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
	AL11964559	A. BUILDING: _____ B. WING _____	03/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIS POINTE	1200 AVENIDA DEL CIRCO VENICE, FL 34285

(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 An unannounced complaint survey for #2021002024 and #2021002439 was conducted on at Maris Pointe, an assisted living facility in Venice, Florida. Complaint #2021002024 was substantiated at A0010, A0008 and A0004. Complaint #2021002439 was substantiated at A0032. The following is description of the deficiencies.	A 000		
A 004 SS=D	59A-36.004 FAC Licensure - Requirements (1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide. (2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in rule 59A-36.005, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and	A 004		

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A 004	Continued From page 1 sanitation inspection standards referenced in rule 59A-36.005, F.A.C. (4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of chapters 408, Part II, 429, Part I, F.S. and rule chapter 59A-35, F.A.C., and this rule chapter. (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to chapter 408, part II, and section 429.14, F.S., and rule chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility provided care and services for 1 (Resident #6) of 4 residents reviewed that were beyond the scope of their license. The findings included:	A 004		

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A 004	Continued From page 2 A review of the facility license showed it had a Standard license for assisted living facilities. Observation on at 12:00 p.m., showed Resident #6 in the dining room for lunch. Staff B, direct care, was feeding Resident #6 her lunch. Resident #6 did not participate in taking her food using utensils or to eat her food. Observation after lunch showed Staff B wheeling Resident #6 to her bedroom in her wheelchair. Staff B said Resident #6 does not move or manipulate her wheelchair. Staff must wheel Resident #6 throughout the facility. Staff B said Resident #6 wears adult briefs and does not use the commode for her toileting needs. She does not change her adult briefs or clean herself during toileting. Staff B said Resident #6 requires total care for her toileting needs. Staff B said Resident #6 requires total care for ambulating, eating and toileting. Resident #6 was also asked to comb/brush her hair. She did not respond to this request. Staff B said Resident #6 does not do any type of grooming, which includes: brushing her hair, her and washing her . She requires total assistance from staff for these tasks also. A review of Resident #6's record did not show she was under hospice care. A review of her health assessment (1823) dated showed Resident #6 was able to perform ambulation with supervision from staff. It also showed she required assistance from staff for bathing, , grooming, eating, toileting, and transfer. On at 1:40 p.m., an interview was conducted with the Executive Director. She said she was not aware Resident #6 requires total assistance with her ADLs. At 5:00 p.m., the Executive Director confirmed the facility has a	A 004		

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A 004	Continued From page 3 Standard license, Class III	A 004		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s condition on the date the examination is performed, becomes a permanent part of the facility ' s record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been	A 008		

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A 008	Continued From page 4 completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator	A 008		

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A 008	Continued From page 5 whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name,	A 008		

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A 008	Continued From page 6 signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by	A 008		

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A 008	Continued From page 7 the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (g) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 008		

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A 008	Continued From page 8 failed to ensure 3 of 6 health assessments were filled out completely. The findings included: A review of Resident #1's health assessment dated . . . . did not show if he was an elopement risk or not. A review of Resident #4's health assessment dated . . . . did not show if she was an elopement risk or not. A review of Resident #5's health assessment dated . . . . . did not show her level to assistance for transfer. An interview was conducted with the director of nursing on . . . . . at 1:30 p.m., She reviewed these health assessments and said she was not aware these health assessments were incomplete. Class III	A 008		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of	A 010		

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A 010	Continued From page 9 appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended	A 010		

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A 010	Continued From page 10 congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days.	A 010		

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A 010	Continued From page 11 (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within	A 010		

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A 010	Continued From page 12 the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to: Ensure 3 of 4 residents continued to meet the criteria for continued residency, Ensure 3 of 3 residents had new health assessments after a significant changes and Ensure 1 of 2 residents under hospice care had an interdisciplinary care plan from hospice. The findings included: 1. A review of Resident #5's health assessment date showed she required total assistance from staff for ambulation and bathing. There were no other documented assessments that showed Resident #5 was able to perform these two Activity of Daily Living (ADLs) independently or with staff assistance. On .. ... at 1:40 p.m., an interview was conducted with the executive director. She reviewed this health assessment for Resident #5 and said she was not aware this health assessment showed Resident #5 requires total care for these two ADLs. 2. Observation on at 12:00 p.m., showed	A 010		

