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	AL11968596	02/08/2019
NAME OF PROVIDER OR SUPPLIER **COLONIAL ASSISTED LIVING AT BOYNTON BEACH FL**	STREET ADDRESS, CITY, STATE, ZIP CODE **1708 NE 4TH STREET** **BOYNTON BEACH, FL 33435**	

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0000 - Initial Comments

An unannounced complaint investigation (CCR #2019001480) was conducted on - at Colonial Assisted Living at Boynton Beach Fl, License #12470. Deficient practice was found at the time of the visit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview and record review, the facility failed to provide the level of care, services and oversight required to meet the needs of the resident. This was evidenced by the failure to ensure the physical and well-being to 1 of 16 sampled residents, (Resident #1), who had a medical diagnosis of memory loss and was identified by the facility to require assistance while being outside of the facility. This failure resulted in Resident #1 eloping from the facility, without the facility observing for the resident's daily whereabouts and wellbeing, and the resident being at immediate risk and suffering injuries that required hospitalization. Additionally, 14 of 16 (Resident # 4 through # 17) sampled residents that are identified as requiring increased supervision while out of the facility remain at risk due to the facility staff's inability to demonstrate competency related to the facility elopement policy and procedures.

The findings include:

Review of Resident #1's health assessment form dated on and signed by the Administrator indicated that the resident was diagnosed with memory loss, and . Resident #1 was independent with his activities of daily living (ADL) and required assistance with self- administration of medications. Resident #1 was identified to require daily observation of his wellbeing, whereabouts and reminders for important tasks. Further review of the assessment form indicated that Resident#1 required assistance with shopping to be provided by family /friends or facility staff.

Review of the Resident #1's admission note completed by the Director of Nursing (DON) on , indicated that the resident was alert, and verbally responsive. The note indicated that Resident#1 had mild memory loss but was able to make his needs known. Review of the note indicated that Resident #1 had been living with a family member and he would be left alone for long periods of the day which was a concern for his family. The note further indicated that the resident's family member agreed to allow Resident#1 to go out of the facility when supervised with family and friends.

Review of the Agency 1- Day Adverse Incident report submitted by the facility on at 4:32 PM indicated an elopement incident involving Resident #1 that occurred on at 8:07 PM. Review

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Indicated that according to the facility's report, Resident #1 left the facility to go to the store with another resident, Resident #2 around 3 PM on . The report indicated that at 8 PM, the police notified the facility that Resident #1 had been transported to the hospital for evaluation after sustaining a . The report indicated that Resident#1 returned to the facility with his family member at approximately 11:15 PM on .
In an interview with the Administrator on at 11:15 AM she stated that she was informed of the incident from the facility staff, after the police notified the facility that Resident#1 had been taken to the hospital.

Review of the Fire Rescue/Emergency Medical Services ( ) report dated on revealed the rescue unit was dispatched at 2:49 PM, and personnel arrived at the intersection of Federal Highway and Turner Road in the City of Boynton Beach at 3:03 PM. The report indicated that personnel found a male, Resident #1 with the chief complaint of . The report further indicated that the male was spotted by bystanders, stumbling down the street, tripped on the sidewalk, and sustained to his . The report indicated that the male was very and could not answer questions appropriately. The resident was transported via to the hospital for evaluation.

Review of the Google maps website indicated the distance from the Assisted Living Facility (ALF) to the accident location, noted on the report where Resident #1 was 3.6 miles, direct route. Further review of the website page indicated that the accident location was identified to be on a 4 lane busy main thoroughfare street with numerous traffic lights and intersections.

Review of the hospital record for Resident #1 indicated that he arrived at the Emergency Room (ER) on at 3:32 PM via . The ER note indicated that Resident #1 was able to "state his name only, he was and did not know why/where he was walking" or how he . The note further indicated that Resident#1 had on his , upper , and forehead. Resident#1 was unable to give his medical history to the hospital staff. Further review of the record indicated that Resident #1 was discharged with his family member to the assisted living facility at 11:13 PM. The report indicated that Resident #1's discharge diagnosis included , and .

