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
	AL11965603	A. BUILDING: _____ B. WING _____	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI	3201 ROUSE ROAD ORLANDO, FL 32817

(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
ZZ821	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.	ZZ821		

AHCA Form 3020-0001

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

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ZZ821	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	ZZ821		

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ZZ821	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	ZZ821		

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ZZ821	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 record review and interview, the facility failed to submit a preliminary report within 1 business day and a full report within 15 calendar days after 1 of 4 sampled residents eloped from the facility (#5.) Findings: Review of the resident elopement policy, revised , revealed the facility defined elopement as an incident in which a resident leaves the community grounds without staff knowledge, and the resident has , decision-making abilities and is unaware of his/her own safety needs. Review of resident #5's record revealed a facility admission date of and move out date of . An admission health assessment form (1823,) dated , indicated the resident's medical history included . The resident was with occasional episodes of and disorientation. The resident required close monitoring due to her mental condition. The question as to whether the	ZZ821		

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ZZ821	Continued From page 4	ZZ821		

resident's needs could be met in a facility which was not a medical, nursing, or , , facility was answered "no." The resident had mild , required close monitoring, and a unit was preferred. The question as to whether the resident was at risk for elopement was not answered.

Review of the residents' record revealed the following:

On a meeting was held with the resident's family member to discuss the resident's paranoia and barricading her apartment door.

A
( ) found the resident was moderately , (score of 10.)

On the Administrator documented the resident left the facility without signing out. The Administrator told her to sign out and let someone know when she wanted to go to a store. The Administrator would notify the family of her concern regarding the resident's appropriateness to be in the facility.

On at 6:20 PM, Caregiver A documented she saw the resident walking down a sidewalk towards a nearby restaurant. The Caregiver stopped and asked the resident where she was going. The resident replied to the library. The resident recognized the Caregiver and asked if she could get in the Caregiver's car. The Caregiver brought the resident to the facility and informed the Administrator.

On the Administrator documented that she informed the resident's friend of the details of the incident. The Administrator expressed

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ZZ821	Continued From page 5	ZZ821		

concern that the resident was inappropriate for the facility because she did not always appear aware of potential dangers or when she was just going for a walk if she would be able to return to the facility. The resident said she was bored in the evenings and just went for a walk. The friend was unsure of what to do but would look for another facility. In the meantime, she would be watched as it seemed to happen only after dinner.

Review of the resident's sign-in and out report revealed she did not sign out when she left on and .

On at 12:31 PM, Caregiver A explained that on she was on a break when she saw the resident. The Caregiver was driving her car when she saw the resident talking to a man. The Caregiver stopped and brought the resident in her car. The resident was very . The resident did not say she was leaving the facility; she just left without signing out. The Caregiver could not remember if she saw the resident between 3 PM when she arrived at work and when she found her outside. The Caregiver explained residents were checked on every two hours. The Caregiver stated she was pretty sure someone from administration told her to make sure she kept an , on this resident. The Caregiver stated she was aware there were service plans but did not know if she had access to this resident's plan.

On at 1:34 PM, the Administrator explained that Caregiver A never told her she saw the resident talking with a man on . The Administrator stated she could not recall if she saw the admission 1823 before today then said she knew she did not see it. She stated she

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ZZ821	Continued From page 6 conducted the admission assessment. She explained that she did not investigate nor submit preliminary and final reports regarding the elopement because she did not consider it an elopement, the resident liked to stand on the sidewalk outside the facility and because there were no other incidents since the one on . Unclassified	ZZ821		
A 000	Initial Comments A complaint investigation (2025012324) and a generator monitoring was conducted at The Bridge Assisted Living at Life Care Center of Orlando on . The facility had deficiencies at the time of the survey.	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	A 008		

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A 008	Continued From page 7 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 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	A 008		

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A 008	Continued From page 8 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 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,	A 008		

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A 008	Continued From page 9	A 008		

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 ,
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.

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A 008	Continued From page 10 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 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	A 008		

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A 008	Continued From page 11 conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the health assessment form (1823) was complete for 1 of 4 sampled residents (#1). Findings: Review of resident #1's Health Assessment f 1823 dated revealed the examiner's telephone number was missing. On at 2:33 PM the findings were discussed with the Administrator, who confirmed the findings and said it was the most recent 1823. 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 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	A 025		

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A 025	Continued From page 12	A 025		

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 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

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A 025	Continued From page 13 additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide adequate supervision when 1 of 4 sampled residents eloped from the facility (#5). Findings: Review of the resident elopement policy, revised , revealed the facility defined elopement as an incident in which a resident leaves the community grounds without staff knowledge, and the resident has , decision-making abilities and is unaware of his/her own safety needs. Prior to moving in, a potential resident is assessed by the Resident Care Director (RCD) or designee to determine appropriateness for the community. If the RCD determines that a potential resident may be at risk for elopement, the Regional Director of Operations or Regional Director of Resident Care must be contacted for approval for the admission. Any resident identified as a risk with a ( ) score of less than 12 will be added to the resident care report retention log and discussed weekly. An elopement assessment will be completed upon move-in and quarterly, if a resident demonstrates exit-seeking behavior, talks about leaving, or attempts to leave alone, an elopement risk assessment will be updated. If the assessment indicates the resident is at-risk for elopement, the Administrator with assistance from the RCD will determine which preventive measures, up to and including discharge to a secure facility, will be put in place. Prevention interventions included, among other things, educating staff to service plan goals and	A 025		

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	AL11965603	A. BUILDING: _____ B. WING _____	10/08/2025

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A 025	Continued From page 14	A 025		

interventions. After resident located, a change of condition evaluation and service plan update to be completed.

