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
	AL11910568	A. BUILDING: _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VIEW ALF	526 N. MARY AVE. PANAMA CITY, FL 32404

(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 complaint number 2023014504 was conducted at Garden View Assisted Living Facility on through . . . . . . Deficient practice was identified at the time of the survey. The facility census was 38 on . The following class I deficiencies were identified on . . . . . : A0025: The facility failed to provide adequate supervision, including maintaining a general awareness of the resident's whereabouts, to a resident identified to be at risk for elopement and with a documented history of elopement which resulted in the elopement and subsequent of the resident sampled for elopement. (Resident #1) A0032: The facility failed to develop and implement elopement response policies and maintain a general awareness of the location of all residents assessed to be at risk for elopement at all times, resulting in the elopement and subsequent of one of the sampled residents at risk for elopement. (Resident #1) The facility Administrator was notified of the class I deficiencies on . . . . . at approximately 9:04 AM.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician	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 when a resident exhibits signs of [illegible] or [illegible] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [illegible] or [illegible]. 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 [illegible] 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 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	A 025		

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A 025	Continued From page 2 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 record review, review of law enforcement records, local news reports, and staff interviews, the facility failed to provide adequate supervision, to include maintaining a general awareness of the resident's whereabouts, for 1 of 1 sampled residents who were identified to be at risk for elopement and who had a previous history of elopements (Resident #1). On , Resident #1 eloped from the facility without signing out per policy. The facility failed to search for the resident and failed to notify law enforcement. Eighteen days later, on , Resident #1 was found in a field located in Panama City Beach. The facility's failure to adequately supervise Resident #1 resulted in a class I deficiency. The facility Administrator was notified of the class I deficiency on at approximately 9:04 AM. The findings include: A review of Resident #1's facility record revealed the resident was admitted to the facility on	A 025		

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A 025	Continued From page 3 . . . . . The resident's health assessment, dated . . . , revealed the resident was at risk for elopement, required observation for well-being and elopement prevention daily, and had medical conditions including , , ... , ... , . . . , and , , . A review of the resident's physician ordered medications revealed the resident's prescribed medications included . . , 10 mg by . . . daily for , and , , . , . 1 mg by . . . twice daily for side effects of . . . , . . . medication, , 5 mg by daily for memory, ... 5 mg by . . . daily for memory, and 15 mg by . . daily for . . . . . . The resident's observation log revealed that on at 7:00 PM, Resident #1 came to Employee A (a Resident Assistant) and stated he was going for a walk. Employee A asked him not to leave while passing medications to residents. At this point, Employee A went to look for the resident and he was gone. The resident's observation log, dated , stated the police came to the facility around 1:00 PM and stated Resident #1 was at an emergency room in Panama City Beach. The resident's observation log dated stated that Employee A called the hospital to check on Resident #1 and they stated he had been discharged. Employee A then called the police to file a missing person report on . The resident's observation log revealed the resident had previously been missing from the facility on and and law enforcement was notified at that time as well. A review of the facility incident reports provided by the Administrator revealed Resident #1 had also eloped from the facility on at 8:30 AM. At	A 025		

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A 025	Continued From page 4 this time, law enforcement was notified and he was safely returned to the facility on at 7:30 AM. A review of the emergency room records dated revealed the resident was transported to the emergency room by law enforcement for complaints of . The emergency room was approximately 16 miles from the assisted living facility. The emergency room (ER) records revealed Resident #1 was discharged from the ER on with diagnoses of , , , and , . Review of a local news website (https://www.mypanhandle.com/news/local-news/bay-county/panama-city-beach/officials-identify-dead-body-found-in-panama-city-beach/), which was posted on , revealed Resident #1 was found in a field located in Panama City Beach on . Law enforcement and the medical examiner reported that details regarding the of Resident #1 were not available at the time of this report. A review of missing person reports provided by law enforcement (LE) revealed the following: On , at 2:30 PM, Resident #1 was reported missing by facility staff and returned to the facility the same evening around 9:00 PM. On at 10:20 PM, Resident #1 was reported missing by facility staff, who reportedly left the facility after 7:00 PM. He was not located by LE. On at 8:03 PM, Resident #1 was reported missing by facility staff, but he returned to the facility of his own accord the same evening. On at 7:47 PM, Resident #1 was reported missing by facility staff, and he was not found by	A 025		