Review of the facility Elopement Policy and Procedure dated indicated that the facility will "promote and foster an environment of safety and good quality of life for all residents". The policy indicated that "a resident will sign out when leaving the facility and sign in upon return to the facility in the "Sign Out/In" Log aka (Temporary Absence Log). The log will include the resident's name, date and reason for temporary absence." Further review of the policy indicated that "although the resident may travel independently in the community, the assisted living staff are responsible for knowing the general whereabouts of all residents" and "when a resident is determined missing or their whereabouts are

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unknown, the facility shall make every attempt as quickly as possible to locate the resident."

In a phone interview with Staff A on at 8:15 AM she stated that she routinely works at the front desk from 7 AM to 3 PM and her responsibilities include monitoring the locked lobby front doors and directing residents to sign the "Sign Out/ In" log when leaving and returning to the facility. She stated that when she is sitting at the front desk, she can easily visualize the locked lobby sliding front doors. She stated that the doors are the only entrance/ exit for residents and visitors and the front door access is controlled by the front desk staff, who must push a button to allow the doors to open. She stated that a pink book titled, "Escorted Residents" is kept at the front desk which included the names of 14 residents considered safety risks and who are not allowed to leave the building unless they are with facility staff or family members to provide supervision. She stated that Resident #1 and Resident #2 were not on the "Escorted Residents" list on . She stated that on at 12 noon, she was relieved to go on her lunch break by Staff B. Staff A stated that she returned to the front desk at around 1:10 PM. Staff A stated that she did not see Resident #1 or Resident #2 anywhere in the front lobby or at the front desk after she returned from her lunch break or during the afternoon on . She stated that she did not see Resident #1 or Resident #2 exiting the facility at any time on . She stated that she did not document any resident information on the facility "Sign Out/In" log on that day and she believes that Resident #1 left the facility while she was on her lunch break. She stated that Staff B had relieved her in the afternoon for a bathroom break but she could not recall the exact time. She stated that she would assist residents who are unable to sign the "Sign Out/In" log book. She stated that she has documented additional observations in the facility electronic record about the residents but she had not made any documentation in the record regarding Resident #1 on .

In an interview with Staff B on at 2:15 PM she stated that she had relieved Staff A for breaks on . Staff B stated that she had relieved Staff A at 12 Noon until she returned around 1 PM and again during the afternoon for a bathroom break at approximately 2 PM, but she was not sure of the exact time and she observed Resident #1 and Resident #2 standing in front of her discussing going out shopping. She stated that Resident #2 was planning to go to the corner store and Resident #1 wanted to go to Walmart. She stated that she assisted Resident #2 to sign out on the "Sign Out/In" log sheet and she watched him exit through the front doors at 2:30 PM. She stated that Resident #1 had signed himself out on the "Sign Out/ In" log sheet but she did not see him exiting the facility. She stated that she was not aware of any transportation request for either of the two residents. She stated that a pink book titled, "Escorted Residents" is kept at the front desk which included the names of 14 residents considered safety risks and who are not allowed to leave the building unless they are with facility staff or family members to provide supervision. She stated that Resident #1 and Resident #2 were not on the "Escorted Residents" list on .

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In an interview with Resident #2 on at 10:55 AM, he was observed sitting in his wheelchair. He presented to be alert and oriented, and stated that he was independent, wheel chair bound but was able to wheel himself around facility and was free to come and go at any time. He stated that he regularly wheeled himself to the corner store, a few blocks away. He stated the trip takes him at least an hour each way since it is" hard work to go that short distance". When questioned if he had taken any recent trips to Walmart, he stated that the facility provides a scheduled weekly van service with a motorized wheelchair lift and he had a standing reservation for the shopping trip. Resident #2 was asked he if knew Resident #1 and he stated that he did not know that name or any person by that name. Resident #2 stated that he went out to the corner store on in the mid-afternoon, but he couldn't recall the exact time. He stated that he went out alone, no other resident went along with him. Resident #2 stated that he has difficulty signing the facility "Resident Sign Out/ In" log but the front desk staff would normally assist him with signing out and in. Resident #2 stated that on /19, he wheeled himself to the corner store, approximately 0.5 miles from the facility and returned before dinner at around 5 PM, adding "it wasn't dark outside". He stated that he was alone on his trip to the corner store and Resident #1 had not accompanied him there. Resident #2 stated that the front desk receptionist staff had signed him out on that day and in upon his return to the facility. Resident #2 stated that he does not have any responsibility, authority or agreement with the facility to escort or supervise any other residents.

