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
	AL11911029	A. BUILDING: _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JC & C ALF	158 WEST 10 STREET HIALEAH, FL 33010

(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 (complaint number 2022006569) was conducted at JC & C ALF on . Deficiencies were identified at the time of the survey.	A 000		
A 032 SS=I	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	A 032		

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record review, interview, the facility failed to ensure that a resident who was identified as at risk of elopement, and who eloped from the facility, had identification on his/her person which included the resident and facility name for one out of four sample residents (Resident #1). Finding include:	A 032		

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A 032	Continued From page 2 A review of Resident #1's Record showed the following medical diagnoses: Major [illegible], and [illegible]. A review of facility records showed that Resident #1 eloped from the facility on [illegible]. A review of the hospital record showed "This 80 yrs. Old female presents to the ER [emergency room] via private vehicle with complaints of [illegible]. Patient presents with [illegible]." The record also stated that the patient was picked up by an unknown individual who found her [illegible] the street in a state, disorientated to time and place. It stated, "Patient currently does not know who brought her to the ER. Does not know why she was brought to the ER. " Further review of the hospital record showed that the resident was " Oriented x 1, [illegible], speech is illogical, her [illegible] is [illegible]. Thought content is mild [illegible]." According to Very Well Health, "Oriented x1 means that the person is oriented to person: the person knows their name and usually can recognize significant others. If Oriented to place: The person knows where they are, such as the hospital, clinic, or town. Oriented to time: The person knows the time of day, date, day of the week, and season. Oriented to situation means: They can explain why they talking to the doctor.Sometimes a person can answer some of this information, but not all. For example, they may know their name and the date but can't say where there are or why. In that case, it would be notated as x2. In some circumstances, healthcare providers might only ask about person, place, and time. In	A 032		

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A 032	Continued From page 3 that situation, x3 is the highest level of orientation tested. When a doctor includes questions about the situation, the highest level would then be x4." Additional review of the hospital record showed a Consultation Note dated which stated, "The patient was laying on the bed, in no acute distress. She is AAOx1, calm, following commands. physical exam remarkable for disorientation in time and space. Likely advance Diagnosis: and Severe " On , it was observed that Resident #1's identification bracelet, which had been left behind at the facility, had the following information: facility address and telephone number. The name of the resident and the facility's name was not included. In an interview on at 9:43 AM, the Administrator stated regarding Resident #1 that prior to the resident's elopement on , the administrator confirmed that the resident had attempted to jump the fence. The Administrator stated that she took the following elopement preventive measures: increase rounding of the resident, placed an identification bracelet on the resident, and increased the number of activities for the resident. She also stated that the resident removed her identification bracelet. Observation revealed that the identification bracelet left behind by the resident only contained the following information: facility address and telephone number. A review of the facility's Elopement Policy and Resident Evaluation on , according to the policy, residents determined to be at risk of	A 032		

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A 032	Continued From page 4 elopement should have an identification on their persons that includes their name, facility's name, address, and telephone number. Class II	A 032		
A 079 SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times	A 079		

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A 079	Continued From page 5 when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or	A 079		

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A 079	Continued From page 6 manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require	A 079		

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A 079	Continued From page 7 additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have enough qualified staff to provide resident supervision appropriate to the scheduled and unscheduled service needs. One staff person was on duty providing care for 14 residents when one out of four sample residents	A 079		

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A 079	Continued From page 8 (Resident #1) eloped . The resident was found and taken to a local hospital by an unknown person who found her . . . . . the street in a state. Finding include: A review of Resident #1's Hospital Record showed that the resident arrived at the emergency department of a local hospital on . . . . . at 10:13 PM. The record stated, "This 80 yrs. Old female presents to the ER via private vehicle with complaints of . . . . . Patient presents with . The record also stated that the patient was picked up by an unknown individual who found her . the street in a . . . . . state, disorientated to time and place. Patient currently does not know who brought her to the ER. Does not know why she was brought to the ER." A review of the Staffing Schedule for the month of . . . . . showed that Staff B was the only staff on duty when the elopement occurred. At the time of the elopement, the facility had 14 residents. In an interview on . . . . . at approximately 9:40 AM, Staff B stated that Resident #1 place a chair next to the fence and climbed over. Staff B also stated that a few days before the incident, Resident #1 attempted several times to jump over the fence. In an interview with Staff B on . . . . . at 11:21 AM, regarding the events leading to the elopement, Staff B stated that she started working at 4:00 PM on . . . . . She stated, "I was the only employee duty, taking care of 14 residents." Staff B further stated that, " Resident #1 was sweeping the patio for about 5 minutes.	A 079		

