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
	AL11966140	A. BUILDING: _____ B. WING _____	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BISHOP GRADY VILLAS	401 BISHOP GRADY COURT SAINT CLOUD, FL 34769

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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 operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (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.	CZ821		

AHCA Form 3020-0001

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

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CZ821	Continued From page 1 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 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	CZ821		

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CZ821	Continued From page 2 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, , 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	CZ821		

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CZ821	Continued From page 3 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. This Statute or Rule is not met as evidenced by: Based on resident record review, facility's documentation and interview, the facility failed to electronically submit to the Agency for Health Care Administration (AHCA,) a preliminary report within 1 business day for elopement for 1 of 3 sampled residents (#3); and the facility failed to submit the full report (15 day) electronically to the agency timely as required for 1 of 3 sampled residents (#1). Findings: 1. Resident #3's record review revealed admission date . The last 1823 Health Assessment dated identified Resident #3 high risk for elopement. In further review his medical history listed were , , , , , , , to lower extremities, , Sinuses, , , , left hearing loss, and left with 3 surgeries. He's , and at risk of . He's independent in activities of daily living (ADLs) ambulating, toileting and transferring, he needs supervision in and eating and needs assistance with bathing and grooming. He needs assistance with self-administration of medications.	CZ821		

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CZ821	Continued From page 4 A facility note dated at 8:26 AM by Adult Day Training (ADT) instructor documented that at 6 AM this morning when she walked into the Walmart store to shop before going to work, she saw Resident #3. She asked Resident #3 if he was with someone and he pointed to the electronics section and immediately ran off and kept going in that direction, fast paced toward the CDs. She immediately called Shift Leader G at the facility to inform the staff that Resident #3 had eloped from the facility and here at Walmart. The ADT instructor asked Resident #3 to come with her and please put all those CDs and he told her no. Resident #3 pushed her out the way and took off to the front of the store. The ADT instructor quickly followed him as she was not sure what he was going to do so she stood in front of Resident #3, so he did not cut the line or leave the store with the CDs without paying for them. Resident #3 went to the cashier to check out. At this time now the Shift Leader G arrived at Walmart and approached Resident #3 but Resident #3 was still refusing to listen to staff. Shift Leader G stated that she was calling the police. Finally, after the Walmart employee paid for a CD for Resident #3 while waiting for the police, Shift Leader G was able to walk Resident #3 out of the store and sat on the bench still waiting for the police. The police came and asked Shift Leader G if she wanted to press charges, she answered no and everyone including Resident #3 returned to the facility. A facility note dated at 2:37 AM by Direct Support Professional G, documented she was outside getting ready to leave for home from work on and was told that Resident #3 was at Walmart (of a mile from the facility) and needed someone to bring him . He left	CZ821		

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CZ821	Continued From page 5 without permission and staff was not aware. The last time Resident #3 was seen was about 5:30 PM earlier after dinner and I told him that I would be tonight working so be good because Christmas was coming and Resident #3 responded yes. I was told when staff arrived at Walmart, Resident #3 was at the self-checkout and a large group of Walmart employees standing around him. I was told it was asked for Resident #3 to put the CD because he did not have enough money to pay for it. He did not have enough funds on his gift card. Resident #3 started yelling "NO" and kept swiping his gift card a few more times getting agitated. One of the Walmart employees de-escalated the situation and paid for one of the CDs and took the rest of the CDs to electronics. Resident #3 thanked the Walmart employee and said he was sorry. Resident #3 and staff walked outside the store and waited for the police to arrive, and Resident #3 repeatedly said he was sorry. On at 3:45 PM, an interview with the Administrator confirmed the finding and further stated that he did not electronically submit the 1-day report to the agency for Resident #3's elopement occurred last week on . 2. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated listed medical history , , Sleep , , Valve , , and . She has physical limitations using cancelling noise headphones and reduced visual , . She's , , with speech delay and uses sign language. Her activities of daily living (ADLs) independent in ambulation, toileting and transferring, supervision with bathing,	CZ821		