Review of Resident #1's electronic progress note dated on (no time noted) indicated documentation made by the "front desk receptionist", that Resident #1 was at front desk and asking to go to store. Further review of the note indicated that Resident #2 "told him you can go with me". Further review of the note indicated that Resident #2 stated "we're going to the corner store and he wants to go to Walmart". Review of the note indicated that both the residents signed out and left facility. Review of the electronic note indicated no time notation.

Review of the facility "Resident Sign Out/In" log sheet dated on indicated Resident #2's name was printed with "time out" as 2:30 PM and with a destination as "shopping". Further review of the same log sheet indicated Resident #1's name was printed on the log sheet with time out as "2:30 PM". The destination notation was illegible.

Review of the facility's pink "Escorted Residents" book located at the front desk on indicated the names of 14 residents identified by the facility as safety risks along with wording "residents that do not go out alone (ambulatory)". Further review indicated Resident #1's name with the word "(New)" and "has arm " noted at the top of the page. The armband identifies residents that have been deemed by the facility as an elopement risk.

Review of the medical records for the 14 residents (Resident # 4 through # 17) identified in the facility's

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pink book "Escorted Residents" book indicated all 14 residents (Resident # 4 through # 17) were assessed on their current resident health assessment to be independent for ambulation and are identified to require either assistance or supervision with shopping by facility staff or family members. Review of Resident #1's health assessment form indicated that he required assistance with shopping to be provided by family /friends or facility staff but Resident #1's name was not located in the "Escorted Residents" book.

In an interview with Staff C on at 2:52 PM she stated that she was routinely assigned to the front desk from 3 PM until 10 PM. She stated that prior to , Resident #1 was not listed in the facility's pink "Escorted Residents" book to require supervision or assistance when going out of the facility. She stated that on at 5:00 PM, she was at the front desk and observed Resident #2 wheeling himself into the facility. She stated that she inquired where Resident #1 was and Resident #2 responded that he didn't know where Resident #1 was since he had not gone with him. She stated that she didn't consider it any concern that Resident #1 had left facility without family, friends or staff supervision since his name was not noted in the "Escorted Residents" book on . She stated that at around 8:00 PM, she was made aware that Resident #1 had been taken to the hospital by the police. She stated that Resident #1 returned to the facility on at around 11:15 PM accompanied by his family member and the police.

In an interview with the DON on at 1:07 PM, she stated that she had never seen Resident #1 and Resident #2 socializing together in the facility. The DON stated that she was aware Resident #1 had previously left the facility with his family members. She stated that Resident #1 required supervision for outside shopping trips. She stated that Resident #1 had been evaluated at the hospital after sustaining a with injury and he returned to the facility on . She stated that the next day on , she observed on Resident #1's upper , and forehead. She stated that she observed Resident #1 to be more on and after reviewing his hospital lab test results, she notified his physician of the abnormal results and also of her observation of the resident's change in mental status/condition. The DON stated that after the incident with Resident #1, she updated the "Escorted Residents" book to reflect the elopement risk. The DON stated that on , she observed Resident #1 to have more mental , he was unable to answer her questions properly and he was , the facility with no sense of purpose. She stated that she called the physician and was instructed by the physician to transfer Resident#1 to the hospital for evaluation of and abnormal lab tests. She stated that Resident #1 remained in the hospital.

In a phone interview with Resident #1's physician on at 2:10 PM, he stated that he had made his first medical examination for Resident #1 on at the hospital. The physician stated that he routinely completes his personal notes via his electronic medical records system and after reviewing his

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records, he confirmed that he had never encountered Resident #1 prior to the hospital visit. He stated that Resident #1 was very , and he had a history of . The physician stated that after his follow-up examination of Resident #1 in the hospital on , he ordered the resident to be transferred to a nursing home for rehabilitation, including gait training and monitoring for . The physician stated that after his evaluation of Resident #1 on , he would assess the resident to be an elopement risk and risk.

