Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351383064M
Compliance #: HL351384984C

Date Concluded: July 20, 2023

Name, Address, and County of Licensee Investigated:
Premier Home Care LLC
7120 13th Avenue South
Richfield, MN, 55423
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when staff failed to provide supervision when the resident left the facility unsupervised and went missing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident left the facility and told staff he was not coming back. Staff failed to search for the resident and did not file a missing person report with law enforcement until 37 hours after the resident left the facility. The resident had a history of drug abuse, unsafe behaviors, and had been assessed to have no more than 30 minutes in the community unsupervised by staff. Bystanders found the resident under a bridge unconscious and gave the resident Narcan (medication used for the emergency treatment of known or suspected opioid overdose.) The resident required emergency transfer to a hospital for altered mental status and drug intoxication.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the resident's guardian. The investigator contacted law enforcement and reviewed the law enforcement report. The investigation included review of the resident's record, assessments, emergency room records, and policy and procedures related to missing person and maltreatment. Also, the investigator observed the facility and staff interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder. The resident's service plan included assistance with medication administration, meal preparation, housekeeping, laundry, reminders for bathing and grooming. The resident was independent with dressing, toileting, transferring, and walking. The resident was alert, oriented, with a history of poor decisions.

The resident's abuse prevention plan indicated the resident had been assessed to have no more than 30 minutes a day in the community unsupervised by staff due to a history of illegal drug use and frequent drug seeking behaviors. In addition, the resident exhibited verbal aggression to others with a history of "badgering" when angry or upset.

Progress notes indicated late one afternoon the resident returned to the facility from work, ate dinner, smoked a cigarette, and sat in the garage. The resident came back inside and watched television for a couple hours. The resident went back outside to smoke, came inside, took his evening medications, and went to his room. An hour later, the resident left his room and sat on the couch. The resident told staff he did not want to be at the facility anymore, he felt trapped, he was leaving, and not coming back. The resident left the facility at 9:00 p.m.

The resident's incident report indicated staff told the resident not to leave but the resident ran out the door. Staff ran after the resident but could not keep running and attempted to call the resident's cell phone. The phone was shut off. Staff called the facility management and received instructions to leave the door to the facility unlocked in case the resident returned and to continue to call the resident's cell phone. The incident report indicated the facility called a non-emergency hotline to report a missing person.

Emergency room records indicated the following mid-morning after leaving the facility, the resident was found unconscious under a bridge by bystanders and received Narcan (medication used for the emergency treatment of known or suspected opioid overdose.) The resident was admitted to a hospital for drug intoxication (methamphetamine) and rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury.), and left buttock pain. The resident received hospital treatment for two days and discharged back to the facility.

Review of the law enforcement report indicated the facility first contacted law enforcement about the resident missing approximately 37 hours after the resident left the facility. Law enforcement responded to the facility to take a written report of the incident. Facility staff reported the resident's diagnoses included schizophrenia with a history of alcohol and drug

abuse. The resident was a vulnerable adult. The report indicated after the facility contacted the resident's family about the resident missing, the family requested the facility file a missing person report. No report was provided by law enforcement regarding a call to a non-emergency phone by the facility the evening the resident eloped.

During an interview, management stated the resident required staff supervision and could not be alone in the community for more than 30 minutes. When the resident did not return by 10:00 p.m. that evening, management notified the resident's guardian and called a non-emergency hotline. Management stated they reported to the hotline the resident ran away, had not returned, and was missing. Management could not provide documentation of the call, the phone number contacted, or the individual they reported the resident as missing.

During an interview, the resident's guardian stated at times the resident did not make good decisions. The guardian stated the resident was able to leave the facility unsupervised for 30 minutes because of his drug use. Facility staff needed to keep track of the resident's coming and going.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, attempted but did not reach.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility notified the resident's guardian the resident was missing and notified law enforcement 37 hours after the resident left.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Richfield City Attorney
Richfield Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35138	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL351384984C/#HL351383064M On June 12, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL351384984C/#HL351383064M, tag identification 0620, 0680, 2360, 3000.	0 000		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and	0 620		