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A 010	Continued From page 13 Resident #6 in the dining room for lunch. Staff B, direct care, was feeding Resident #6 her lunch. Resident #6 did not participate in taking her food using utensils of , to eat her food. Observation after lunch showed Staff B wheeling Resident #6 to her bedroom in her wheelchair. Staff B said Resident #6 does not move or manipulate her wheelchair. Staff B wheels her around the facility. Staff B said Resident #6 wears adult briefs and does not use the commode for her toileting needs. Resident #6 does not change her adult briefs or clean herself during toileting. Staff B said Resident #6 requires total care for her toileting needs. Staff B said Resident #6 requires total care for ambulating, eating and toileting. Resident #6 was also asked to comb/brush her hair, she did not respond to this request. Staff B said Resident #6 does not do any type of grooming, which includes: brushing her hair, her and washing her . She requires total assistance for these tasks also. A review of Resident #6's record did not show she was under hospice care. On at 1:40 p.m., an interview was conducted with the Executive Director. She said she was not aware Resident #6 requires total assistance with her ADLs. 3. A review of Resident #1's health assessment dated showed he requires 24-hour skilled nursing and/or , , care. An interview was conducted with the Director of Nursing on at 1:30 p.m., She reviewed this health assessment and confirmed she was not aware of this documentation. Resident #1's health assessment dated showed he required assistance with all of his	A 010		

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	AL11964559	A. BUILDING: _____ B. WING _____	03/15/2021

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A 010	Continued From page 14 ADLs. He started receiving hospice services on . Observation throughout the course of the survey showed he requires total assistance from staff for his ADLs. There was no new health assessment that showed the significant change in his participation of his ADLs since . A review of Resident #5's health assessment dated showed she requires assistance with , grooming and toileting. She is independent with eating. There is also a check mark showing she needs assistance with eating and "needs lots of encouragement." Observation on at 12:00 p.m., showed Staff A feeding Resident #5. After lunch an assessment with Staff A was conducted with Resident #5. This assessment showed Resident #5 requires total assistance with ambulation. She uses a wheelchair and staff wheel Resident #5 around the facility. Staff A said Resident #5 does not manipulate the wheelchair for her to move around. Staff A also said Resident #5 does not use the commode for her toileting needs. She wears adult briefs. She does not change her adult briefs or clean herself after each use. She requires total assistance for this. Staff A said Resident #5 has been like this for at least 2 months. A review of Resident #5's record showed hospice was notified on for a referral. There was no updated health assessment to show this significant change in her ADLs. A review of Resident #6's health assessment dated showed she requires assistance with all ADLs except one. She requires supervision for ambulation. Observation on during the survey showed Resident #6 requires total assistance for eating, ambulation, toileting, and grooming. See paragraph 3 for	A 010		

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A 010	Continued From page 15 more detailed information concerning her ADL care. Further review of Resident #6's record showed there was no updated health assessment showing her decline in her ADLS. On at 1:30 p.m., an interview was conducted with the Director of Nursing. She stated they have not completed updated health assessments for these three residents showing their significant changes in their ADLs. 4. A review of Resident #1's record showed he is under hospice care since . Further review of his record showed there was no interdisciplinary care plan from hospice. On at 1:30 p.m., the Director of Nursing said she has been asking hospice to send the care plan but has not received it yet. Class III	A 010		
A 032 SS=D	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 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	A 032		

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A 032	Continued From page 16 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 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,	A 032		

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A 032	Continued From page 17 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 observation, staff interviews and record review the facility failed to ensure 5 Residents (#2, #3, #4, #8, and #9) of 5 residents reviewed out of a possible 32 total residents residing in a secured memory care unit were assessed as to their level of possible elopement from the facility. The facility failed to ensure 5 Residents (#2, #3, #4, #8, and #9) of 5 residents had identification on their persons which included their name, the facility's name, facility's address, and telephone. The findings include: On . . . a review of the facility's "Elopement/Missing Person" policy, which is not dated, states staff will respond immediately with emergency procedures when a resident has been identified as missing. In the section titled, "Procedures": #1 - The Director of Memory Care (Director of Health and Wellness) will develop and maintain a current listing of all resident identified as . . . . risks. #3 - The staff will be routinely alerted as to the individual residents who have been identified to be at risk via service plan, communication records and shift change reports. #4 - Full-bodied photos of each resident will be maintained on file along with each resident's emergency numbers such as physician and	A 032		