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A 025	Continued From page 5 LE. On . . . . . at 9:12 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On . . . . . at 8:56 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On . . . . . at 8:02 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On . . . . . at 2:32 PM, Resident #1 was reported missing by facility staff, and he had not been seen since he was discharged from the ER on . . . . . The report stated the facility staff called the ER on . . . . . and were advised Resident #1 was released from the ER on at noon. An interview was conducted with Employee A on . . . . . at 9:02 AM. Employee A stated it was normal for Resident #1 to go out for walks, usually in the evenings. Employee A reported the resident stayed out overnight once before. Staff were aware he was leaving but were not aware that he was not going to come that night. She could not recall when this had occurred. He left once before and the police brought him . She stated the facility is an open-door facility, but the residents are to let the staff know they are going somewhere and where they are going, and to keep them informed of when they are coming . . . . There was no process for residents to sign out when leaving facility grounds. When Resident #1 left on . . . . . , he told the employee he was going for a walk, but did not say where or how long he would be gone. He left about 7:00 PM. She worked from at 3:00 PM until at	A 025		

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A 025	Continued From page 6 7:00 AM. She stated she knew he did not come when she left on the morning of . She stated Employee B (another Resident Assistant) took over when she left on at 7:00 AM and she let Employee B know the resident had not returned. She stated the staff check to see if the residents are in the building about once an hour. She stated some of the residents walk off the property during the day and night but then come . She stated Resident #1 was going off the facility grounds more than usual in the past month prior to the event on , but he would always come . . . in the morning. She stated she did not notify law enforcement because he had always come . . . to the facility. She stated she notified the Administrator that he had not returned around 8:00 PM on . . . . . She did not notify the Administrator again the morning of when Resident #1 had not returned to the facility. Employee A stated she had elopement training "about months ago". She stated she does not know if there was a standard amount of time before she would notify the Administrator that a resident did not return from an outing. A telephone interview was conducted with Employee B on at 10:09 AM. Employee B stated she worked from 6:00 AM to 3:00 PM on and relieved Employee A. She was aware Resident #1 was not at the facility when she arrived and throughout her shift on . She was informed by Employee A that the Administrator was made aware the resident was not at the facility. She stated there had been other times that Resident #1 would leave the facility and stay gone all night and all day the following day. An interview was conducted with the Facility	A 025		

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A 025	Continued From page 7 Administrator on ..... at 11:22 AM. She stated Resident #1 would not sign out when he left the facility. She indicated the facility had a sign out procedure for residents to utilize when they left the facility. She confirmed no staff had contacted law enforcement when the resident left on ..... and did not return. The facility was contacted by law enforcement on and informed that the resident was being treated at an emergency room. The Administrator confirmed she did not know where the resident was until she was contacted by law enforcement on , even though she was aware on ..... that the resident had not returned to the facility. She stated it was a mistake not to report this as an elopement and she was hoping he would come ..... An additional interview with the Administrator was conducted on at 12:23 PM. She stated that facility staff did not call the ER on ..... to check on the resident because law enforcement stated the ER would call the facility when the resident was ready to be discharged. In subsequent interviews with the Administrator on at 2:49 PM and at 8:54 AM, she stated the facility is located about mile from the intersection of Highway 22 and it is sometimes a busy highway because of a school near the intersection. She also stated that when Resident #1 previously left the facility on the dates of , , and , the facility had no knowledge of where the resident was going when he left the facility. A review of the facility's policy for "Residents in/out log book" revealed, "It will be the policy of Garden View assisted living facility to advise all new residents upon admission that they should sign out in the residents in/out log book before	A 025		

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A 025	Continued From page 8 leaving the facility with the time they are leaving and their destination and if the resident should know what time they may be expected to return to the ALF it should also be included. This is essential to assist the staff members to monitor the whereabouts of the residents for their safety." A review of the log since , revealed Resident #1 had never signed out. A review of the facility's policy for supervision revealed: "(1) Garden View ALF will offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well being of the resident. (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	A 025		

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A 025	Continued From page 9 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." Class I	A 025		
A 032 SS=J	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.	A 032		

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A 032	Continued From page 10 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, 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, review of law enforcement records, local news reports, and staff interviews, the facility failed to develop and implement elopement response policies and maintain a general awareness of the location of all residents assessed to be at risk for elopement	A 032		

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A 032	Continued From page 11 at all times, resulting in the elopement and subsequent of one of one sampled residents at risk for elopement. (Resident #1) The facility's failure to develop and implement elopement policies and maintain awareness of the location of Resident #1 resulted in a class I deficiency. The facility Administrator was notified of the class I deficiency on at approximately 9:04 AM. The findings include: A review of Resident #1's facility record revealed the resident was admitted to the facility on . The resident's health assessment, dated , revealed the resident was at risk for elopement, required observation for well-being and elopement prevention daily, and had medical conditions including , , and . A review of the resident's physician ordered medications revealed the resident's prescribed medications included , 10 mg by daily for , and , 1 mg by twice daily for side effects of medication, , 5 mg by daily for memory, 5 mg by daily for memory, and 15 mg by daily for . The resident's observation log revealed that on at 7:00 PM, Resident #1 came to Employee A (a Resident Assistant) and stated he was going for a walk. Employee A asked him not to leave while passing medications to residents. At this point, Employee A went to look for the resident and he was gone. The resident's observation log, dated , stated the police	A 032		