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CZ821	Continued From page 6 and eating, needs assistance with grooming. In further review, on page 3 it is documented that Resident #1 needs medication administration. Resident #1 was identified as an elopement risk. A facility note dated 11/7/2024 at 5:06 PM by Villa Manager A documented at 2:36 PM on , two police officers came to the administration building and spoke with the Residential & Life Skills Program (ADT Manager) and the Human Resources Manager. The police officer was checking if a young woman (Resident #1) lived at the facility. Both staff confirmed yes, Resident #1 lived at the facility. The third police officer arrived with Resident #1 in the police vehicle. The third police officer said that the police was contacted by the Helping Counseling Center (about mile from the facility) where Resident #1 was found. The staff asked what happened to Resident #1 and Resident #1 stated that she wanted to go to her dad's home and that she had called her dad, but he did not answer. Staff reminded her that she could call her dad first or ask for assistance from staff to call dad if she is having trouble reaching him. Resident #1as reminded of the facility's policies/procedures of signing out when leaving campus and taking her cellphone. Resident #1 asked staff to call her dad now, and she informed him what happened, and her dad reminded her to notify staff when wanting to leave campus. The Villa Manager notified the mother and Waiver Support Coordinator. The mother and father are separated and currently in the process of divorce. On at 3:50 PM, an interview with the Administrator confirmed the findings. (Photographic Evidence Obtained)	CZ821		

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CZ821	Continued From page 7 Unclassified	CZ821		
A 000	Initial Comments A Complaint Investigation #2024016159 and a generator monitoring was conducted at Bishop Grady Villas Assisted Living Facility on . The facility had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical	A 008		

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A 008	Continued From page 8 examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of	A 008		

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A 008	Continued From page 9 Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of ‘ . . require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or . , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , . . . Resistant	A 008		

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A 008	Continued From page 10 , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children	A 008		

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A 008	Continued From page 11 and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , to be administered in the case of or , . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to ensure that the 1823 Health Assessment, Agency for Healthcare Administration (AHCA) Form was completed	A 008		

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A 008	Continued From page 12 correctly by the healthcare provider for 1 of 3 sampled resident (#1) as required. Findings: Resident #1's record review revealed an admission date of . The last 1823 Health Assessment dated listed medical history , Sleep , , Valve , , and . She has physical limitations using cancelling noise headphones and reduced visual , . She's with speech delay and uses sign language. Her activities of daily living (ADLs) independent in ambulation, toileting and transferring, supervision with bathing, and eating, needs assistance with grooming. In further review, on page 3 it is documented that Resident #1 needs medication administration. On at 3:55 PM, an interview with the Administrator confirmed the findings and stated that staff assist with self-administration of medications to Resident #1, and he will get a new 1823 Health Assessment to reflect the correct information. (Photographic Evidence Obtained) Class III	A 008		
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	A 025		

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A 025	Continued From page 13 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 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	A 025		

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	AL11966140	A. BUILDING: _____ B. WING _____	12/26/2024

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A 025	Continued From page 14 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 resident record review, facility's documentation and interview, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 sampled resident (#3) as required. Findings: Resident #3's record review revealed admission date . The last 1823 Health Assessment dated identified Resident #3 high risk for elopement. In further review his medical history listed were , , , , , , to lower extremities, , , Sinuses, , , left hearing loss, and left with 3 surgeries. He's , , and at risk of . He's independent in activities of daily living (ADLs) ambulating, toileting and transferring, he needs supervision in and eating and needs assistance with bathing and grooming. He needs assistance with self-administration of medications. A facility note dated 11/24/2024 at 1:11 PM by Shift Leader K documented that this was the first elopement for Resident #3 went to the local thrift	A 025		

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A 025	Continued From page 15 store located next door unattended and stole two (2) CDs. Shift leader K convinced Resident #3 to return the two CDs to the thrift store with a companion the next morning . A facility note dated at 8:06 AM (one month later from the first elopement) by Direct Support Professional E, documented she completed early morning rounds at 5:50 AM. She walked to the dining hall and saw Resident #3 walking outside around the corner of the dining hall. It was 45 degrees this morning. A couple of minutes later after 6 AM received a call from Adult Day Training (ADT) instructor and she saw Resident #3 in Walmart. The ADT instructor tried to tell him to come near her, but Resident #3 ran off to the CD area of the store and started picking up CDs and she told him to put them and he became aggressive and pushed her out of the way. The ADT instructor was trying to redirect him to come to her so both could go to the facility together and Resident #3 said no. It was asked again to put the CDs , and Resident #3 yelled no. Shift Leader G had to come to Walmart to help de-escalate the situation. Shift Leader G told Resident #3 that he did not have enough money to pay for the CD and he kept yelling and getting agitated. Shift Leader G stated that she was going to call the police. A facility note dated at 8:26 AM by Adult Day Training (ADT) instructor documented that at 6 AM this morning when she walked into the Walmart store to shop before going to work, she saw Resident #3. She asked Resident #3 if he was with someone and he pointed to the electronics section and immediately ran off and kept going in that direction, fast paced toward the CDs. She immediately called Shift Leader G at the facility to inform the staff that Resident #3 had	A 025		