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0 620	Continued From page 1 implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a vulnerable adult policy and procedure to include immediately reporting suspected maltreatment and failed to comply with the requirements for immediately reporting suspected maltreatment of vulnerable adults to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who eloped from facility, was found unconscious under a bridge, and required treatment and hospitalization. This practice had the potential to affect all of the residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record indicated R1's diagnoses included bipolar disorder. R1's assessment dated May 25, 2022, indicated R1 was alert, oriented, and due to R1's mental heath diagnoses, made poor decisions. R1's individual abuse prevention assessment and plan dated May 25, 2022, indicated R1 had no history of intentionally leaving the facility or	0 620		

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0 620	Continued From page 2 wandering away. R1 was allowed 30 minutes unsupervised time in the community a day. R1's signed service plan dated May 25, 2022, indicated R1's services included mental health management, managing wandering, anxiety, agitation, verbal aggression, and self-injurious behaviors (drug seeking). R1's care plan dated May 27, 2022, indicated R1's services included assistance with medication management, meal preparation, housekeeping, laundry, and reminders for bathing and grooming. R1's progress notes dated September 17, 2022, indicated R1 returned to the licensee residence from work at 5:00 p.m., ate dinner, smoked a cigarette, and sat in the garage. R1 came back inside and watched television for a couple hours. R1 went back outside to smoke, came inside, took his 8:00 p.m. medications, then went to his room. An hour later, R1 left his room and sat on the couch. R1 told staff he did not want to be at the facility anymore, he felt trapped, was leaving, and not coming back. R1 left the licensee's residence at 9:00 p.m. An incident report dated September 17, 2022, indicated R1 left the facility at 9:00 p.m. and told staff he was leaving and not coming back. R1 told staff he felt trapped, depressed, and said he did not want to live at the facility anymore. Staff told R1 it was not a good idea to leave. R1 ran out the door. Staff ran after him but could not keeping running. Staff called R1's cell phone. The phone was shut off. Staff called the licensed assisted living director (LALD)-A to inform her R1 left the facility. LALD-A told staff to keep doors to the licensee's residence unlocked for R1 if he	0 620		

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0 620	Continued From page 3 returned to the residence and to continue to call R1's cell phone. The incident report did not indicate the licensee reported R1's elopement to MAARC. R1's emergency room records dated September 18, 2022, at 10:53 a.m., indicated R1 was found unresponsive under a bridge by bystanders and received Narcan (medication used for the emergency treatment of known or suspected opioid overdose.) R1 admitted to the hospital for substance intoxication (methamphetamine) and rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury.) R1 received hospital treatment for two days and discharged back to the licensee. During an interview on June 26, 2023, at 10:59 a.m., the LALD-A stated R1 eloped from the facility on September 17, 2022. When R1 did not return by 10:00 p.m.that evening, she notified R1's guardian and called a non-emergency hotline to report R1 as a missing person. On September 18, 2022, the licensee did not know R1's whereabouts. The LALD-A stated on September 19, 2022, R1's guardian informed her that R1 was in the hospital. On September 20, 2022, R1 discharged from the hospital back to the facility. The LALD-A stated the licensee did not report R1's elopement to MAARC. The licensee's policy titled Vulnerable Adult/Child Protection dated May 26, 2020, indicated the licensee employees are mandated to report suspected maltreatment of a vulnerable adult to MAARC. The policy failed to address the timeframe for reporting suspected maltreatment of a resident. No further information was provided.	0 620		

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0 620	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
0 680 SS=I	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a missing resident policy and procedure identifying a plan with required components under Minnesota Rules,	0 680		

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0 680	Continued From page 5 Part 4659.0110, and failed to implement a missing resident plan including notifying law enforcement immediately when one of one resident (R1) eloped and was missing from the licensee's residence, later found under a bridge unconscious, and required treatment and hospitalization. The failure had the potential to affect all the residents living at the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's medical record indicated R1's diagnoses included bipolar disorder. R1's assessment dated May 25, 2022, indicated R1 was alert, oriented, and made poor decisions . R1's individual abuse prevention assessment and plan dated May 25, 2022, indicated R 1 did not intentionally leave the facility or wander away. R1 was allowed alone time without supervision in the community for 30 minutes a day. R1's signed service plan dated May 25, 2022, indicated R1's services included mental health management, managing wandering, anxiety, agitation, verbal aggression, and self-injurious behaviors (drug seeking). R1's care plan dated May 27, 2022, indicated	0 680		

