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
	AL11969737	A. BUILDING: _____ B. WING _____	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An emergency power plan monitoring and complaint investigation #2025018694 was conducted at the Gallery of Cape Coral on through . Deficiencies were identified at the time of the survey. Class I deficiencies were found at A025, A032, and a Class II deficiency was found at A081. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate correction is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to provide proper supervision for residents to prevent elopement for 1 (Resident #1) out of 3 residents. Failure to provide proper supervision resulted in Resident #1 exiting the secure memory care without staff being aware on a morning with temperatures at 50 degrees Fahrenheit. The facility failed to ensure facility policies and procedures related to elopement prevention, alarm response, and resident accountability were implemented, monitored, and enforced. The noncompliance began on . The Facility's Administrator/Executive Director and Assistant Executive Director were notified of the Class I and Class II deficiencies on at 11:50 a.m.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements;	A 010		

AHCA Form 3020-0001

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

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A 010	Continued From page 1 examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a	A 010		

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A 010	Continued From page 2 facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection,	A 010		

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A 010	Continued From page 3	A 010		

criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:
(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.
(b) A resident requiring care of a ,
may be retained provided that:
1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed

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A 010	Continued From page 4 hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure that 3 (Residents #1, #2, and #3) out of 3 residents reviewed had an updated Agency for Health Care Administration Health Assessment (HA) Form 1823 after the significant change/determination of being an elopement risk.	A 010		

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A 010	Continued From page 5 Findings included: On at 8:00 a.m., a list of residents deemed as elopement risks was requested. A list was obtained which indicated all residents in the facility's memory unit were deemed as elopement risk. On at 8:30 a.m., during an interview, the Director of Health and Wellness (DHW) said that all 26 residents in the facility's memory unit were deemed as elopement risk. Per DHW no resident in the main building had been deemed as an elopement risk. 1. Record review showed Resident #1 was admitted to the facility on in to assisted living and moved into the facility's memory unit on . Record review for Resident #1 showed a HA Form 1823 that was completed on with diagnosis of , and valve and documented Resident #1 was not elopement risk, however under or Behavioral Status: the doctor wrote, " [sign for with] behaviors, agitation, can hit other residents." Review of progress notes for Resident #1 revealed: Progress note dated: " LATE ENTRY Resident followed staff member out to their car in the staff parking lot and attempted to get into various cars looking for a "way home". Staff member escorted resident to the building and into her room so she could lay down and rest. [Family member] was made aware." Progress note dated: " 15:03 LATE ENTRY Resident spent day in the memory care unit when she was noted going out the door, alarm sounded, and staff redirected resident	A 010		

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A 010	Continued From page 6 to her room in AL where resident stated she was trying to go to. {Family member} notified." Progress note dated: " Resident has moved to our MC neighborhood. . . " Progress note dated: " Resident triggered the egress door and opened the door to exit. Staff arrived before resident was able to leave building and escorted her to the community." Progress note dated: " This writer called over to MC to observe resident going after a staff member, trying to hit her. Staff member reports that she had stopped resident from going out the fire door. resident has become angry/agitated and started pulling another resident around by his arms, digging her nails in. Staff removed the other resident and escorted him to his room. Several attempts were made to redirect the resident with no results. . . " Resident #1 eloped from the facility on at 4:51 a.m. Progress note dated: " At approximately 0457 on , resident left MC neighborhood through the egress door. The alarm was tripped, care staff checked the area around the door and the surrounding area. Resident walked approximately 100 yards to the fire station next door, Station 12 and rang the doorbell at approximately 0502 according to Lieutenant [name] at the station. They took the resident to the ED [emergency department] and fire staff came to the community to speak to staff. . . " Progress note dated: " Resident continuing to exit seek. Continually attempting to leave out egress door and triggering alarm, Difficult to redirect and very angry. Combative with staff. . . " 2. Record review showed Resident #2 was admitted to the facility on and resides in	A 010		