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A 025	Continued From page 16	A 025		

eloped from the facility and here at Walmart. The ADT instructor asked Resident #3 to come with her and please put all those CDs and he told her no. Resident #3 pushed her out the way and took off to the front of the store. The ADT instructor quickly followed him as she was not sure what he was going to do so she stood in front of Resident #3, so he did not cut the line or leave the store with the CDs without paying for them. Resident #3 went to the cashier to check out. At this time now the Shift Leader G arrived at Walmart and approached Resident #3 but Resident #3 was still refusing to listen to staff. Shift Leader G stated that she was calling the police. Finally, after the Walmart employee paid for a CD for Resident #3 while waiting for the police, Shift Leader G was able to walk Resident #3 out of the store and sat on the bench still waiting for the police. The police came and asked Shift Leader G if she wanted to press charges, she answered no and everyone including Resident #3 returned to the facility.

A facility note dated at 11:17 AM by Direct Support Professional J, documented that she was informed that Resident #3 had eloped earlier to Walmart, and she asked if any more assistance was needed. All staff agreed and stated that it would be better if more than one staff member went with Resident #3 on outings since his aggressive behavior increased when things do not go his way. Resident #3 wanted a CD that cost a little more than $11.00 and he did not have enough money on his gift card and got very agitated where the Walmart employee stepped in and paid for the CD for Resident #3.

A facility note dated at 2:37 AM by Direct Support Professional G, documented she was outside getting ready to leave for home from

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A 025	Continued From page 17 work on and was told that Resident #3 was at Walmart (of a mile from the facility) and needed someone to bring him . He left without permission and staff was not aware. The last time Resident #3 was seen was about 5:30 PM earlier after dinner and I told him that I would be tonight working so be good because Christmas was coming and Resident #3 responded yes. I was told when staff arrived at Walmart, Resident #3 was at the self-checkout and a large group of Walmart employees standing around him. I was told it was asked for Resident #3 to put the CD because he did not have enough money to pay for it. He did not have enough funds on his gift card. Resident #3 started yelling "NO" and kept swiping his gift card a few more times getting agitated. One of the Walmart employees de-escalated the situation and paid for one of the CDs and took the rest of the CDs to electronics. Resident #3 thanked the Walmart employee and said he was sorry. Resident #3 and staff walked outside the store and waited for the police to arrive, and Resident #3 repeatedly said he was sorry. There was no other documented evidence provided to demonstrate that the facility provided appropriate supervision & additional efforts put in place to prevent elopement for Resident #3 to continually ensure safety after being identified as an elopement risk. Furthermore, the facility was on notice that Resident #3 was an elopement risk, and two elopements had occurred within a month. The facility did not document any interventions put in place for both elopements. On at 3:58 PM, an interview with the Administrator confirmed the findings. (Photographic Evidence Obtained)	A 025		

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A 025	Continued From page 18 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 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	A 032		

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A 032	Continued From page 19 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 resident record review, facility's documentation, and interview, the facility failed to follow the elopement policies & procedures for 2 of 3 sampled residents (#1, #3) identified as elopement risks including an elopement risk assessment completed, the facility was making a daily effort at minimum to check for identification on their persons that includes the resident's name, facility's name, facility's address and facility's telephone number; and {2} the facility failed conduct two elopement drills twice a year	A 032		