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A 032	Continued From page 12 came to the facility around 1:00 PM and stated Resident #1 was at an emergency room in Panama City Beach. The resident's observation log dated stated that Employee A called the hospital to check on Resident #1 and they stated he had been discharged. Employee A then called the police to file a missing person report on . The resident's observation log revealed the resident had previously been missing from the facility on and and law enforcement was notified at that time as well. A review of the facility incident reports provided by the Administrator revealed Resident #1 had also eloped from the facility on at 8:30 AM. At this time, law enforcement was notified and he was safely returned to the facility on at 7:30 AM. A review of the emergency room records dated revealed the resident was transported to the emergency room by law enforcement for complaints of . The emergency room was approximately 16 miles from the assisted living facility. The emergency room (ER) records revealed Resident #1 was discharged from the ER on with diagnoses of , , , , , , and , , , , . Review of a local news website (https://www.mypanhandle.com/news/local-news/bay-county/panama-city-beach/officials-identify-dead-body-found-in-panama-city-beach/), which was posted on , revealed Resident #1 was found in a field located in Panama City Beach on . Law enforcement and the medical examiner reported that details regarding the of Resident #1 were not available at the time of this report. A review of missing person reports provided by law enforcement (LE) revealed the following:	A 032		

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A 032	Continued From page 13 On , at 2:30 PM, Resident #1 was reported missing by facility staff and returned to the facility the same evening around 9:00 PM. On at 10:20 PM, Resident #1 was reported missing by facility staff, who reportedly left the facility after 7:00 PM. He was not located by LE. On . . . . . at 8:03 PM, Resident #1 was reported missing by facility staff, but he returned to the facility of his own accord the same evening. On . . . . . at 7:47 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On . . . . at 9:12 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On . . . . . at 8:56 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On at 8:02 PM, Resident #1 was reported missing by facility staff, and he was not found by LE. On . . . . at 2:32 PM, Resident #1 was reported missing by facility staff, and he had not been seen since he was discharged from the ER on . . . . . The report stated the facility staff called the ER on . . . . . and were advised Resident #1 was released from the ER on at noon. An interview was conducted with Employee A on . . . . . at 9:02 AM. Employee A stated it was normal for Resident #1 to go out for walks,	A 032		

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	AL11910568	A. BUILDING: _____ B. WING _____	09/28/2023

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A 032	Continued From page 14 usually in the evenings. Employee A reported the resident stayed out overnight once before. Staff were aware he was leaving but were not aware that he was not going to come that night. She could not recall when this had occurred. He left once before and the police brought him . She stated the facility is an open-door facility, but the residents are to let the staff know they are going somewhere and where they are going, and to keep them informed of when they are coming . . . . There was no process for residents to sign out when leaving facility grounds. When Resident #1 left on . . . . . , he told the employee he was going for a walk, but did not say where or how long he would be gone. He left about 7:00 PM. She worked from at 3:00 PM until at 7:00 AM. She stated she knew he did not come when she left on the morning of . She stated Employee B (another Resident Assistant) took over when she left on at 7:00 AM and she let Employee B know the resident had not returned. She stated the staff check to see if the residents are in the building about once an hour. She stated some of the residents walk off the property during the day and night but then come . She stated Resident #1 was going off the facility grounds more than usual in the past month prior to the event on , but he would always come in the morning. She stated she did not notify law enforcement because he had always come to the facility. She stated she notified the Administrator that he had not returned around 8:00 PM on . . . . . She did not notify the Administrator again the morning of when Resident #1 had not returned to the facility. Employee A stated she had elopement training "about months ago". She stated she does not know if there was a standard amount of time before she would notify the Administrator that a	A 032		