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A 010	Continued From page 7 the facility's memory unit and included on the list of residents deemed as an elopement risk. Record review for Resident #2 showed a HA Form 1823 that was completed on included diagnosis of , , , , under hospice services and indicated Resident #2 is no elopement risk. 3. Record review showed Resident #3 was admitted to the facility on , and was included at the list of residents deemed as elopement risk. HA Form 1823 for Resident #3 was completed on included diagnosis infraction due to of right cerebellar , . General . forgetful. Resident #3 was not deemed as elopement risk. A prior HA Form completed on also documented Resident #3 was not deemed as elopement risk. During a follow up interview with the facility's DHW on at 1:00 p.m., she confirmed that all 3 residents were deemed as elopement risk and their Health Assessments had not been updated yet. She said that was an oversight on her end. Class III .	A 010		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying	A 025		

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A 025	Continued From page 8 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 change.	A 025		

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A 025	Continued From page 9 (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and staff interviews, the facility to provide proper supervision for 1 (Resident#1) out of 3 residents reviewed. Failure to provide supervision for a resident who was exit seeking during the night allowed Resident #1, with a diagnosis of with behaviors and agitation, requiring a secure environment, to leave the facility at 4:51 a.m., unknown to Staff A and Staff B in the Memory Care Unit (MCU) and walk to a neighboring Fire Station estimated to be 100 yards away along a busy 4 lane street. This failure put Resident #1 at risk for an immediate and serious threat to health and safety, including risk of injury, harm or due to environmental exposure, darkness, temperatures, and lack of supervision. The findings included: Record review revealed on at approximately 4:51 a.m., during the overnight hours an exit door alarm activated showing that a secured door had been opened. Staff A and Staff B, assigned to the secured Memory Care Unit, heard the alarm and opened the door. Staff A and B did not observe anyone existing in the unit. Despite the alarm activation, Staff A and B failed to conduct an immediate resident headcount	A 025		

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A 025	Continued From page 10	A 025		

using the resident roster, failed to verify that all Memory Care residents were present, and failed to initiate Elopement Response - Simulated and Actual protocols. Staff A and B continued routine duties without confirming all residents whereabouts.

Record review showed Resident #1 was admitted to the facility on in to assisted living and moved into the facility's memory unit on . Resident #1 is .
Record review for Resident #1 showed a Health Assessment (HA) Form 1823 that was completed on with diagnosis of , and valve and documented Resident #1 was not an elopement risk, however under or Behavioral Status: the doctor wrote, " [sign for with] behaviors, agitation, can hit other residents."

Review of progress notes for Resident #1 revealed:
Progress note dated: " At approximately 0457 on , resident left MC neighborhood through the egress door. The alarm was tripped, care staff checked the area around the door and the surrounding area. Resident walked approximately 100 yards to the fire station next door, Station 12 and rang the doorbell at approximately 0502 according to Lieutenant [name] at the station. They took the resident to the ED [emergency department] and fire staff came to the community to speak to staff. . . "

Other progress notes revealed:
Progress note dated: " LATE ENTRY
Resident followed staff member out to their car in the staff parking lot and attempted to get into various cars looking for a "way home". Staff member escorted resident to the building

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A 025	Continued From page 11 and into her room so she could lay down and rest. [Family member] was made aware." Progress note dated: " 15:03 LATE ENTRY Resident spent day in the memory care unit when she was noted going out the door, alarm sounded, and staff redirected resident to her room in AL where resident stated she was trying to go to. {Family member} notified." Progress note dated: " Resident has moved to our MC neighborhood. . . " Progress note dated: " Resident triggered the egress door and opened the door to exit. Staff arrived before resident was able to leave building and escorted her to the community." Progress note dated: " This writer called over to MC to observe resident going after a staff member, trying to hit her. Staff member reports that she had stopped resident from going out the fire door. resident has become angry/agitated and started pulling another resident around by his arms, digging her nails in. Staff removed the other resident and escorted him to his room. Several attempts were made to redirect the resident with no results. . . " Progress note dated: " Resident continuing to exit seek. Continually attempting to leave out egress door and triggering alarm, Difficult to redirect and very angry. Combative with staff. . . " Resident #1 was moved to the facility's Memory Unit on . Per Director of Health and Wellness (DHW) on at 9:05 a.m. it was due to decline. Emergency Medical Services record review showed an assessment completed on at 5:00 a.m. Per record Resident#1 appeared to be , disoriented, not able to provide information other than her name. She said she	A 025		