In an interview with Resident #1's daughter on at 12:15PM, she stated that the resident was admitted to the facility in and lived there until . She stated that the resident departed the facility on at an unknown time and he was found several miles away from the facility by bystanders when the resident on the street and injured his on before 3:00PM. She stated that Resident #1 was not accompanied by any family members, staff members or personal friends when he departed the facility on and this was contrary to what she agreed on with the facility staff when the resident was admitted to the facility. She stated that the facility did not present her or discuss with her the resident's health assessment which required a physician's medical examination of the resident upon admission to the facility. She stated that Resident #1 was not capable to maintain his personal wellbeing if he departed the facility without assistance or supervision due to his and physical condition, which included the diagnosis of . She stated that the administrator informed her on at approximately 9:30PM that the police contacted the facility to inform them that Resident #1 was in the hospital because he departed the facility and injured himself while he was outside of the facility. She stated that when she arrived to the facility on at approximately 10:00 PM to seek more information regarding Resident #1's departure from the facility, police personnel were onsite at the facility and the police officer informed her that the resident was sent to the local hospital after bystanders found that the resident injured his due to a . She stated that the police officer also told her that the police informed the facility that Resident #1 was in hospital on at approximately 9:00PM. She stated that she went to the hospital with the police officer on at approximately 10:30PM and the resident was discharged from the hospital when she arrived there. She stated that she transported Resident #1 to the facility on so he could rest. She stated that she received a telephone call from the facility DON on to inform her that Resident #1's laboratory values "were off" and that he was discharged from the facility to another hospital per physician's order. She stated that Resident #1's condition after he was hospitalized on declined because he was considerably more unstable with his ambulation and was more as well. She stated that this was the reason why the physician ordered the resident to be admitted to a nursing home after the second hospitalization on .

Class I

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0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i)

Based on observation, interview and record review, the facility failed to develop detailed written policies and procedures for identifying and responding to resident elopements. As a result of this facility failure, 1 out of 16 sampled residents (Resident #1) eloped from the facility and sustained injuries that required hospitalization. Additionally, 14 of 16 (Resident # 4 through # 17) sampled residents that are identified as requiring increased supervision while out of the facility remain at risk due to 7 of 36 (DON, Activities Director, Staff B, Staff D, Staff E Staff F & Staff G) sampled facility staff inability to demonstrate competency related to the facility elopement policy and procedures.

The findings are:

Interview with the Administrator on at 10:45 AM, she stated that Resident #1 signed out to depart the facility on at around 2:30 PM and then got lost while outside of the facility. She stated that the resident ended up going to the hospital that day and that she believed that Resident #1 was allowed to leave the facility with Resident #2.

In an interview with Resident #2 on at 10:55 AM, he stated that that he did not know Resident #1 by name or by personal identification. Resident #2 stated he went out alone; no other resident went along with him.

In an interview with the Administrator on at 11:15 AM, she stated that she was informed of Resident #1 being in the hospital from the facility staff, after the police notified the facility that Resident#1 had been taken to the hospital on .
In an interview with the Administrator on at 11:45 AM, she stated that the facility concluded its investigation relating to Resident #1 leaving the facility on . She stated that she was aware that Resident #1 needed assistance to go shopping as identified in his health assessment and she believed that Resident #2 was Resident #1's friend. She stated that she was not aware if the police developed a report when the resident was found outside of the Walmart and transported to the hospital due to his injuries on .

Review of Resident #1's health assessment dated on indicated that the resident was diagnosed with and memory loss. Review of this health assessment indicated that the resident needed assistance with his daily tasks that included shopping, personal and financial affairs. Review of this health assessment indicated that the resident needed to receive assistance from family members, staff members and/or friends to go shopping. Review of this health assessment indicated that the resident needed daily observation of his wellbeing and his whereabouts. Further

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review of this health assessment indicated that the Administrator signed this document on 11-16-18 to represent the resident's daily care needs.

