

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Glendora Grand, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 805 W. Arrow Hwy. Glendora, CA 91740	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision to prevent elopement (when an individual leaves the healthcare facility unsupervised and/or undetected) for one of five sampled residents (Resident 1) who was assessed as at risk for elopement as indicated in the facility's policy and procedure titled, Elopements and Wandering Residents, by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Janitor 1 ([DATE]) did not unlock the door of the facility's secured unit (any area in the facility designed and operated to ensure that all its entrances and exits are locked to prevent residents from leaving the facility without permission and/or supervision) to allow Resident 1 to leave the facility without a staff chaperone (a person who goes with and looks after another person or group of people) or helper. 2. Ensure a staff chaperone or helper was present to accompany Resident 1 before allowing Resident 1 to leave the facility with the rideshare (a car service that allows a person to use a smartphone application to arrange a ride in a privately owned vehicle usually driven by its owner) driver to go to Resident 1's ophthalmologist's (a medical doctor who specializes in treating and caring for the eyes) appointment scheduled on 8/13/24 at 8 am. <p>As a result, on 8/13/24 at 7:07 am, Resident 1 left the facility unsupervised to go to Resident 1's ophthalmologist appointment scheduled on 8/13/24 at 8 am. Resident 1 did not check in at the ophthalmologist's office for Resident 1's scheduled appointment. The facility staff were unable to locate Resident 1 and the facility filed a missing person report with the local police department on 8/13/24 at 11:17 am. As of 8/16/24 at 11 am, Resident 1 had not been found. This failure had the potential to put Resident 1 at risk for serious injury, harm, and/or death due to not receiving diabetic medication (medication used to treat diabetes mellitus [disease that results in too much sugar in the blood due to the body's inability to process carbohydrates [one of the basic food groups]], psychotropic medication (medication that affects behavior, mood, thoughts, or perception), not having food and shelter, and being exposed to hot weather.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056079
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/15/24 at 5:15 pm, while onsite at the facility, the surveyor identified an Immediate Jeopardy situation (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) due to Resident 1 left the facility's secured unit without a staff chaperone. The surveyor called an IJ in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to monitor and supervise Resident 1, under 42 Code of Federal Regulations Section 483.25(d) Accidents, including providing adequate (acceptable in quality or quantity) supervision to prevent accidents to Resident 1 who was at risk for elopement and had a history of attempting to leave the facility.</p> <p>On 8/16/24 at 9:17 am, the facility submitted an acceptable IJ Removal Plan (IJRP, a list of steps taken to correct the deficient practices). While onsite at the facility, the surveyor verified the facility provided in-service training to [DATE] and all staff regarding safety to ensure staff (all staff) did not unlock the secured unit's door for any reason without the approval of the charge nurse (Licensed Vocational Nurse) or the supervisor (Registered Nurse) and confirmed the implementations of the IJRP through observation, interview, and record review. The surveyor determined an IJ situation was no longer present and removed the IJ on 8/16/24 at 9:50 am, in the presence of the ADM and the DON.</p> <p>The IJ removal plan, dated 8/16/24, included the following:</p> <p>a. On 8/15/24, the ADM provided [DATE] with one-on-one in-service training regarding safety to ensure [DATE] did not unlock the locked door of the secured unit without the approval of the charge nurse or the supervisor for any reason.</p> <p>b. On 8/15/24, the DON initiated in-service training to all staff regarding safety to ensure staff did not unlock the locked door of the secured unit without the approval of the charge nurse or the supervisor for any reason. Any staff that were off or on vacation would be in-serviced upon return and would not be assigned to the secured unit until staff completed the in-service.</p> <p>c. On 8/15/24, the DON initiated in-service training to all licensed nurses to ensure residents in the secured unit had a staff chaperone or helper for every appointment.</p> <p>d. On 8/15/24, the DON initiated in-service training to all licensed nurses regarding new Appointment Log to ensure licensed nurses logged driver information and staff chaperone or helper assigned (to accompany [go somewhere with someone as a companion] the resident to his/her appointment) before releasing the resident.</p> <p>e. On 8/15/24, a sign indicating Before exiting with any resident please obtain clearance from the charge nurse and or supervisor, was posted on every entrance and exit doors in the secured unit.</p> <p>f. The DON or Director of Staff Development (DSD) and/or designee would provide in-service regarding safety, supervision, and elopement Prevention every 10th of the month. The DON and/or designee would monitor the new Appointment Log in the secured unit weekly to ensure residents with appointments had a helper or staff chaperone assigned and no resident would leave for an appointment without a helper.</p> <p>Findings: (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Face Sheet (FS, document that contains a patient's personal and contact information, diagnoses, and medical history), the FS indicated, the facility admitted Resident 1 on 9/7/22, with diagnoses which included diabetes mellitus and schizophrenia (a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others). The FS indicated, the responsible party for Resident 1 was the facility's Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care).