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A 025	Continued From page 12	A 025		

was lost and unsure where she is or where she came from. She reported she is , ran away from home and she walked from Missouri. She was observed disoriented denied , or complaints and did not have identification on. Awake, alert, with . Strong radial , , clear , minor in right for arm, but otherwise unremarkable. The Fire Department EMTs took Resident #1 to the local hospital Emergency Department (ED) for evaluation and the fire staff came to the community on at around 6:15 a.m. to speak with staff.

On , the temperature overnight was 57 degrees Fahrenheit, Sunrise was 7:11 a.m. in Cape Coral, FL per timeanddate.com. Observation on of the facility building and parking lot found there was a street light located at the corner of the building facility lot over the sidewalk going out over the 4-lane street. There are street lights on the street that leads to the fire station. There is a 2-lane road between the facility/parking lot and the fire station and a second 2-lane road behind the Facility. The fire station had multiple lights.

During an interview on at 9:28 a.m., Staff C said the was the medication tech on that day in the Assisted living side of the facility when the EMTs arrived. She said they came about 6:12 a.m. and told her Resident #1 was not on the facility premises, that she had come to the fire station. The EMT's said they had taken Resident #1 to the hospital for evaluation. Staff C said she called Assistant Executive Director, and then went to tell Staff A and B the resident was missing and was now at the hospital. She said Staff A and B did not know the resident had gone missing.

During an interview on at 11:45 a.m., the

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A 025	Continued From page 13	A 025		

Memory Care Director (MCD) said she got a call about 6:15 a.m. and went to the Hospital and identified the resident at the ED early on . She said Resident#1 was unable to give a description of the incident. Resident#1 had no recollection of the incident or the motivation for the elopement.

On at 9:20 a.m., during an interview, Staff B said, around 4:55 a.m., we put Resident #1 to bed. I don't remember exactly what she was wearing. She was and we tried to redirect her. The alarm did not go off. We found out at around 6:00 a.m. when Staff C, the med tech in the main AL, came and told us was here to let us know Resident #1 was missing and they were taking her to the hospital for evaluation. Staff B said the alarm did not go off, they did not hear anything. Staff B said they get the notifications on the iPad when the alarm goes off when the door is opened but she did not get a notification. Staff B said she knew Resident #1 was restless and she was up. Staff B said they do round every two hours.

On at 10:32 a.m., during an interview, Staff A said Resident #1 was very restless that night she was walking up and down the hallway and trying to open all the doors. They redirected her and she was still trying to open doors. They had her sit next to me, then offered her assistance with personal care and it still did not work. Staff A said the last time she saw Resident #1 was around 4:50 a.m. She was wearing a short-sleeved shirt, shorts and white socks with sneakers. It was close to 5:50 a.m. I think when Staff C came and told us was here saying Resident #1 left the building, we did not hear the alarm going off. The alarm did not go off period. I would have run to her, it did not go off. Staff A