Review of resident #5's record revealed a facility admission date of and move out date of .

An admission health assessment form (1823,) dated , indicated the resident's medical history included . The resident was with occasional episodes of and disorientation. The resident required close monitoring due to her mental condition. The question as to whether the resident's needs could be met in a facility which was not a medical, nursing, or , , facility was answered "no." The resident had mild , required close monitoring, and a unit was preferred. The question as to whether the resident was at risk for elopement was not answered.

Review of the record revealed the following:

On a meeting was held with the resident's family member to discuss the resident's paranoia and barricading her apartment door.

A found the resident was moderately , (score of 10.)

On the Administrator documented the resident left the facility without signing out. The Administrator told her to sign out and let someone know when she wanted to go to a store. The Administrator would notify the family of her concern regarding the resident's appropriateness to be in the facility.

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A 025	Continued From page 15 On at 6:20 PM, caregiver A documented she saw the resident walking down a sidewalk towards a nearby restaurant. The caregiver stopped and asked the resident where she was going. The resident replied to the library. The resident recognized the caregiver and asked if she could get in the caregiver's car. The caregiver brought the resident to the facility and informed the Administrator. On the administrator documented that she informed the resident's friend of the details of the incident. The administrator expressed concern that the resident was inappropriate for the facility because she did not always appear aware of potential dangers or when she was just going for a walk, if she would be able to return to the facility. The resident said she was bored in the evenings and just went for a walk. The friend was unsure of what to do but would look for another facility. In the meantime, she would be watched as it seemed to happen only after dinner. A found the resident was severely , (score of 1.) On the Administrator documented that she received a call from a local hospital asking about the resident. The administrator confirmed the resident lived at the facility. The resident was transported to the hospital after falling at a nearby restaurant. The employees there observed the then called 911. The resident injured her and right ankle. On the Administrator documented the resident's ankle was .	A 025		

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A 025	Continued From page 16 Review of the resident's service plan revealed it did not identify the resident as an elopement risk nor was it updated each time the resident eloped. Review of the sign-out report revealed the resident did not sign out when she left on , , and . On at 12:31 PM, Caregiver A explained that on she was on a break when she saw the resident. The Caregiver was driving her car when she saw the resident talking to a man. The Caregiver stopped and brought the resident in her car. The resident was very . The resident did not say she was leaving the facility; she just left without signing out. The Caregiver could not remember if she saw the resident between 3 PM when she arrived at work and the time she found her outside. The caregiver explained residents were checked on every two hours. The caregiver stated she was pretty sure someone from administration told her to make sure she kept an on this resident. The caregiver stated she was aware there were service plans but did not know if she had access to this resident's plan. The caregiver did not recall seeing the resident on prior to learning the resident eloped. On at 12:58 PM, Caregiver B explained that she worked from 3 PM to 11 PM on . She did not see the resident prior to learning the resident eloped. Usually, she just stood out front before returning inside. The resident was . She did not know where her room was. Residents were checked on every two hours. The Caregiver stated each resident had a service plan, but she never reviewed this resident's plan. On at 1:34 PM, the Administrator	A 025		

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explained that Caregiver A never told her she saw the resident talking with a man on . The Administrator stated she could not recall if she saw the admission 1823 before today then said she knew she did not see it. She stated she conducted the admission assessment. She explained that on she was manning the front desk and recalled seeing the resident in the lobby at 3 PM. She did not see the resident leave but even if she had she may not have thought anything of it because the resident usually went out front. The Administrator stated there was not a retention log, no elopement assessments, and no change of condition evaluation, as indicated in the resident elopement policy. She explained the information on the service plans transferred to the Point of Care software, which was used by the Caregivers only to acknowledge completion of activities of daily living tasks.

On at 2:21 PM, Caregiver C explained that on at 2:45 PM she was going home when she saw the resident sitting in a chair in the lobby. The resident asked if she could go with her. The Caregiver asked the resident where she was going to which the resident replied to Long Island, New York. Although the resident's spouse was no longer alive, the resident said her house, spouse, and family member were in New York. The Caregiver told the resident to stay there, that she had to wait for her family member. The Caregiver stated the resident was very that week. The Caregiver was unaware the resident previously eloped in , and .

On at 2:33 PM, Caregiver D explained she saw the resident in the lobby on between 2:50 PM and 3 PM. The resident was normally . The resident never expressed

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A 025	Continued From page 18 her desire to leave to the Caregiver. The Caregiver was aware of the previous elopements. The Caregiver stated the resident enjoyed walking. Over time the resident became more and got lost which led staff to keep her in the facility. 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	A 032		

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A 032	Continued From page 19 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 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 and interview, the facility failed to ensure that as part of its resident elopement response policies and procedures, the facility would make, at a minimum, a daily effort to determine that at risk residents have identification	A 032		

Agency for Health Care Administration

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A 032	Continued From page 20 on their persons that includes their name and the facility's name, address, and telephone number and the continued care of all residents within the facility in the event of an elopement. Findings: Review of the facility's resident elopement response policy, revised , revealed it did not indicate the facility would 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. The policy also did not provide for the continued care of all residents within the facility in the event of an elopement. On at 2:12 PM, the Administrator confirmed the findings. Class III	A 032		