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
	AL11967791	A. BUILDING: _____ B. WING _____	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANYAN RESIDENCE ASSISTED LIVING, LLC	100 BASE AVE EAST VENICE, FL 34285

(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 for #2025001261 and an emergency power plan monitoring survey was conducted at Banyan Residence Assisted Living 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 as 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	A 032		

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A 032	Continued From page 1 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 a resident at risk of elopement did not elope from the facility for 1 (Resident #1) of 4 reviewed for elopement. The facility failed to ensure 3 (Residents #2, #3, and #4) of 4 review for being at risk for elopement, had identification on their person that included their name, the facility name, the facility	A 032		

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A 032	Continued From page 2 address, and telephone number. The findings included: 1. a. Review of the Health Assessment Form 1823 dated revealed Resident #1 was at risk for elopement. Review of the progress note dated revealed Resident #1 eloped from the facility at 11:24 a.m. Staff searched for the resident but could not locate the resident. Staff review of the security cameras revealed the resident exited the locked facility through the front gate at 11:24 a.m. Resident #1 was found uninjured at 12:30 p.m. and returned to the facility. On at 9:11 a.m., during an interview, Resident Care Coordinator Staff A said she was at the facility on the day Resident #1 eloped. She said a family member let Resident #1 out of the front gate. b. Review of the Health Assessment Form 1823 dated revealed Resident #2 was at risk for elopement. Review of the List of High Elopement Risk Residents revealed Resident #2 was at high risk for elopement. On at 9:00 a.m. and at 12:28 p.m., Resident #2 was observed outside independently. Resident #2 did not have identification (ID) on his person that included his name, facility name, address and telephone number. c. Review of the Health Assessment Form 1823 dated revealed Resident #3 was not an elopement risk. Review of the List of High Elopement Risk	A 032		

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A 032	Continued From page 3 Residents revealed Resident #3 was at high risk for elopement. On at 11:44 a.m. during an interview, Resident #3's daughter, sitting at the lunch table, she said Resident #3 is and needs to be in a locked community. She said before being admitted to the facility he rode his bicycle away from home several times and the family could not find him. She said she told the facility. She said Resident #3 does not carry ID because the resident would lose it. She said there is no or ankle ID. On at 11:50 a.m. observed Resident #3 at the lunch table. The and ankles were exposed. There was no ID on the or ankles. d. Review of the Health Assessment dated revealed Resident #4 was an elopement risk. Review of the List of High Elopement Risk Residents revealed Resident #4 was at high risk for elopement. On at 12:40 p.m., Resident #4 was observed in the apartment sitting in the chair. The resident did not have ID on the or ankles that contained the resident's name, facility name, facility address, and telephone. On at 12:34 p.m., during interview, Resident #4's spouse in the apartment, she said the resident moved in a few days ago. She said she does not live here, and the resident does not want her to leave when it is time for her to go home. She said the resident does not wear an ID on the ankles or and does not carry ID. She said the resident wants to come home. She said before getting the recliner chair, the	A 032		

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A 032	Continued From page 4 resident roamed the outdoor area at 2:00 a.m. and 3:00 a.m. in the morning. 2. On at 10:40 a.m., during an interview, Supervisor Staff B she said she has worked at the facility for almost 7 years. She said the residents don't wear ID and she just knows who they are. On at 12:00 p.m., during an interview, Medication Technician Staff C said Residents #2, #3, and #4 are . Staff C said she was not instructed to check ID for these residents, and they do not wear a a or ankle ID. On at 12:23 p.m., during an interview, Care Giver Staff 4 said she was not instructed to check residents to make sure they have ID on their person. On at 12:56 p.m., during an interview, the Administrator confirmed there was a list of elopement risk residents and Residents #2, #3, and #4 did not have identification on their person. Class III .	A 032		