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THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 025	Continued From page 14 said they used to check on her every 2 hours. After the incident, it went to every half hour (30 minutes). She said they do not document on checking on Resident #1. During an interview on at 8:03 a.m., the Maintenance Director said he was not on premises when the incident took place, but he tested the alarms and all were in good working order the next day. The Maintenance Director said the alarm is activated when the door opens and continues to sound until someone goes and deactivates by using the key. Record review of the egress door alarm print out revealed the door alarmed at 4:51 a.m. on . During an interview on at 8:30 a.m., the Director of Health and Wellness (DHW) said that all 26 residents in the facility's memory unit were deemed as elopement risk. The DHW said no resident in the main Assisted Living (AL) building was deemed an elopement risk. During a follow-up interview on at 10:00 a.m., the DHW said Resident #1 was in the main Assisted Living before they moved her to the Memory Care Unit due to her decline. She moved in . The DHW said Resident #1 was fully clothed when they found her. She was not wearing her ID, she threw it in the trash; they found it there. During an interview on at 11:00 a.m., the Assistant Executive Director ( ) said Staff C called her around 6:13 a.m. The left a message for the DHW and a message for Resident #1's family at 6:27 am. said she was at the facility by 7:10 a.m. and spoke to Staff A and B. The said Staff A and Staff B told	A 025		

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A 025	Continued From page 15	A 025		

her they heard the alarm, and they looked outside and did not see anyone. Then they retracted their statements and said they did not hear the alarm. The said she did not realize there was a difference between what the staff said and what they wrote. The said she did not have any witnesses when she was talking to them and did not take any notes. Based on their verbal statement she filled out the incident report. The said after the fact both Staff A and B retracted their statement saying they never heard the alarm going off, but they had the printout indicating the alarm was in good order.

At a follow-up interview on at 8:15 a.m., the said Staff A and B lied and provided false information to her. The said she did not have witnesses when she spoke to them, and she did not take notes and have them sign their statement while having the verbal interview. The said basically it is her word against them, but they have the evidence that the alarm went off documented. The said she is new in this role and she did not think she needed witnesses or notes. The said the staff told her she was fully clothed with long sleeve clothes and that is why she put that on the report.

During an interview on at 10:20 a.m., the said, they have a tool that we utilize upon admission as part of the initial assessment. Either the DHW or her assistant will complete the assessment upon admission and every 6 months or significant change. Based on the answers during the initial assessment the resident may deem as elopement risk. During the initial assessment when Resident #1 was admitted to the facility she was not deemed as elopement risk. It was changed later on, and Resident #1 was admitted to the Memory Care Unit. As a

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A 025	Continued From page 16 precaution all the residents in the Memory Care Unit are deemed as an elopement risk. Class I .	A 025		
A 032 SS=J	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 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 17 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 staff interviews, the facility failed to provide Elopement training and failed to ensure all direct care and administrative staff participated in a minimum of 2 elopement drills each year. Record review revealed of the 42 direct care staff, 23 had participated in 1 or more trainings, while 17 staff had no elopement drill participation in 2025.	A 032		

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A 032	Continued From page 18 Failure to provide supervision and elopement training and twice annual drill participation allowed a resident who was exit seeking during the night, with a diagnosis of with behaviors and agitation, requiring a secure environment, to leave the facility at 4:51 a.m., unknown to Staff A and Staff B in the Memory Care Unit (MCU) and walk to a neighboring Fire Station estimated to be 100 yards away along a busy 4 lane street. This failure put Resident #1 at risk for an immediate and serious threat to health and safety, including risk of injury, harm or due to environmental exposure, darkness, temperatures, and lack of supervision. The findings included: Review of the facility policy revealed: Facility policy titled: Elopement Response - Simulated and Actual: Date of Issue: . Last Revised: . Last Reviewed: . Program Interpretation and Implementation: [The Corporation] identifies an elopement as an event in which an unassisted resident crosses any threshold of which they are categorized as being unable to leave unassisted. An example of this is a Memory Care resident who exits the secure Memory Care environment without accompaniment. . . It is the responsibility of Team Members to immediately respond to activated door alarms.. . Response Processes . . Team Member to perform a headcount using the Resident Roster, accounting for each resident to verify the identity of the missing resident. 1. Record review showed Resident #1 was admitted to the facility on in to assisted living and moved into the facility's memory unit on . Resident #1 is , .	A 032		