In an interview with Staff B on at 11:00 AM, she stated that her duties included providing direct care to the residents and her shift was usually from Monday to Friday, 9 AM to 5 PM. She stated that if the facility declared a resident elopement, she would immediately begin searching everywhere around the facility. She stated that she did not know of any time limitations for this search and that she would wait to receive further instructions from the Director of Nursing (DON.) She did not elaborate further on her required duties and procedures during a resident elopement event. She stated that she was present on at around 2:30 PM, and this was when Resident #1 signed out of the facility. She stated that she was not aware if Resident #1 was listed in the "elopement book" on , to which she referred to by pointing to a pink-colored book located on the reception desk. In an observation at this time, this pink-colored book was titled "escorted residents".

Review of the facility REPP dated on revealed that the policy did not indicate that the facility kept a book to document residents who were at risk for elopement or needed staff supervision or assistance when leaving the facility.
In an interview with the Administrator on at 11:05 AM, she stated that the "escorted residents" book was used as a guide for the staff in the event of a resident elopement. She stated that the staff was required to review this book to determine whether a resident was an elopement risk or was not able to go outside of the facility alone.

In an interview with Staff B on at 2:15 PM, she stated that she saw Residents #1 and #2 in the front lobby on at around 2:30 PM. Staff B stated she overheard that Resident #2 was planning to go to the corner store, which was approximately mile from the facility, and Resident #1 was planning to go to Walmart, which was approximately 3.6 miles from the facility. She stated that she only saw Resident #2 exit through the front doors at around 2:30 PM that day.

In an interview with the DON on at 1:07 PM, she stated that she had never seen Resident #1 and Resident #2 socializing together in the facility. She stated that Resident #1 required supervision for outside shopping trips. She stated that Resident #1 had been evaluated at the hospital after sustaining a with injury after he eloped form the facility. Resident #1 returned to the facility on . She stated that the next day on , she observed on Resident #1's upper , and forehead. She stated that she observed Resident #1 to be more on and after reviewing his hospital lab test results, she notified his physician of the abnormal results and of her observation of the resident's change in mental status/condition. The DON stated that on , she observed Resident #1 to have more mental , he was unable to answer her questions properly and he was

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the facility with no sense of purpose. She stated she called the physician and was instructed to transfer Resident#1 to the hospital for evaluation for and abnormal lab tests.

Review of the Agency 1-Day Adverse Incident report submitted by the facility on at 4:32 PM indicated an elopement incident involving Resident #1 that occurred on at 8:07 PM. According to the facility's report, Resident #1 left the facility to go to the store with another resident, Resident #2 around 3 PM on . The report indicated that at 8 PM, the police notified the facility that Resident #1 had been transported to the hospital for evaluation after sustaining a . The report indicated that Resident#1 returned to the facility with his family member at approximately 11:15 PM on .

In an interview with the Police Officer on at 6:20 PM, he stated that Resident #1 was found by himself by emergency medical services on at around 3:00 PM. He stated that the resident was nearby the Walmart in East Boynton Beach, the resident presented to be and had to his . He stated that the resident did not have any identification to represent that he lived in the facility. The police determined that he lived in this facility and notified the facility on at around 8:30 PM that the resident was found and taken to hospital.

In an interview with Resident #1's daughter on at 12:15 PM, she stated that the resident was admitted to the facility in and lived there until . She stated that the resident departed the facility on at an unknown time and he was found several miles away from the facility by bystanders when the resident on the street and injured his on before 3:00 PM. She stated that Resident #1 was not accompanied by any family members, staff members or personal friends when he departed the facility on and this was contrary to what she agreed on with the facility staff when the resident was admitted to the facility. She stated that Resident #1 was not capable to maintain his personal wellbeing if he departed the facility without assistance or supervision due to his and physical condition, which included the diagnosis of . She stated that the Administrator informed her on at approximately 9:30 PM that the police contacted the facility to inform them that Resident #1 was in the hospital because he departed the facility and injured himself while he was outside of the facility.

