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
	AL11970069	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR OF PUNTA GORDA LLC	10211 TAMIAMI TRL PUNTA GORDA, FL 33950

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A 000	Initial Comments An unannounced complaint investigation for #2025001022 and an emergency power plan monitoring survey was conducted at Hampton Manor of Punta Gorda LLC on . Deficiencies were identified at the time of survey.	A 000		
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	A 032		

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A 032	Continued From page 1 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 observation, interview and record review, the facility failed to ensure residents at risk for elopement had identification on their persons that included their name, the facility name, address and telephone number for 4 residents (#1, #2, #3, and #4) of 4 residents deemed at risk for elopement.	A 032		

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A 032	Continued From page 2 The findings included: Review of the facility policy "Clinical 10 - Elopement. Policy Date . Procedure 7. 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..." On at 10:04 a.m., during an interview with the Power of Attorney (POA) for Resident #1. He said he was notified of Resident #1's elopement in , of this year and that he had incurred some injuries from the facility staff. Review of Resident #1's Health Assessment Form (1823) dated indicated Resident #1 was an elopement risk. Resident #1 required staff assistance for ambulation. On at 10:22 a.m., Resident #1 was observed in the memory care unit in the television room. Resident #1 did not have identification on his person, to include his name, the facility name, address and telephone number. On at 10:25 a.m., care giver Staff A said she has worked at the facility for 2 weeks, and she helps residents in memory care unit get dressed. Staff A said the residents do not wear identification on their person. On at 10:59 a.m., during an interview, the Regional Director (RD) said Resident #1 was at risk for elopement and pretty much everyone in the memory care unit are considered at risk for elopement. The Regional Director said Resident	A 032		

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A	Continued From page 3 #1 eloped from a window in a vacant room. On at 11:14 a.m., Residents #1, #2, #3, and #4 were observed sitting at a large table in the dining area. They were not wearing any identification on their persons. Review of Resident #2's Health Assessment Form 1823 dated indicated Resident #2 was at risk for elopement. Review of Resident #3's Health Assessment Form 1823 dated indicated Resident #3 was at risk for elopement. Resident #3 needs supervision for ambulation. Review of Resident #4's Health Assessment Form 1823 dated indicated Resident #4 was at risk for elopement. Resident #4 needs supervision for ambulation. On at 11:21 a.m., during an interview, the Regional Director said Resident #1 eloped from the facility on , and all residents at risk for elopement wear identification with the resident's name, facility location and telephone number. The Regional Director confirmed Resident #1 did not have identification on his person. The Regional director checked for identification for Residents #2, #3, and #4 and confirmed they did not have identification on their persons that includes their name, the facility name, address and telephone number. The RD said Residents #1, #2, #3, and #4 should be wearing identification bracelets. On at 11:30 a.m., Staff B said she is a care giver and assists memory care residents with _ themselves. Staff B said no one told her she needs to make sure memory care	A 032		

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A 032	Continued From page 4 residents wear identification bracelets. On at 11:35 a.m., Staff C said she is a care giver in memory care. She said she was trained to put identification (ID bracelets) on memory care residents. Staff C said she does not know why the residents are not wearing the identification bracelets. Class III	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph	A 081		

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A 081	Continued From page 5 (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or	A 081		

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A 081	Continued From page 6 home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living.	A 081		

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A 081	Continued From page 7 (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff completed in-service training for elopement based on the facility's policies and procedures for 5 (Staff A, B, C, D, and E) of 5 records reviewed for elopement training. The findings included: Review of Staff A's training file revealed a Certificate of Achievement on "Elopement and ␣" dated . The certificate of completion was from MyAlfTraining.com an online computer-based training company. The training completed was not based on facility policies and procedures. Review of Staff B's training file revealed a	A 081		

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A 081	Continued From page 8 Certificate of Achievement on "Elopement and ␣" dated . The certificate of completion was from MyAlfTraining.com an online computer-based training company. The training completed was not based on facility policies and procedures. Review of Staff C's training file revealed a Certificate of Achievement on "Elopement and ␣" dated . The certificate of completion was from MyAlfTraining.com an online computer-based training company. The training completed was not based on facility policies and procedures. Review of Staff D's training file revealed a Certificate of Achievement on "Elopement and ␣" dated . The certificate of completion was from MyAlfTraining.com an online computer-based training company. The training completed was not based on facility policies and procedures. Review of Staff E's training file revealed a Certificate of Achievement on "Elopement and ␣" dated . The certificate of completion was from MyAlfTraining.com an online computer-based training company. The training completed was not based on facility policies and procedures. On at 1:51 p.m., during an interview, the Regional Director and the Administrator said the elopement training was computer based from a generic company and not based on facility policies and procedures. Class III .	A 081		