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A 079	Continued From page 9 At 7:00 PM, I went inside the facility (kitchen) to prepare the residents snacks. At approximately 7:01 PM, I was notified by other residents that the resident has eloped. I called the Administrator. I could not leave the facility. I only searched the interior of the facility. At 7:20 PM, the Administrator called 911 and started searching the surrounding area." In an interview with Resident #3 on at 11:29 AM, regarding the elopement, Resident #3 stated that approximately PM, Resident #1 place a chair next to the fence. He stated, "As soon as the staff went inside the facility, she jumps the fence. I did not saw her jumping the fence. (sic) I only saw her when she was outside of the facility. I then notified the staff. [Resident #1] turned right on the street. I went after her. As she was running away, [Resident #1] was yelling "they are going to kill me". When she started walking along the highway, I stopped following her and returned to the facility." In an interview on at 11:35 AM, Resident #2 stated that he saw Resident #1 jumping the fence. He stated that the Resident #1 placed a chair next to the fence and jumped. Once outside, she turned right on the street. Resident #2 stated that there was no staff on the patio at the time of the elopement. He stated, "I then notified the staff." A review of the facility's Admission and Discharge Log , the resident's demographic sheet and the observation notes showed that Resident #1 was admitted to the facility on . A review of Resident #1's Record showed the following medical diagnoses: Major	A 079		

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A 079	Continued From page 10 , and . Further review revealed that the resident was taking the following medications: 1. , 5 mg- according to www.medlineplus.gov, , is used to treat in people with 's . 2. , ER 250 mg- according to www.medlineplus.gov, , is used to treat (episodes of frenzied, abnormally exited) in people with , . 3. , 0.5 mg- according to www.medlineplus.gov, , is used to treat the symptoms of , . It is also used to treat episodes of (frenzied, abnormally excited, or irritated) or mix episodes (symptoms of and , that happened together). A review of Resident #1's Observation Notes dated at 7:10 PM, showed the Administrator wrote "received a call from the night shift. Staff B reported that the resident was able to climb the fence. Other residents saw her when she moved a chair and climb the fence. Elopement Emergency procedure was implemented. Started a local search of the area". At 7:20 PM, call the local police to report the elopement and that the resident was missing. At 7:40 PM, the resident's daughter was notified." A review of resident records found that at least one other resident, Resident #4, was diagnosed with and was at risk for elopement. Class II	A 079		

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A 000	Initial Comments A complaint investigation (complaint number 2022006569) was conducted at JC & C ALF on . Deficiencies were identified at the time of the survey.	A 000		
A 032 SS=I	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	A 032		

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record review, interview, the facility failed to ensure that a resident who was identified as at risk of elopement, and who eloped from the facility, had identification on his/her person which included the resident and facility name for one out of four sample residents (Resident #1). Finding include:	A 032		

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A 032	Continued From page 2 A review of Resident #1's Record showed the following medical diagnoses: Major [illegible], and [illegible]. A review of facility records showed that Resident #1 eloped from the facility on [illegible]. A review of the hospital record showed "This 80 yrs. Old female presents to the ER [emergency room] via private vehicle with complaints of [illegible]. Patient presents with [illegible]." The record also stated that the patient was picked up by an unknown individual who found her [illegible] the street in a state, disorientated to time and place. It stated, "Patient currently does not know who brought her to the ER. Does not know why she was brought to the ER. " Further review of the hospital record showed that the resident was " Oriented x 1, [illegible], speech is illogical, her [illegible] is [illegible]. Thought content is mild [illegible]." According to Very Well Health, "Oriented x1 means that the person is oriented to person: the person knows their name and usually can recognize significant others. If Oriented to place: The person knows where they are, such as the hospital, clinic, or town. Oriented to time: The person knows the time of day, date, day of the week, and season. Oriented to situation means: They can explain why they talking to the doctor.Sometimes a person can answer some of this information, but not all. For example, they may know their name and the date but can't say where there are or why. In that case, it would be notated as x2. In some circumstances, healthcare providers might only ask about person, place, and time. In	A 032		

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	AL11911029	A. BUILDING: _____ B. WING _____	05/04/2022

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A 032	Continued From page 3 that situation, x3 is the highest level of orientation tested. When a doctor includes questions about the situation, the highest level would then be x4." Additional review of the hospital record showed a Consultation Note dated which stated, "The patient was laying on the bed, in no acute distress. She is AAOx1, calm, following commands. physical exam remarkable for disorientation in time and space. Likely advance Diagnosis: and Severe " On , it was observed that Resident #1's identification bracelet, which had been left behind at the facility, had the following information: facility address and telephone number. The name of the resident and the facility's name was not included. In an interview on at 9:43 AM, the Administrator stated regarding Resident #1 that prior to the resident's elopement on , the administrator confirmed that the resident had attempted to jump the fence. The Administrator stated that she took the following elopement preventive measures: increase rounding of the resident, placed an identification bracelet on the resident, and increased the number of activities for the resident. She also stated that the resident removed her identification bracelet. Observation revealed that the identification bracelet left behind by the resident only contained the following information: facility address and telephone number. A review of the facility's Elopement Policy and Resident Evaluation on , according to the policy, residents determined to be at risk of	A 032		