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0 680	Continued From page 6 R1's services included assistance with medication management, meal preparation, housekeeping, laundry, reminders for bathing and grooming. A progress note dated September 17, 2022, indicated R1 returned to the licensee's residence from work at 5:00 p.m., ate dinner, smoked a cigarette, and sat in the garage. R1 came back inside and watched television for a couple hours. R1 went back outside to smoke, came inside, took his 8:00 p.m. medications, then went to his room. An hour later, R1 left his room and sat on the couch. R1 told staff he did not want to be at the facility anymore, he felt trapped, was leaving, and not coming back. R1 left the residence at 9:00 p.m. An incident report dated September 17, 2022, indicated R1 left the residence at 9:00 p.m. and told staff he was leaving and not coming back. R1 told staff he felt trapped, depressed, and did not want to live at the facility anymore. Staff told R1 it was not a good idea to leave. R1 ran out the door. Staff ran after him but could not keeping running. Staff called R1's cell phone. The phone was shut off. Staff called the licensed assisted living director (LALD)-A to inform her R1 left the facility. The LALD-A told staff to keep doors to the residence unlocked in case R1 returned and to continue calling R1's cell phone. The incident report indicated staff contacted a non-emergency hotline to report R1 was missing a person. R1's incident report did not include evidence the licensee conducted an immediate and thorough search of the facility's premises, immediate search of the neighborhood in each direction, date and time the licensee notified a non-emergency hotline, or immediate contact with law enforcement.	0 680		

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0 680	Continued From page 7 R1's emergency room records dated September 18, 2022, at 10:53 a.m., indicated R1 was found unresponsive under a bridge by bystanders and received Narcan (medication used for the emergency treatment of known or suspected opioid overdose.) R1 admitted to the hospital for substance intoxication (methamphetamine) and rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury.) R1 received hospital treatment for two days and discharged back to the licensee. During an interview on June 26, 2023, at 9:12 a.m., R1's guardian (GD-C), stated at times R1 did not make good decisions. R1 was able to leave the facility unsupervised for only 30 minutes a day because there was a risk of R1 drug seeking when not doing well with his mental health.. The licensee staff needed to keep track of R1's coming and going. During an interview on June 26, 2023, at 10:59 a.m., the LALD-A stated R1 required staff supervision and could not be alone in the community for more than 30 minutes. R1 eloped from the residence on September 17, 2022. When R1 did not return by 10:00 p.m.the same night, LALD-A notified R1's guardian and called a non-emergency hotline to report a missing person. LALD-A stated she had no record of the call to the non-emergency hotline. After those calls, the licensee waited for R1 to return. On September 18, 2022, the licensee did not know R1's whereabouts. The LALD-A stated she called R1's family and they said they had not heard from R1. On September 19, 2022, the LALD-A stated R1's guardian called to report R1's hospitalization. On September 20, 2022, R1 discharged from the hospital back to the facility.	0 680		

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0 680	Continued From page 8 The LALD-A stated if a resident ran away they could not stop them. During an interview on June 26, 2023, at 3:14 p.m., registered nurse (RN)-B stated R1 could not be alone in the community for more than 30 minutes. Review of the law enforcement report indicated law enforcement received a missing person report from the licensee on September 19, 2022, at 10:47 a.m. (a day and one-half following R1 missing) and went to the residence. Staff stated R1 left the facility on September 17, 2022, at approximately 9:45 p.m., and had not returned. R1 typically left the residence for a walk but did not take more than 30 minutes. The licensee notified R1's family and R1's family requested the licensee contact law enforcement to report R1 as a missing person. The same report indicated on October 31, 2022, law enforcement returned to the licensee to check whether R1 had returned. Staff stated R1 was at work but had returned to the licensee approximately four weeks earlier and staff forgot to tell law enforcement he was no longer missing. Law enforcement requested staff bring R1 to the police station on R1's way home from work to confirm R1 was okay. Staff did not bring R1 by the police station. On November 1, 2022, law enforcement went to the licensee and confirmed R1 had returned to the licensee. Minnesota Rules, Part 4659.0110. Subp.2 indicated a facility must develop and follow a missing resident plan that includes at least the following: -identify a staff member for each shift who was responsible for implementing the missing resident plan, and ensure at least one staff member who was responsible for implementing the	0 680		