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A 032	Continued From page 19 Record review for Resident #1 showed a Health Assessment (HA) Form 1823 that was completed on with diagnosis of , and valve and documented Resident #1 was not an elopement risk, however under or Behavioral Status: the doctor wrote, " [sign for with] behaviors, agitation, can hit other residents." Review of progress notes for Resident #1 revealed: Progress note dated: " At approximately 0457 on , resident left MC neighborhood through the egress door. The alarm was tripped, care staff checked the area around the door and the surrounding area. Resident walked approximately 100 yards to the fire station next door, Station 12 and rang the doorbell at approximately 0502 according to Lieutenant [name] at the station. They took the resident to the ED [emergency department] and fire staff came to the community to speak to staff. . . " Other progress notes revealed: Progress note dated: " LATE ENTRY Resident followed staff member out to their car in the staff parking lot and attempted to get into various cars looking for a "way home". Staff member escorted resident to the building and into her room so she could lay down and rest. [Family member] was made aware." Progress note dated: " 15:03 LATE ENTRY Resident spent day in the memory care unit when she was noted going out the door, alarm sounded, and staff redirected resident to her room in AL where resident stated she was trying to go to. {Family member} notified." Progress note dated: " Resident has moved to our MC neighborhood. . . " Progress note dated: " Resident triggered	A 032		

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A 032	Continued From page 20 the egress door and opened the door to exit. Staff arrived before resident was able to leave building and escorted her to the community." Progress note dated: " This writer called over to MC to observe resident going after a staff member, trying to hit her. Staff member reports that she had stopped resident from going out the fire door. resident has become angry/agitated and started pulling another resident around by his arms, digging her nails in. Staff removed the other resident and escorted him to his room. Several attempts were made to redirect the resident with no results. . . " Progress note dated: " Resident continuing to exit seek. Continually attempting to leave out egress door and triggering alarm, Difficult to redirect and very angry. Combative with staff. . . " Resident #1 was moved to the facility's Memory Unit on . Per Director of Health and Wellness (DHW) on at 9:05 a.m. it was due to decline. On , the temperature overnight was 57 degrees Fahrenheit, Sunrise was 7:11 a.m. in Cape Coral, FL per timeanddate.com. Observation on of the facility building and parking lot found there was a street light located at the corner of the building facility lot over the sidewalk going out over the 4-lane street. There are street lights on the street that leads to the fire station. There is a 2-lane road between the facility/parking lot and the fire station and a second 2-lane road behind the Facility. The fire station had multiple lights. Emergency Medical Services record review showed an assessment completed on at 5:00 a.m. Per record Resident#1 appeared to be	A 032		

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A 032	Continued From page 21 , disoriented, not able to provide information other than her name. She said she was lost and unsure where she is or where she came from. She reported she is , ran away from home and she walked from Missouri. She was observed disoriented denied , or complaints and did not have identification on. Awake, alert, with . Strong radial , , clear , minor in right for arm, but otherwise unremarkable. The Fire Department EMTs took Resident #1 to the local hospital Emergency Department (ED) for evaluation and the fire staff came to the community on at around 6:15 a.m. to speak with staff. During an interview on at 8:30 a.m., the Director of Health and Wellness (DHW) said that all 26 residents in the facility's memory unit were deemed as elopement risk. The DHW said no resident in the main Assisted Living (AL) building was deemed an elopement risk. During a follow-up interview on at 10:00 a.m., the DHW said Resident #1 was in the main Assisted Living before they moved her to the Memory Care Unit due to her decline. She moved in . The DHW said Resident #1 was fully clothed when they found her. She was not wearing her ID, she threw it in the trash; they found it there. During an interview on at 9:28 a.m., Staff C said the was the medication tech on that day in the Assisted living side of the facility when the EMTs arrived. She said they came about 6:12 a.m. and told her Resident #1 was not on the facility premises, that she had come to the fire station. The EMT's said they had taken Resident #1 to the hospital for evaluation. Staff C said she called Assistant Executive Director, and then went to tell Staff A and B the resident was missing	A 032		

