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
	AL11963788	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

(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 A complaint investigation #2021012262 was conducted at Panorama Living Assisted Living Facility on . Deficiencies were identified at the time of survey.	A 000		
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 Resident Care Standards. 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	A 025		

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 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. (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 police reports, record review and interviews the facility failed to provide adequate supervision and general awareness of whereabouts for 1 of 4 sampled residents (#4), who was forgetful, disoriented and eloped from the facility twice. Findings: On . . . . . at 9:45 AM, staff B said resident #4 eloped from the facility and was returned when the police K9 found him in a neighborhood in the area of the facility. She did not mention that he had any other elopements.	A 025		

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A 025	Continued From page 2 Record review for resident #4 revealed a resident health assessment form 1823 dated that noted diagnosis that included , , , and . The health care provider noted the resident was disoriented and forgetful. A health care providers note documented on the resident had with behaviors. The health care provider noted he was able to leave the facility in an unsafe manner. A health care providers note documented on the resident left the facility unattended last week and was brought by the police. Review of the facility notes revealed the following: at 3:15 PM-a caregiver called and reported she did not see resident #4 present at the facility. The last time was 20 minutes ago. Other residents said he had gone out of the facility on the side. The administrator instructed the caregiver to keep searching the neighborhood. at 5:41 PM-after thorough searching of the neighborhood, two caregivers drove along with their friend and found resident #4 at Bear Lake Road Unharmed. They drove the resident to the facility. at 10:08 AM, the owner called and reported resident #4 was nowhere to be found at the facility. Caregivers have been searching for him. Verified with the caregivers the last time that he was seen was 10 AM. She had just seen him 2 minutes ago heading to his room. The owner and 2 caregivers drove thoroughly around neighborhood and to a quite far distance, searching for resident #4.	A 025		

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A 025	Continued From page 3 -11:38 AM-the administrator decided to report to the police after searching, Resident #4 was nowhere to be found. Called 911. -12 PM-Police arrive, and event reported with demographics/medical report paper and photo provided. -1:50 PM-police brought resident #4 . . . to the facility/ alert/ambulatory/ verbally responsive good , contact/ moves upper and lower extremities equally. Resident #4 was found at the gated community at Orange Blossom Trail. at 4:15 PM-Placed an armband for his identification. . . . . . -3:43 PM-staff C, the caregiver called and reported of resident #4 continuous walking around. Instructed caregiver go keep reorienting the resident and to closely monitor him physically. -6:46 AM staff B called and reported resident #4 temperature was 100.8, told her to increase fluid and give , 650 milligrams. . . . . . -8:27 AM-hospice said resident needed to go to the hospital and have , done-resident brought to the hospital. On . . . . . at 10:45 AM staff A, a caregiver said on , after the resident had not been seen for about 20 minutes and searching the building, she and another staff drove around and found the resident on Bear Lake Road and returned him to the facility. She was asked at the time what interventions were put in place to ensure the resident would be monitored to	A 025		

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A 025	Continued From page 4 prevent him from leaving the facility again. Staff A said she was not informed of anything that she needed to do. She was not aware of any identification that was placed on him. She further stated the second time resident #4 left, staff C, the kitchen staff noticed he was missing because after he had breakfast, he was always would go to the living room area. She said they searched the building and outside and did not locate him. She and staff C left in their cars to search for him also the owner was searching and resident #4 could not be located. She said the administrator called the police, the police search the premises and later used their K9 to find the resident and returned him to the facility. On ..... at 2:15 PM staff B, a caregiver said on at around 10 AM she observed the resident in the living room where he always sat. She said he began walking around and she told him he could go to his room if he wanted to, she said she left the area briefly to get laundry and then returned to the area and was asked by staff C if she had seen him. She said he would always be around the area of the kitchen and staff C was used to seeing him there. She said the resident was able to move around quickly. She said they did a search of all the rooms and the premises and could not locate him. She said she was left behind with the residents and other staff went to search for resident #4. She said when everyone returned to the facility, the police began to start the search with the K9. She said she left walking with K9 to search. She said when the K9 began to run she had to turn around. She said the K9 found the resident in a subdivision and returned the resident safe. She was asked about any interventions in place to ensure that the resident would not be able to leave without the staff's knowledge. She said they watched the resident	A 025		

