will start encouraging residents when signing out to put down a destination. The AA reported that the facility does not have a policy on how often the sign-out and sign-in logs are checked to determine residents' whereabouts. The AA reported that after 5:00 PM there is not a staff at the front desk to observe who goes in and out because the Nurse aides are working on the floor. The AA reported that after the incident she could not provide any documentation that either the AA or administrator had met with residents or staff to go over the sign-out/sign in log, The AA reported that she had verbally informed all residents during medication pass, breakfast, lunch and dinner. The AA reported that the facility was an open facility, the doors are always unlocked during the day, upstairs and downstairs. She Stated that residents could leave the facility from second floor without staff knowledge. The AA revealed that the facility currently have no residents deemed as an elopement risk. She indicated that

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A 032	Continued From page 20 if a resident would be deemed an elopement risk by a health provider, administration will not accept the admission because the facility does not have a locked unit. The AA also stated that if a resident becomes an elopement risk while a resident of the facility, staff would notify the resident medical provider and family that resident needs cannot be met and the resident will be given a 45-day discharge. Record review of the report dated . . . . revealed that the facility became aware that resident #1 was not in the facility for 5:00 PM medication pass on and contacted her family to come pick up medications so the would be able to give her while she was with them but had to leave a message because there was not an answer. Resident #1's daughter returned the AA's call on . . . . . around 7:30 PM informing the AA that resident #1 was not with them and on . . . . around 5:30 the resident's husband called informing AA that resident #1 was also not with him. Once informed resident#1's family was not aware of the resident's whereabouts, the facility did not implement its missing person elopement policy which would have included a thorough search of the building, unoccupied rooms and the surrounding area of each building. Record review of the report dated indicated resident #1 eloped from the facility and facility administrative staff identified this as an elopement. Resident #1 was admitted in behavioral hospital for approximately 10 days and returned as resident to the facility. Record review of resident #1 medical record indicated no photo identification in it and facility was not aware if resident #1 had identification on her possession that included her name, and the facility's name and telephone number.	A 032		

Agency for Health Care Administration

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A 032	Continued From page 21 On at approximately 9:00 AM, a phone interview was conducted with County Medical Examiner's office. This surveyor was informed that the resident #1's body was found in the Bay on . The resident's cause of was determined to be drowning and the examiner ruled the resident's to be accidental. Record review of facility's record revealed the last elopement drills were done and . Record review revealed there to be no documentation of elopement drills, training, or policy updates following resident#1's elopement on , which resulting in the resident's . Class I	A 032		