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A 032	Continued From page 22 and was now at the hospital. She said Staff A and B did not know the resident had gone missing. On at 9:20 a.m., during an interview, Staff B said, around 4:55 a.m., we put Resident #1 to bed. I don't remember exactly what she was wearing. She was and we tried to redirect her. The alarm did not go off. We found out at around 6:00 a.m. when Staff C, the med tech in the main AL, came and told us was here to let us know Resident #1 was missing and they were taking her to the hospital for evaluation. Staff B said the alarm did not go off, they did not hear anything. Staff B said they get the notifications on the iPad when the alarm goes off when the door is opened but she did not get a notification. Staff B said she knew Resident #1 was restless and she was up. Staff B said they do round every two hours. On at 10:32 a.m., during an interview, Staff A said Resident #1 was very restless that night she was walking up and down the hallway and trying to open all the doors. They redirected her and she was still trying to open doors. They had her sit next to me, then offered assistance with personal care and it still did not work. Staff A said the last time she saw Resident #1 was around 4:50 a.m. She was wearing a short-sleeved shirt, shorts and white socks with sneakers. It was close to 5:50 a.m. I think when Staff C came and told us was here saying Resident #1 left the building, we did not hear the alarm going off. The alarm did not go off period. I would have run to her, it did not go off. Staff A said they used to check on her every 2 hours. After the incident, it went to every half hour (30 minutes). She said they do not document on checking on Resident #1.	A 032		

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A 032	Continued From page 23 During an interview on at 8:03 a.m., the Maintenance Director said he was not on premises when the incident took place, but he tested the alarms and all were in good working order the next day. The Maintenance Director said the alarm is activated when the door opens and continues to sound until someone goes and deactivates by using the key. Record review of the egress door alarm print out revealed the door alarmed at 4:51 a.m. on . During an interview on at 11:00 a.m., the Assistant Executive Director ( ) said Staff C called her around 6:13 a.m. The left a message for the DHW and a message for Resident #1's family at 6:27 am. said she was at the facility by 7:10 a.m. and spoke to Staff A and B. The said Staff A and Staff B told her they heard the alarm, and they looked outside and did not see anyone. Then they retracted their statements and said they did not hear the alarm. The said she did not realize there was a difference between what the staff said and what they wrote. The said she did not have any witnesses when she was talking to them and did not take any notes. Based on their verbal statement she filled out the incident report. The said after the fact both Staff A and B retracted their statement saying they never heard the alarm going off, but they had the printout indicating the alarm was in good order. At a follow-up interview on at 8:15 a.m., the said Staff A and B lied and provided false information to her. The said she did not have witnesses when she spoke to them, and she did not take notes and have them sign their statement while having the verbal interview. The	A 032		

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A 032	Continued From page 24 said basically it is her word against them, but they have the evidence that the alarm went off documented. The said she is new in this role and she did not think she needed witnesses or notes. The said the staff told her she was fully clothed with long sleeve clothes and that is why she put that on the report. 2. Record review of Staff training for Elopement revealed the facility failed to ensure staff completed elopement in service training based on the facility's policy and procedure for 20 (B, D, E,F,G,H,I , J, K, L ,M N, O P, Q, R, S, T U , V) of 42 employees reviewed. Further the provider failed to provide documentation of Elopement training for 16 (Staff A, C, AA, CC, GG, HH, II, JJ, KK, LL, NN, OO, PP, QQ, RR, and TT) of 42 staff during the 2 and day survey. Refer to Citation A0081 for details. 3. Staff Elopement Drill documentation was requested for the year 2025. Facility Elopement Drills were provided for , , , , and . Record review of Elopement Drills provided by the facility on revealed the following: The Drill for included a Elopement Drill Evaluation form which documented the person was discovered behind a shower curtain in within 3 minutes. The drill was documented for 9 a.m. to 945 a.m. with the resident found at 9:03 a.m. However, the sign-in-log attached to the drill showed a whited out date with written over the whitened area. The 22 signatures on the sheet are all dated . A request was made for the sign-in-sheet for the training and it matched exactly except for the date. This training was disregarded.	A 032		