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A 025	Continued From page 5 closely when he returned. On ..... at 2:30 PM, the administrator said the resident did leave the facility twice, she believed that the resident was taking too much medication causing him to sleep too much when he was admitted into the facility. She said she spoke with the resident's health care provider who decreased some of his medication so that he would be more alert and not sleep all the time. She said by decreasing his medications he did become more alert and would move around more, which possible lead to him becoming exit seeking. She said she informed the staff to monitor him closely after he left the first time. She said the resident moved quickly and the staff was aware that he was not present within a few minutes and found that he was not on the premises. She said after the second elopement she gave the resident a notice of discharge, the staff were told to monitor him closely. She said he had a high temperature on and was sent to the hospital and would not be returning because they found another facility that would accept him that was secure. Review of the elopement policy revealed it noted: Residents identified as and/or potential for elopement will be monitored very closely and an interdisciplinary plan will be in place to help protect the resident. The plan will include taking a picture of the resident, posting at all vital resident movement areas. Staff on duty need to be monitoring resident (taking note on what the resident is doing, behavior, what the resident is wearing.). Doors need to be armed at all times. Resident or resident's guardian consent to photograph form. Record review for resident #4 did not reveal an interdisciplinary plan as stated in the elopement	A 025		

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A 025	Continued From page 6 policy, nor was there a photo in his record. The administrator provided a picture that she had in her cell phone. She confirmed there was no picture of him in the facility. Observation on at 3 PM, revealed the facility doors did not have alarms on the doors as stated in the elopement policy. On at 3:15 PM, the administrator confirmed there was no interdisciplinary plan for resident #4 and she confirmed the facility's doors did not have alarms. Review of the police report revealed it noted the following: On at 11:44 AM, the administrator informed the officer that around 10 AM resident #4 left the facility on and gave a description of the clothes he was wearing. The officer canvassed the property and did not find resident #4. Dispatch advised they checked all the local hospitals, and they did not have anyone resembling the resident. A Sergeant requested an ALERT, but they could not assist due to inclement weather in the area. The Sergeant requested for nearby K9 to assist and an Orange County Office K9 responded to the facility. A reverse 911 search was enacted The Orange County K9 deputy picked up a scent from resident #4's used laundry. The track from the K9 took the officers around the property heading south on Balmy Beach drive and into the Bel Air I subdivision. During their track, deputies assisting on the call received a contact through reverse-911 that came from a resident of the community (name listed). She had called earlier about a someone on her property (she	A 025		

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A 025	Continued From page 7 gave a description of the person and the clothes he was wearing). The deputies responded to the address and made contact with the resident who was in the driveway of the residence. The resident was transported to the facility. The facility was located on a busy road that was a single lane. Based on the staff description of where the resident was found on the first elopement, he would have had to cross the single land road to get to the area that was a mile or more away. Based on the address where the resident was found during the second elopement was 0.9 miles away from the facility. Resident #4 had to cross several busy streets to get to the location where he was found by the police. According to the police report there was also inclement weather at the time of the search. The resident's health care provider documented that he was disoriented and forgetful. The resident should have been monitored more closely after his first elopement from the facility. Each of the elopements placed him at a risk for harm. Class II	A 025		
A 032 SS=D	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	A 032		

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A 032	Continued From page 8 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 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	A 032		

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A 032	Continued From page 9 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 review, elopement policy review, observation and interviews, the facility failed to follow their elopement policy, did not maintain photo identification of at risk residents on file at the facility for 2 of 2 sampled residents (#1 and #4), who was at risk of elopement and did not have identification on a resident that included her name, the facility's name, address and telephone number for 1 of 2 sampled who was an elopement risk (#1). Findings: 1. Record review for resident #2 revealed a resident health assessment form 1823 dated that noted a diagnosis of , An Elopement risk form dated noted the resident had slight in the morning and evening. The form noted: Does the resident have a history of elopement at home. If yes, number of times and explain	A 032		

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A 032	Continued From page 10	A 032		

occurrences: Yes was check for this question.
written in the space was " 1 time-resident had a miscommunication with a previous facility." The facility notes documented the following:

-1:52 PM-staff b, the caregiver called and reported resident #1 attempt to walk out of the facility at the front of the parking area and verbalized of wanting to get out. Per staff b, resident #1 has been very agitated but able to bring her . . . inside.

. . 1:30 PM-noted resident #1 ambulates with her walker out of the facility about 100 . . . away. Verified with resident #1 of her agitation and expressed of wanting her roommate out. Resident #1 was brought to the facility Informed resident #1 of moving her to another room. Resident #1 agreed to move to another room and ambulates with her walker with tolerance. Resident #1 has episodes of incoherent .

at 3:28 PM- A caregiver called and reported she had been following resident #1 from the facility to the pathway at the neighborhood and resident #1 refuses to come . . . .

at 3:33 PM-Staff c and the other caregiver drove to bring resident #1 to the facility. Resident #1 continued to refuse to get in the car. Resident #1 was . . . . . and physically aggressive. Attempts to speak with resident #4 was resistant to get . . . to walk/ ride to the car to the facility. Beverly verbalized who's going to pay?