In an observation during this inspection from to , the facility lobby reception area had unobstructed view of the facility's electronically operated front door. This front door had sliding action dual glass doors, which allowed observation of the parking lot area of the facility. (Photograph obtained)

Review of the facility resident elopement policy and procedures (REPP) dated on included the following:

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a. Resident will sign out when leaving the facility and sign in upon return to the facility in the sign out/in log.
b. This log will include the resident's name, date and reason for temporary absence.
c. Should a resident not sign out in the facility's sign out/in log, recording their name, date and reason for temporary absence and not communicate with staff regarding his/her temporary absence, it's understood that the resident left the facility without following the REPP.
d. Elopement is when a resident leaves the facility without following the REPP and the point in which the resident's general whereabouts are unknown to the facility staff.
e. Any staff member who is unable to locate a resident after checking the temporary absence log to verify the general whereabouts of the resident, must immediately notify the Administrator.
f. Each staff member is assigned a specific area to search, including storage areas, closets, stairs and parked cars.
g. Preliminary search efforts should last longer than an hour.
h. The Administrator or designee will notify the police.

Further review of this REPP indicated that the facility did not identify with detail each staff member's responsibilities during an elopement. The REPP lacked directions to maintain the continued care of all the residents in the facility during an elopement and did not accurately document its resident elopement drills. The REPP did not direct the facility staff to use or review the "escorted residents" book as indicated in a previous interview with the Administrator. (Copy obtained)

A review of the facility Elopement Drill Report training dated on revealed that 4 of 35 (DON, Activities Director, Staff D and Staff E) facility staff attended the elopement drill training. On , 7 of 35 (DON, Activities Director, Staff B, Staff D, Staff F, Staff G & Staff I) facility staff attended the elopement drill training. Each Elopement Drill Report training document revealed that the Administrator was the person in charge of the drill and signed by the Administrator to represent the completion.

In an interview with Staff D on at 11:15 AM, she stated that she worked in the facility for approximately 2 years, her duties included providing direct care to the residents and her shift was usually from 7am to 3 PM. She stated that she did not know what a resident elopement was and she did not know the procedures to respond to a resident elopement.

In an interview with Staff G on at 10:05 AM, she stated that she worked in the facility for about 2 months and her duties included providing direct care to the residents. She stated that if the facility declared a resident elopement, she would immediately call 911 to inform the police the identity of the missing resident. She stated that she would then expect to meet with all the staff members present to receive orders from her supervisor. She did not elaborate further on her required duties and procedures

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during a resident elopement event and she was not aware of the REPP.

In an interview with the DON on at 10:20 AM, she stated that she worked in the facility for about 5 months and her duties included providing direct care to the residents with nursing supervision. She stated that if the facility declared a resident elopement, she would immediately call the Administrator and then call 911 to inform the police the identity of the missing resident. She stated that she would then send a couple staff members to search the streets around the facility and then call the resident 's family member to inform them of the missing resident. She stated that she would continue her work until the two staff members came to the facility from their search and report their findings. She did not elaborate further on the time limitations for the search, the locations to search for the resident within the facility and her required duties during a resident elopement event.

In an interview with Staff F on at 10:50 AM, she stated that she worked in the facility for a total of 4 years and her duties included providing direct care to the residents. She stated that if the facility declared a resident elopement, she would immediately check the computer to determine the resident's status and then begin searching for the resident all throughout the facility. She stated that she would then report this to her supervisor, the DON, and wait for directions from the DON. She did not elaborate on the time limitations of the search and any further on her required duties and was not aware of the facility REPP.

In an interview with the Administrator on at 11:25 AM, she stated that the staff member stationed in the reception was responsible to ensure that any resident leaving/returning to the facility would sign out and in on the log. She stated that the receptionist would sign out and in for the resident shall the resident forget to or not do this.