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A 032	Continued From page 25 The Drill for included a Elopement Drill Evaluation form which documented the person was discovered during a room to room search in the activity room corner at 2:04 a.m. The drill was documented for 2 a.m. to 2:20 a.m. on the pm shift. However, the sign-in-log attached to the drill showed the in-service had been provided for Hurricane Preparedness and Elopements was written above that with a slash after elopements. The inservice was dated for but start time was 2:30 p.m. The 26 signatures were dated . This training was disregarded. The Drill for was documented for 4:30 p.m. to 4:45 p.m. on the shift. The sign-in-log documented the drill was from 4:00 p.m. to 4:30 p.m.; the 24 signatures were from all position types, not just direct care and administrative staff. The log contained 7 direct care staff signatures. These 7 direct care staff were accepted. The Drill for documented it was from 2:30 p.m. to 2:45 p.m. on the shift. The sign-in-log documented 2:30 to 3;30. with 42 signatures of all position types. These 19 direct care staff were unduplicated and accepted. The Drill for documented it was from 11 a.m. to 11:20 a.m. on the shift. The sign-in-log documented 23 signatures of all position types. 10 of the signatures were from direct care or administrative staff. These 10 signatures were accepted. The final Drill was run on . The drill documents it was from 12:20 p.m. to 12:25 p.m., on the day shift, as a community search and the resident was found in the stairwell at 12:25 p.m.	A 032		

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THE GALLERY AT CAPE CORAL	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 032	Continued From page 26 The documentation showed 27 signatures of all position types. 10 of these signatures were direct care or administrative signatures and were accepted. The following Staff had less than 2 elopement drill participation's annually for 2025: Staff A Care Partner hired on had no drill participation's in 2025. Staff B Care Partner hired on 11/19/24 had no drill Participation. Staff C Care Partner hired on had no drill participation in 2025. Staff F Care Partner hired on 11/8/25 had no drill participation. Staff G Med Tech hired on had not drill participation. Staff H Care Partner hired on , had no drill participation. Staff I Med Tech hired on had no drill participation in 2025. Staff K Care Partner hired on had no drill participation in 2025. Staff M Med Tech hired on had no drill participation in 2-025. Staff O Care Partner hired on had no drill participation in 2-025. Staff P Care Partner hired on had no drill participation in 2025. Staff R Care Partner hired on had no drill participation in 2025. Staff S Care Partner hired on had only 1 drill participation in 2025. Staff T Care Partner hired on had only 1 drill participation in 2025. Staff U Care Partner hired on had only 1 drill participation in 2025. Staff V Care Partner hired on had no drill participation in 2025. Staff BB Medication Tech hired on 11/19/24 had	A 032		

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A 032	Continued From page 27 no drill participation. Staff CC Med Tech hired on only participated in 1 drill in 2025. Staff Staff DD Med tech hired on had only 1 drill participation. Staff FF Care Partner hired on , had only 1 participation in 2025. Staff HH Med Tech hired on had no drill participation in 2025. Staff JJ Care Partner hired on had no drill participation in 2025. Staff KK Care Partner hired on had no drill participation in 2025. Staff PP Care Partner hired on 11/14/24 had only 1 drill participation in 2025. Staff QQ Med tech hired on had no drill participation in 2025. Class I .	A 032		
A 081 SS=G	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	A 081		

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A 081	Continued From page 28	A 081		

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).