at 3:46 PM-the resident's grandson was call and informed that the staff were following resident #1 and she was refusing to go to the facility. The grandson came to bring the resident to the facility

2:28 PM-the caregiver called and reported resident #1 walking with her walker at

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A 032	Continued From page 11 the . . . of the facility, very resistant to get . . . inside and . After attempts made, resident #1 called to get inside and remains agitated On . . . . . at 2 PM, the administrator stated that the resident was exit seeking. She said after the resident's medication was adjusted she was doing better and was not trying to exit seek. Observations of resident #4 at 2:45 PM, who was ambulating with a walker, the resident approach the administrator and asked if she would be able to leave. The administrator was asked at the time if the resident had any identification on her person. The resident answered and said no, I do not have any identification on me. While raising her arms. The administrator said at the time the resident did not have identification on her person as required. Record review for resident #4 revealed he was disoriented and forgetful and had eloped from the facility on and and the staff were unaware that he had left the facility. Review of the elopement policy revealed it noted: Residents identified as and/or potential for elopement will be monitored very closely and an interdisciplinary plan will be in place in order to help protect the resident. The plan will include taking a picture of the resident, posting at all vital resident movement areas. Staff on duty need to be monitoring resident (taking note on what the resident is doing, behavior, what the resident is wearing.). Doors need to be armed at all times. Resident or resident's guardian consent to photograph form. Record review for residents #1 and #4 revealed there was no evidence of an interdisciplinary plan found in their records as stated in the elopement policy, nor was there a photo in their records or	A 032		

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A 032	Continued From page 12 the facility's records. The administrator provided a picture of resident #4 that she had in her cell phone. She confirmed there was no pictures of residents #1 and 4 at the facility that was accessible to all facility staff and law enforcement in the event of an elopement. Observation on . . . . . at 3 PM, revealed the facility doors did not have alarms on the doors as stated in the elopement policy. On at 3:15 PM, the administrator confirmed there were no interdisciplinary plans for residents #1 and #4 and she confirmed the facility's doors did not have alarms as their elopement policy noted. Class III	A 032		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;	A 055		

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A 055	Continued From page 13 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If	A 055		

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
	AL11963788	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

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A 055	Continued From page 14 centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain documentation of the disposition of a medication, did not return medications to the residents or their responsible party when 2 of 2 sampled resident's stay ended (#3 and #4). Findings: Record review for resident #3 revealed she was discharged from the facility on and	A 055		

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PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

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A 055	Continued From page 15 resident #4 was discharged from the facility on . Further record review for resident's #3 and #4 revealed there was no documentation to confirm that their medications were returned to the residents or their representative or disposed of after their stay had ended. On at 3:30 PM, the administrator said that she would return the resident's medication to the pharmacy when their stay ended. She said she did not document what medications were sent to the pharmacy, the amounts and date. She further stated she was not aware that she was to return all medications to the resident or representative and if it was not returned to the family, she was to notify the family that the medications were still at the facility giving them 15 days to respond before disposing of the medication. Class III	A 055		
CZ821	59A-35.110 FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day	CZ821		

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CZ821	Continued From page 16 operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections; and, (f) Approval of revisions to emergency management plans. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be	CZ821		

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CZ821	Continued From page 17 accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, ,	CZ821		

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CZ821	Continued From page 18 2018, which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored.	CZ821		

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CZ821	Continued From page 19 This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to electronically submit to the agency, a preliminary adverse incident report within 1 business day of an events follow by 15 days after the occurrence of an elopement. Findings: On [redacted] at 9:45 AM, staff b said resident #4 eloped from the facility and was returned when the police K9 found him in a neighborhood in the area of the facility. She did not mention that he had any other elopements. Record review for resident #4 revealed a resident health assessment form 1823 dated that noted diagnosis that included [redacted]. The health care provider noted the resident was disoriented and forgetful. A health care providers note documented on [redacted] the resident had [redacted] with behavior. The health care provider noted he was able to leave the facility in an unsafe manner. Review of the facility notes revealed the following: [redacted] at 3:15 PM-a caregiver called and reported she did not see resident #4 presence at the facility. The last time was 20 minutes ago. Other residents said he had went out of the facility on the side. The administrator instructed the caregiver to keep searching the neighborhood. at 5:41 PM-after thorough searching of the neighborhood, two caregiver drove along with their friend and found resident #4 at Bear Lake	CZ821		

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CZ821	Continued From page 20 road. Unharmed. They drove the resident . . . to the facility. The administrator was asked if she had submitted an electronic report of the occurrences to the agency for the elopement. On at 2 PM, the administrator said she did not think she needed to complete and adverse report because resident #4 was found. Unclassified	CZ821		