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A 032	Continued From page 4 elopement should have an identification on their persons that includes their name, facility's name, address, and telephone number. Class II	A 032		
A 079 SS=I	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times	A 079		

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A 079	Continued From page 5 when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or	A 079		

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A 079	Continued From page 6 manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require	A 079		

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A 079	Continued From page 7 additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have enough qualified staff to provide resident supervision appropriate to the scheduled and unscheduled service needs. One staff person was on duty providing care for 14 residents when one out of four sample residents	A 079		

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A 079	Continued From page 8 (Resident #1) eloped . The resident was found and taken to a local hospital by an unknown person who found her . . . . . the street in a state. Finding include: A review of Resident #1's Hospital Record showed that the resident arrived at the emergency department of a local hospital on . . . . . at 10:13 PM. The record stated, "This 80 yrs. Old female presents to the ER via private vehicle with complaints of . . . . . Patient presents with . The record also stated that the patient was picked up by an unknown individual who found her . the street in a . . . . . state, disorientated to time and place. Patient currently does not know who brought her to the ER. Does not know why she was brought to the ER." A review of the Staffing Schedule for the month of . . . . . showed that Staff B was the only staff on duty when the elopement occurred. At the time of the elopement, the facility had 14 residents. In an interview on . . . . . at approximately 9:40 AM, Staff B stated that Resident #1 place a chair next to the fence and climbed over. Staff B also stated that a few days before the incident, Resident #1 attempted several times to jump over the fence. In an interview with Staff B on . . . . . at 11:21 AM, regarding the events leading to the elopement, Staff B stated that she started working at 4:00 PM on . . . . . She stated, "I was the only employee duty, taking care of 14 residents." Staff B further stated that, " Resident #1 was sweeping the patio for about 5 minutes.	A 079		

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A 079	Continued From page 9 At 7:00 PM, I went inside the facility (kitchen) to prepare the residents snacks. At approximately 7:01 PM, I was notified by other residents that the resident has eloped. I called the Administrator. I could not leave the facility. I only searched the interior of the facility. At 7:20 PM, the Administrator called 911 and started searching the surrounding area." In an interview with Resident #3 on at 11:29 AM, regarding the elopement, Resident #3 stated that approximately PM, Resident #1 place a chair next to the fence. He stated, "As soon as the staff went inside the facility, she jumps the fence. I did not saw her jumping the fence. (sic) I only saw her when she was outside of the facility. I then notified the staff. [Resident #1] turned right on the street. I went after her. As she was running away, [Resident #1] was yelling "they are going to kill me". When she started walking along the highway, I stopped following her and returned to the facility." In an interview on at 11:35 AM, Resident #2 stated that he saw Resident #1 jumping the fence. He stated that the Resident #1 placed a chair next to the fence and jumped. Once outside, she turned right on the street. Resident #2 stated that there was no staff on the patio at the time of the elopement. He stated, "I then notified the staff." A review of the facility's Admission and Discharge Log , the resident's demographic sheet and the observation notes showed that Resident #1 was admitted to the facility on . A review of Resident #1's Record showed the following medical diagnoses: Major	A 079		

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A 079	Continued From page 10 , and . Further review revealed that the resident was taking the following medications: 1. , 5 mg- according to www.medlineplus.gov, , is used to treat in people with 's . 2. , ER 250 mg- according to www.medlineplus.gov, , is used to treat (episodes of frenzied, abnormally exited) in people with , . 3. , 0.5 mg- according to www.medlineplus.gov, , is used to treat the symptoms of , . It is also used to treat episodes of (frenzied, abnormally excited, or irritated) or mix episodes (symptoms of and , that happened together). A review of Resident #1's Observation Notes dated at 7:10 PM, showed the Administrator wrote "received a call from the night shift. Staff B reported that the resident was able to climb the fence. Other residents saw her when she moved a chair and climb the fence. Elopement Emergency procedure was implemented. Started a local search of the area". At 7:20 PM, call the local police to report the elopement and that the resident was missing. At 7:40 PM, the resident's daughter was notified." A review of resident records found that at least one other resident, Resident #4, was diagnosed with and was at risk for elopement. Class II	A 079		