In an interview with Staff E on at 11:40 AM, she stated that she worked in the facility for approximately 1 year and her duties included providing direct care to the residents. She stated that if the facility declared a resident elopement, she would immediately begin searching for the resident and then call 911 to report that a resident had eloped. She stated that she would keep searching for the resident and she did not know of any time limitations for this search. She stated that she would review the "elopement book" in the reception area and would use her walkie-talkie to communicate with her supervisor, the DON. She did not elaborate further on her required duties during a resident elopement event and she was not aware of the facility REPP. In an interview with Staff H on 4:00 PM she stated that Resident #1 did not receive his routine medications on at 5:00 PM because the resident was not in the facility. She stated she reviewed the sign out/in log and the "escorted residents" book to determine if the resident was identified to need supervision while out of the facility and the resident was not identified to need supervision.

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	AL11968596	02/08/2019
NAME OF PROVIDER OR SUPPLIER **COLONIAL ASSISTED LIVING AT BOYNTON BEACH FL**	STREET ADDRESS, CITY, STATE, ZIP CODE **1708 NE 4TH STREET BOYNTON BEACH, FL 33435**	

SUMMARY STATEMENT OF DEFICIENCIES
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In an interview with the Activities Director on at 12:25 PM, she stated that she worked in the facility for over 2 years and her duties included providing direct care to the residents. She stated that if the facility declared a resident elopement, she would immediately review the resident sign out/in log to see where the identified resident went to and the begin searching for the resident in the facility. She stated that she would then report to the Administrator and expand the search if needed. She stated that if the resident was not found, she would call the hospital and the police to determine if the resident was found then "call around" and continue to look in the facility for the missing resident. She did not elaborate further on the time limitations for the resident's search and her required duties during a resident elopement event.

In an interview with the Consultant on at 2:20 PM, she stated that she was principally responsible to update the facility resident elopement policy and procedures on . She stated that she provided the updated resident elopement policy and procedures to the Administrator on or about and that she expected that the Administrator train or update the staff members with any changes in this policy and procedures as the Administrator felt appropriate.

In an interview with the Administrator on at 2:30 PM, she stated that the facility revised the resident elopement policy and procedures on because the previous REPP, dated on , had typographical errors. She stated that she did not know what the previous typographical errors in this document were. She stated that the resident elopement policy and procedures dated on was the current document the facility used to reduce and/or eliminate risk exposure to missing residents and to respond to any resident elopement. She stated that she felt that the facility staff did not need to be trained with the current REPP because it only contained typographical corrections from the previous one.

Class I

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on observation, record review and interview, the facility altered 1 out of 16 sampled resident (resident #1's record) medical records and its facility resident elopement drills documentation. The facility failure to ensure that Resident #1 received a to medical examination to determination the appropriate admission to an assisted living facility placed the resident at direct risk of harm.

The findings are:

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Review of the facility resident elopement policy and procedures (REPP) dated on indicated that the facility shall conduct a minimum of two (2) resident elopement prevention and response drills per year in order to reduce/eliminate the risk exposure to missing residents in order to protect the safety and well-being of the residents subsequently to resident elopements. Review of this REPP indicated that the elopement drills shall be conducted with total involvement of the administrator and direct care staff and shall be documented on a prescribed form after the drill is completed.

In an observation on at approximately 10:30 AM, the administrator provided a copy of its two (2) most recent resident elopement drills dated on and . Review of these resident elopement drill forms at this time indicated that each form was comprised of two (2) pages each, which included the titled page "elopement drill report" and a staff participation page.

On at 10:30 AM Review of the facility elopement drill report dated and revealed that Staff D and the DON participated in these elopement drills on both dates. The record revealed that Staff E participated on and also indicated that Staff G and Staff F participated in the elopement drill held on . The record indicated that the person in charge of these drills was the administrator and were signed by the administrator to represent their accuracy and completeness.

In an interview with Staff D on at 11:15 AM, she stated that she worked in the facility for approximately 2 years, her duties included providing direct care to the residents and her shift was usually from 7 AM to 3 PM. She stated that she did not participate in an elopement drill or training session at the facility on or .
In an interview with staff G on at 10:05 AM, she stated that she worked in the facility for about 2 months and her duties included providing direct care to the residents. She stated that she did not receive any elopement training or drill in the facility since she started to work there.