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A 032	Continued From page 18 family. In the section titled: "Missing Resident": #2 - The Executive Director (ED) and Director of Memory care are immediately notified of missing resident. The section titled "If Resident Returns and Remains in the Community": #2 - Update service plan to reflect risk. #4 - complete and file incident report. #6 - The ED and Director of Memory Care will evaluate Community's continued ability to meet the resident's needs. On . . . . at 10:45 a.m., Staff C, a Caregiver said the facility is a secured memory care unit and some of the residents are . . . . who are at a higher risk of attempting to elope. He said he didn't know if the facility had a list of residents who are at a higher list of eloping from the facility. He said all residents were required to have a . . on with their names, facility name and address and a contact number. He said he was unaware if any residents had eloped from the facility within the last year. On . . . . at 11:05 a.m., during an interview with the Lifestyle Coordinator, she said the facility is a secure memory care unit with residents who are considered . She said she tried to keep the residents busy with activities but some of the are at a higher risk of elopement. She said she was unaware of the residents who were at a higher risk of elopement. She said all residents were required to have a on with their names and other information so they can be identified and brought safely in case they eloped from the facility. On at 12:00 p.m., the Director of Health	A 032		

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A 032	Continued From page 19 and Wellness (DHW) said she considered all residents who can ambulate and are at risk for elopement from the facility. She said a couple of months ago she did a full facility audit to make sure all residents had a / which had their names, facility name and address and the facility's phone number, in case they eloped from the facility. She said all shifts were required to make sure if a resident is missing their to notify administration so a new one could be made immediately for that resident. On at 12:15 p.m., during lunch observation in the main dining room Residents (#2, #3, #4, #8 and #9) were identified by the DHW as not having the / bracelet with the required information. On a review of Resident #2's medical record revealed on , he had attempted to exit the facility's front door and was stopped by the DHW. Later when Staff D went to provide Resident #2's medication to him, she was unable to find him in the facility. Staff D alerted caregivers and the DHW that she was unable to locate Resident #2. Resident #2 was found by the police a couple of blocks away at the airport and was returned to the facility. It was unable to be determined how long Resident #2 was missing. He was last seen by staff more than 2 hours before Staff D could not locate him. Further review of Resident #2's medical record revealed the Advanced Registered Nurse Practitioner (ARNP) wrote on Resident #2 was having episodes of agitation, combative and exit seeking. The ARNP also wrote on Resident #2's behaviors included exit seeking and he would become extremely agitated. There is no documentation Resident	A 032		

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A	Continued From page 20 #2's service plan was updated to reflect his higher risk of elopement as required by the facility's Elopement/Missing Person policy and procedure. On . . . . a review of Resident #3's medical record revealed she was admitted to the facility on . . . . . A Resident Health Assessment dated , noted Resident #3 was a and elopement risk. On . . . . . at 1:56 p.m., the Executive Director (ED) said Resident #2 had eloped in . . because an outside contractor left one of the exit doors ajar which allowed Resident #2 to elope from the facility. She said she was unaware Resident #2 had eloped from the facility until a police officer informed her over the phone, he had located Resident #2 at the airport a few blocks away. She said all residents were required to wear a / with their name and facility identifier in case they left the facility unattended. She said she was unaware several of the residents were not wearing the required / and was now conducting a full facility audit to ensure all the residents were wearing their as required. On at 2:35 p.m., Staff D and Staff E, both License Practical Nurse's (LPN) said the facility was a secured locked facility to keep the residents safe due to their . . . . . They said some of the residents are . . . . and are at a higher risk of elopement from the facility. They said the facility did not have a list of residents who were at a higher risk of elopement with a full body picture, maintained in a file with their physician and family members contact information as stated in the Elopement/Missing Person policy and procedure. They said all residents are required to wear an identification	A 032		

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A 032	Continued From page 21 (ID) with their name and facility information. They said they were unaware until this afternoon, Residents (#2, #3, #4, #8 and #9) were missing their On at 4:45 p.m., the DHW said the facility is a secured locked unit to keep the residents safe due to their , cognition. She confirmed Resident #2 eloped the facility on and the ARNP wrote on and on Resident #2 is exit seeking. She also confirmed Resident #3's Resident Health Assessment dated stated she was an elopement risk. She said she did not create and/or updated a service plan for Residents #2 and #3 reflecting their higher risk of elopement as required in their Elopement/Missing Person policy and procedure. The DHW confirmed the facility did not identify residents who were at a higher risk of elopement and a binder/list of those residents was not created identifying those residents which should have included a full body picture, used for identification and the contact information of the primary care physician and family which was easily assessable to the staff. The DHW also confirmed Residents (#2, #3, #4, #8 and #9) did not have the required with their name, the facility's name, the facility's address, and telephone as required. Class III	A 032		