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A 032	Continued From page 20 as required. Findings: 1. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated listed medical history , Sleep , , Valve , , , and . She has physical limitations using cancelling noise headphones and reduced visual , . She's , , with speech delay and uses sign language. Her activities of daily living (ADLs) independent in ambulation, toileting and transferring, supervision with bathing, and eating, needs assistance with grooming. In further review, on page 3 it is documented that Resident #1 needs medication administration. Resident #1 was identified as an elopement risk. A facility note dated 11/7/2024 at 5:06 PM by Villa Manager A documented at 2:36 PM on , two police officers came to the administration building and spoke with the Residential & Life Skills Program (ADT Manager) and the Human Resources Manager. The police officer was checking if a young woman (Resident #1) lived at the facility. Both staff confirmed yes, Resident #1 lived at the facility. The third police officer arrived with Resident #1 in the police vehicle. The third police officer said that the police was contacted by the Helping Counseling Center (about mile from the facility) where Resident #1 was found. The staff asked what happened to Resident #1 and Resident #1 stated that she wanted to go to her dad's home and that she had called her dad, but he did not answer. Staff reminded her that she could call her dad first or ask for assistance from staff to call dad if she is having trouble reaching him. Resident #1 was	A 032		

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A 032	Continued From page 21 reminded of the facility's policies/procedures of signing out when leaving campus and take her cellphone. Resident #1 asked staff to call her dad now, and she informed him what happened, and her dad reminded her to notify staff when wanting to leave campus. The Villa Manager notified the mother and Waiver Support Coordinator. The mother and father are separated and currently in the process of divorce. 2. Resident #3's record review revealed admission date . The last 1823 Health Assessment dated identified Resident #3 high risk for elopement. In further review his medical history listed were , , , , , , , , to lower extremities, , , Sinuses, , , left hearing loss, and left with 3 surgeries. He's , , and at risk of . He's independent in activities of daily living (ADLs) ambulating, toileting and transferring, he needs supervision in and eating and needs assistance with bathing and grooming. He needs assistance with self-administration of medications. A facility note dated at 8:26 AM by Adult Day Training (ADT) instructor documented that at 6 AM this morning when she walked into the Walmart store to shop before going to work, she saw Resident #3. She asked Resident #3 if he was with someone and he pointed to the electronics section and immediately ran off and kept going in that direction, fast paced toward the CDs. She immediately called Shift Leader G at the facility to inform the staff that Resident #3 had eloped from the facility and here at Walmart. The ADT instructor asked Resident #3 to come with her and please put all those CDs and he	A 032		

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A 032	Continued From page 22	A 032		

told her no. Resident #3 pushed her out the way and took off to the front of the store. The ADT instructor quickly followed him as she was not sure what he was going to do so she stood in front of Resident #3, so he did not cut the line or leave the store with the CDs without paying for them. Resident #3 went to the cashier to check out. At this time now the Shift Leader G arrived at Walmart and approached Resident #3 but Resident #3 was still refusing to listen to staff. Shift Leader G stated that she was calling the police. Finally, after the Walmart employee paid for a CD for Resident #3 while waiting for the police, Shift Leader G was able to walk Resident #3 out of the store and sat on the bench still waiting for the police. The police came and asked Shift Leader G if she wanted to press charges, she answered no and everyone including Resident #3 returned to the facility.

A facility note dated at 2:37 AM by Direct Support Professional G, documented she was outside getting ready to leave for home from work on and was told that Resident #3 was at Walmart (of a mile from the facility) and needed someone to bring him . He left without permission and staff was not aware. The last time Resident #3 was seen was about 5:30 PM earlier after dinner and I told him that I would be tonight working so be good because Christmas was coming and Resident #3 responded yes. I was told when staff arrived at Walmart, Resident #3 was at the self-checkout and a large group of Walmart employees standing around him. I was told it was asked for Resident #3 to put the CD because he did not have enough money to pay for it. He did not have enough funds on his gift card. Resident #3 started yelling "NO" and kept swiping his gift card a few more times getting agitated. One of the

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A 032	Continued From page 23 Walmart employees de-escalated the situation and paid for one of the CDs and took the rest of the CDs to electronics. Resident #3 thanked the Walmart employee and said he was sorry. Resident #3 and staff walked outside the store and waited for the police to arrive, and Resident #3 repeatedly said he was sorry. There was no documented evidence of an elopement assessment completed found in both Resident #1 and Resident #3 file. In addition, there was no documentation that both resident's identification was checked every day on their persons. Unfortunately, both Resident #1 and Resident #3 were home with family during the Christmas and New Year's holidays to observe if they were wearing their identifications. The facility did not conduct two elopement drills for 2024 as required, there was documented evidence that only one elopement drill on was completed. On at 4:15 PM, an interview with the Administrator confirmed the findings and stated that unfortunately his Human Resource Manager that had them filed in a different location was at the airport for time off. (Photographic Evidence Obtained) Class III	A 032		