In an interview with the DON on at 10:20 AM, she stated that she worked in the facility for about 5 months and her duties included providing direct care to the residents with nursing supervision. She stated that she received at least one elopement drill or training since she started to work in the facility. She stated that she remembered that one elopement drill and training she participated in was on .

In an interview with the Consultant on at 10:25 AM, she stated that the DON participated in an elopement drill on . In an interview with the DON at this time, she stated that the consultant was correct and that she participated in a second elopement drill on .

Review of the facility elopement drill report on at 10:30 AM, this document was dated on

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and it represented that the DON participated in this elopement drill.

In an interview with staff F on at 10:50 AM, she stated that she worked in the facility for a total of 4 years and her duties included providing direct care to the residents. She stated that she last received elopement training or drill in the facility about 2 months ago, before the 2018 Christmas holiday. She stated that she did not participate in any elopement training or drill last week, including or .

In an interview with Staff E on at 11:40 AM, she stated that she worked in the facility for approximately 1 year and her duties included providing direct care to the residents. In an interview with staff E on at 12:10 PM, she stated that she last received elopement training or drill in the facility about 3 to 6 months ago and that she did not participate in any elopement training or drill last week, including or .

In an interview with the Activities Director on at 12:25 PM, she stated that she worked in the facility for over 2 years and her duties included providing direct care to the residents. She stated that she remembered participating in one elopement training or drill after , but could not remember if it was on or . She stated that she actually remembered that she participated in an elopement drill on which took place before lunch at 12:00 PM and it involved about 12 or 13 staff members.

Review of the facility elopement drill report on at 12:30 PM, this document was dated on and it took place from 1:00 PM to 1:15 PM. Further review of this document indicated that a total of 7 staff members participated in this elopement drill. Review of the facility elopement drill report dated on it represented that the Activities Director participated in this elopement drill.

Review of the facility elopement drill reports submitted to the Agency's field office on indicated that the first page of elopement drill report dated on represented that 7 staff members participated and the second page of this report it represented that 14 staff members participated in this same drill.

Review of the facility elopement drill reports submitted to the Agency's field office on indicated that the facility conducted in-service training sessions on and .

Further review of the facility elopement drill reports submitted to the Agency's field office on indicated that the facility conducted elopement response tests to 12 staff members on .

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In an interview with the Administrator on at 11:45 AM, she stated that the facility concluded its investigation relating to Resident #1 leaving the facility on . She stated that she was aware that Resident #1 needed assistance to go shopping as identified in his health assessment.

Review of Resident #1's health assessment dated on indicated that the resident was diagnosed with and memory loss. Review of this health assessment indicated that the resident needed assistance with his daily tasks that included shopping, personal and financial affairs. Review of this health assessment indicated that the resident needed to receive assistance from family members, staff members and/or friends to go shopping. Review of this health assessment indicated that the resident needed daily observation of his wellbeing and his whereabouts. Further review of this health assessment represented that resident's physician and the administrator signed this document on . Review of this health assessment indicated that the resident or the resident's representative did not sign this document to represent the care and services by the facility were made known to the resident or the resident's representative.

In an interview with Resident #1's physician on at 12:55 PM, he stated that he did not sign the resident health assessment dated on because he was certain that he did not perform a medical examination on the resident until . He stated that he did not have any record of having examined Resident #1 in the facility and he first met the resident on when the resident was in the hospital.

In an interview with Resident #1's daughter on at 12:15 PM, she stated that the resident was admitted to the facility in and lived there until . She stated that the resident departed the facility on at an unknown time and he was found several miles away from the facility by bystanders when the resident on the street and injured his on before 3:00 PM. She stated that Resident #1 was not accompanied by any family members, staff members or personal friends when he departed the facility on and this was contrary to what she agreed on with the facility staff when the resident was admitted to the facility. She stated that the facility did not share with her the results of any health assessment from a medical examination of Resident #1. She stated that Resident #1 was not capable to maintain his personal wellbeing if he departed the facility without assistance or supervision due to his and physical condition, which included the diagnosis of . She stated that the administrator informed her on at approximately 9:30 PM that the police contacted the facility to inform them that Resident #1 was in the hospital because he departed the facility and injured himself while he was outside of the facility.

Class II