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A 032	Continued From page 15 resident did not return from an outing. A telephone interview was conducted with Employee B on at 10:09 AM. Employee B stated she worked from 6:00 AM to 3:00 PM on and relieved Employee A. She was aware Resident #1 was not at the facility when she arrived and throughout her shift on . She was informed by Employee A that the Administrator was made aware the resident was not at the facility. She stated there had been other times that Resident #1 would leave the facility and stay gone all night and all day the following day. An interview was conducted with the Facility Administrator on at 11:22 AM. She stated Resident #1 would not sign out when he left the facility. She indicated the facility had a sign out procedure for residents to utilize when they left the facility. She confirmed no staff had contacted law enforcement when the resident left on and did not return. The facility was contacted by law enforcement on and informed that the resident was being treated at an emergency room. The Administrator confirmed she did not know where the resident was until she was contacted by law enforcement on , even though she was aware on that the resident had not returned to the facility. She stated it was a mistake not to report this as an elopement and she was hoping he would come . An additional interview with the Administrator was conducted on at 12:23 PM. She stated that facility staff did not call the ER on to check on the resident because law enforcement stated the ER would call the facility when the resident was ready to be discharged. In	A 032		

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A 032	Continued From page 16 subsequent interviews with the Administrator on at 2:49 PM and at 8:54 AM, she stated the facility is located about mile from the intersection of Highway 22 and it is sometimes a busy highway because of a school near the intersection. She also stated that when Resident #1 previously left the facility on the dates of , , and , the facility had no knowledge of where the resident was going when he left the facility. The facility's elopement procedures are as follows: "ELOPEMENT POLICIES AND PROCEDURES: It is the policy of Garden View ALF to conduct elopement drills twice per year. All staff will be trained within thirty (30) days of employment on Garden View ALF elopement policy and procedures by the administrator. Topics of the drill will consist of: 1. Ways to reduce the risk of resident elopement. 2. Identifying residents with the potential to be an elopement risk. 3. Identifying staff to remain with the other residents while the designated staff is making efforts to locate the missing resident. 4. What to do if a resident does elope: A) Discovery by staff/employee. B) Search process by to include all bedrooms, closets, bathrooms, kitchen, and outdoors around the immediate property. C) Staff to inform Administrator and/or Manager. D) Police to be informed by the Administrator and/or Manager within 10 minutes after search of Garden View ALF. E) File 1-day adverse incident report to the	A 032		

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A 032	Continued From page 17 Agency for Health Care Administration (AHCA) F) File 15-day adverse incident report to AHCA). Any resident diagnosed with 's or other forms of which has the potential for elopement will have a current picture in his/her filed within 10 calendar days of admission or within 10 calendar days of the behavior being identified. Any elopement attempt or actual elopement will be documented in the resident's file. The 1-day and 15-day adverse incident reports will be submitted in accordance with the statutes if an actual elopement would occur. The 1-day and 15-day adverse incident reports are confidential and will be maintained by Garden View ALF in locked files. Adverse incident reports are not discoverable and will only be available to AHCA representatives, upon request." The facility policy failed to describe the procedure for an actual elopement that is not a drill. Class I	A 032		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and	A 165		

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A 165	Continued From page 18 develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in	A 165		

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A 165	Continued From page 19 this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section.	A 165		

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A 165	Continued From page 20 This Statute or Rule is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete and document a thorough investigation of resident elopements to identify possible factors leading to the incidents, failed to develop actions plans to reduce the likelihood of reoccurrence, and failed to file adverse incident reports for all elopements for 1 of 1 resident sampled for elopement. (Resident #1) Cross reference A0032. The findings include: A review of Resident #1's facility record as well as law enforcement records revealed the resident eloped from the facility a total of 9 times in 2023 on [redacted], and . On [redacted], and , missing person reports were filed with law enforcement. The facility had no documentation or record of the elopements occurring on [redacted], and . The Administrator was asked to produce any evidence of correction related to the elopements. There was no evidence provided indicating investigations of the elopements or corrective measures related to any of the elopements. A review of the agency adverse incident reporting system accessed on revealed the elopements on [redacted], and were not reported to the agency. An interview was conducted with the Administrator on	A 165		

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A 165	Continued From page 21 at 10:35 AM. She stated she did not file adverse incidents for the dates of , , , , , , , and because the resident was coming to the facility and he told the staff he was leaving. An additional interview was conducted with the Administrator on at 12:00 PM. She stated she did not document any additional training with staff after Resident #1 eloped on , she "just talked to the staff". An interview was conducted with Employee A (Resident Assistant) on at 2:15 PM. She stated after Resident #1 eloped on , she had not received any additional training regarding elopement or resident supervision. A telephone interview was conducted with Employee B (Resident Assistant) on at 2:18 PM. She stated after Resident #1 eloped on she had not received any additional training regarding elopement or resident supervision. An interview was conducted with Employee C (Resident Assistant) on at 2:36 PM. He stated after Resident #1 eloped on he had not received any additional training regarding elopement or resident supervision. Class III	A 165		