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0 680	Continued From page 9 missing-resident plan was on site 24 hours a day, seven days a week -require that staff alert the staff member identified immediately if it was suspected that a resident may be missing; -identify staff by position description who were responsible for searching for missing residents or suspected missing residents; -require that staff conduct an immediate and thorough search of the facility, the facility's premises, and the immediate neighborhood in each direction when a resident was suspected to be missing; -require that a suspected missing resident be considered missing if the resident was not located after staff completed the search -require that staff immediately notify local law enforcement when a facility determines that a resident was missing; -require that staff cooperate with local law enforcement and provide any information that was necessary to identify and locate the missing resident. -When a resident was missing or was suspected missing, a facility's implementation of a missing resident plan does not relieve the facility of its obligation to provide assisted living services and appropriate care to all residents in the facility according to each resident's service plan, assisted living contract, and the requirements of this chapter and Minnesota Statutes, chapter 144G. The licensee's policy titled Missing Resident, dated May 26, 2020, indicated any resident noted absent from the facility without prior arrangement would be treated as missing. Leadership would determine when a resident was missing after a search and take into account the residents daily routine and usual behavior. If the resident was	0 680		

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0 680	Continued From page 10 not found, leadership would notify the police and details of the call would be recorded. The policy indicated once the resident was located all persons involved in the search would be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 680		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. The findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35138	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

(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
03000	Continued From page 11 common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The	03000		

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03000	Continued From page 12 lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one residents (R1) who eloped from facility, was found under a bridge unconscious, and hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include R1's medical record indicated R1's diagnoses included bipolar disorder. R1's assessment dated May 25, 2022, indicated R1 was alert, oriented, and made poor decisions. R1's individual abuse prevention assessment and plan dated May 25, 2022, indicated R 1 did not intentionally leave the facility or wander away. R1 was allowed alone time without supervision in the community for 30 minutes a day. R1's signed service plan dated May 25, 2022, indicated R1 services including mental health management, managing wandering, anxiety,	03000		

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03000	Continued From page 13 agitation, verbal aggression, and self-injurious behaviors (drug seeking). R1's care plan dated May 27, 2022, indicated R1's services included assistance with medication management, meal preparation, housekeeping, laundry, reminders for bathing and grooming. A progress note dated September 17, 2022, indicated R1 returned to the licensee's residence from work at 5:00 p.m., ate dinner, smoked a cigarette, and sat in the garage. R1 came back inside and watched television for a couple hours. R1 went back outside to smoke, came inside, took his 8:00 p.m. medications then went to his room. An hour later, R1 left his room and sat on the couch. R1 told staff he did not want to be at the facility anymore, he felt trapped, he was leaving, and not coming back. R1 left the facility at 9:00 p.m. An incident report dated September 17, 2022, indicated R1 left the facility at 9:00 p.m. and told staff he was leaving and not coming back. R1 told staff he felt trapped, depressed, and said he did not want to live at the facility anymore. Staff told R1 it was not a good idea to leave. R1 ran out the door. Staff ran after him but could not keeping running. Staff called R1's cell phone. The phone was shut off. Staff called the licensed assisted living director (LALD)-A to inform her R1 left the facility. The LALD-A told staff to keep the doors to the residence unlocked for R1 if he returned and to continue to call R1's cell phone. The incident report indicated staff called a non-emergency hotline to report R1 was missing. The report did not indicate the licensee reported R1's elopement to MAARC.	03000		

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03000	Continued From page 14 R1's emergency room records dated September 18, 2022, at 10:53 a.m., indicated R1 was found unresponsive under a bridge by bystanders and received Narcan (medication used for the emergency treatment of known or suspected opioid overdose.) R1 admitted to the hospital for substance intoxication and rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury.) R1 received hospital treatment for two days and discharged back to the facility. During an interview on June 26, 2023, at 10:59 a.m., the LALD-A stated R1 eloped from the facility on September 17, 2022. When R1 did not return by 10:00 p.m. that evening, she notified R1's guardian and called a non-emergency hotline to report R1 as a missing person. On September 18, 2022, the licensee did not know R1's whereabouts and spoke with R1's guardian. The LALD-A stated on September 19, 2022, R1's guardian contacted her that R1 was found at a hospital. On September 20, 2022, R1 discharged from the hospital back to the facility. The LALD-A stated the licensee did not report R1's elopement to MAARC. The licensee's policy titled Vulnerable Adult/Child Protection dated May 26, 2020, indicated the licensee's employees are mandated to report suspected maltreatment of a vulnerable adult to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	03000		