(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

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A 081	Continued From page 29 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 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	A 081		

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A 081	Continued From page 30 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. (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 record review the facility failed to ensure staff completed elopement in service training based on the facility's policy and procedure for 20 (B, D, E,F,G,H,I , J, K, L ,M N, O P, Q, R, S, T U , V) of 42 employees reviewed. Further the provider failed to provide documentation of Elopement training for 16 (Staff	A 081		

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A 081	Continued From page 31 A, C, AA, CC, GG, HH, II, JJ, KK, LL, NN, OO, PP, QQ, RR, and TT) of 42 staff during the 2 and day survey. Failure to train staff in the facility's policies and procedures regarding elopement resulted to Resident #1's elopement on from the secure memory care unit. On at approximately 4:50 a.m., during the overnight hours when conditions were dark and (57 F), an exit door alarm activated indicating that a secured door had been opened. Staff A and Staff B, assigned to the secured Memory Care Unit, heard the alarm and opened the door. Staff A and B did not observe anyone existing in the unit. Despite the alarm activation, Staff A and B failed to conduct an immediate resident headcount, failed to verify that all Memory Care residents were present, and failed to initiate elopement response protocols. The elopement exposed Resident #1 to an immediate and serious threat to health and safety, including risk of injury, harm or due to environmental exposure, darkness, temperatures, and lack of supervision. The findings included: On at 1:52 p.m., the facility provided an up-dated employee list documenting 42 direct care staff al of whom had been hired more than 30 days. On at 7:59 a.m. the facility provided documentation of Elopement training for 26 of the 42 staff listed. 20 staff had no documentation provided for Elopement training from to Record review showed that Staff B, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by	A 081		

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A 081	Continued From page 32 an instructor in North Carolina. Record review showed that Staff D, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff E, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff F, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff G, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff H, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff I, hired on , completed 30 minutes of training on , regarding elopement. The training was	A 081		

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A 081	Continued From page 33 not tailored to the facility's polices and procedures. It was an on line training provided by an instructor in North Carolina. Record review showed that Staff J, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff K, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an on line training provided by an instructor in North Carolina. Record review showed that Staff L, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff M, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff N, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff O, hired on	A 081		

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A 081	Continued From page 34	A 081		

, completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina.

Record review showed that Staff P, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina.

Record review showed that Staff Q, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina.

Record review showed that Staff R, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina.

Record review showed that Staff S, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina.

Record review showed that Staff T, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina.

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A 081	Continued From page 35 Record review showed that Staff U, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. Record review showed that Staff V, hired on , completed 30 minutes of training on , regarding elopement. The training was not tailored to the facility's polices and procedures. It was an online training provided by an instructor in North Carolina. On at 7:59, the facility failed to provide documentation showing the following staff's participation in Elopement training: Staff A Care Partner hired on . Staff C Medication Tech hired on . Staff AA Med Tech hired on . Staff CC Med Tech hired .. Staff GG Med Tech hired on . . . . Staff HH Med Tech hired on . Staff II Care Partner hired on 11/17/25. Staff JJ Care Partner hired on . Staff KK Care Partner hired on . . . Staff LL Care Partner hired on . Staff NN Wellness Nurse hired on . Staff OO Care Partner hired on 11/8/25. Staff PP Care Partner hired on 11/14/24. Staff QQ Med Tech hired on . Staff RR Care Partner hired on . . . Staff TT Care Partner hired on 11/8/25. In an interview on at 2:00 p.m., the Assistant Executive Director ( ) and Executive Directorsaid that all trainings were completed online and the copies of the certificates were sent to the main office in Colorado. The said all	A 081		

Agency for Health Care Administration

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A 081	Continued From page 36 staff needed to follow corporate trainings online and that is a decision that was made on a corporate level. The AEDirector acknowledged the elopement training was not based on the facility's elopement polices and procedures. Class II .	A 081		