</p> <p>During a review of Resident 1's Wandering Risk Assessment (WRA, tool used to evaluate a resident's risk of wandering and elopement), dated 12/16/22, the WRA indicated, Resident 1 was at risk for wandering outside the facility. The WRA indicated, the facility tried multiple alternatives but Resident 1 continued to attempt to wander out of facility premises due to Resident 1's delusional thoughts (fixed false beliefs that are based on an inaccurate interpretation of reality).</p> <p>During a review of Resident 1's Physician Order (PO), dated 12/16/22, the PO indicated, an order for the facility to admit Resident 1 to the secured unit after Resident 1 attempted multiple times to wander out of the facility.</p> <p>During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 9/12/23, the H&P indicated, Resident 1 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 1's untitled Care Plan (CP), dated 9/13/23, the CP indicated, Resident 1 was at risk for elopement due to wandering behavior and confusion. The CP indicated, Resident 1 exhibited exit-seeking behavior. The CP interventions indicated for the staff to allow Resident 1 to wander within the secured unit and assure that Resident 1's environment was safe and secured.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/13/24, the MDS indicated, Resident 1 communicated verbally and required supervision or touching assistance (helper provided verbal cues and/or touching/steadying assistance as resident completed activity) from staff for oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and walking 150 feet.</p> <p>During a review of Resident 1's PO, dated 7/12/24, the PO indicated, an order for an ophthalmologist appointment scheduled on 8/13/24 at 8 am at ophthalmologist's office address.</p> <p>During a review of Resident 1's Licensed Personnel Progress Notes (LPPN), dated 8/13/24, timed at 8 am, the LPPN indicated, Licensed Vocational Nurse (LVN) 1, who worked the night shift (on 8/12/2024 from 11 pm to 7 am), informed LVN 3 that Resident 1 left the facility with the rideshare driver at 7:10 am (on 8/13/24).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's LPPN, dated 8/13/24, timed at 12:30 pm, the LPPN indicated, LVN 3 informed LVN 7 that Resident 1 was not at the ophthalmologist's office. The LPPN indicated, Resident 1 was dropped off by the rideshare driver at the ophthalmologist's office at 7:58 am (on 8/13/24). The LPPN indicated LVN 7 called the ophthalmologist's office on 8/13/24 at 8:20 am and was unable to speak with anyone. The LPPN indicated, Activities Assistant (AA) 1 and the facility's driver (Van Driver [DRV] 1) followed Resident 1 to the ophthalmologist's office but Resident 1 was not there. The LPPN indicated, staff at the ophthalmologist's office (unidentified) told AA 1 and DRV 1 Resident 1 did not check in at the ophthalmologist's office (on 8/13/24 at 8 am). The LPPN indicated, the facility filed a missing person report with the local police department on 8/13/24 at 11:17 am.</p> <p>During a review of Resident 1's Situation, Background, Appearance, Review Communication Form (SBAR, a standardized communication tool between healthcare providers), dated 8/13/24, untimed, the SBAR indicated, (on 8/13/24, at 8 am), Resident 1 did not go to Resident 1's scheduled ophthalmologist appointment. The SBAR indicated, facility staff (unidentified) called hospitals, shelters, stores, and nearby areas (to locate Resident 1), and involved the local police department (on 8/13/24 at 11:17 am).</p> <p>During an interview on 8/15/24 at 10:18 am with the ADM, the ADM stated the rideshare driver picked up Resident 1 on 8/13/24 (at 7:10 am) for an appointment with the eye doctor (ophthalmologist). The ADM stated LVN 1 gave the needed paperwork to the rideshare driver for Resident 1's scheduled eye appointment and told the rideshare driver to wait for the staff helper assigned to accompany Resident 1. The ADM stated after LVN 1 gave the paperwork to the rideshare driver, LVN 1 and another staff (unable to identify) in the secured unit could not find the driver and Resident 1 inside the secured unit. The ADM stated DRV 1 and AA 1 drove to Resident 1's ophthalmologist's office (on 8/13/24 at 8:20 am) but did not find Resident 1 there. The ADM stated DRV 1 and AA 1 checked all the offices around Resident 1's ophthalmologist's office and the surrounding areas but were unable to find Resident 1. The ADM stated AA 1 went inside Resident 1's ophthalmologist's office and the ADM called the ophthalmologist's office, and the ophthalmologist's office receptionist told the ADM Resident 1 did not show up for Resident 1's appointment. The ADM stated the facility filed a missing person report with the local police department (on 8/13/24 at 11:17 am). The ADM stated Resident 1 was moved to the secured unit in 2022 because Resident 1 tried to leave the facility without staff supervision. The ADM stated AA 1 needed to accompany Resident 1 to Resident 1's eye appointment.</p> <p>During an interview on 8/15/24 at 10:55 am with the Director of Nursing (DON), the DON stated Resident 1 was admitted to the facility on [DATE], and was moved to the secured unit on 12/16/22, because Resident 1 was confused and tried to leave the facility without staff supervision.</p> <p>During a concurrent observation of the facility's secured unit, and interview on 8/15/24 at 11:05 am with the DON, in the facility's secured unit, the DON stated Resident 1 and the rideshare driver exited through the locked door of the secured unit located between the Manor (name of a building in the facility) and the Center (name of secured unit building in the facility). The DON stated the facility did not know who opened the locked door of the secured unit to let Resident 1 and the rideshare driver out. The DON stated all the entrance and exit doors in the secured unit were locked and could only be opened with a passcode. A security camera (a video camera used to monitor activity in an area) was observed above the secured unit's locked door. The DON stated AA 1, who was the helper assigned to accompany Resident 1 to Resident 1's appointment, needed to be in the secured unit with Resident 1 before the scheduled pick-up time (on 8/13/24 at 7 am), but AA 1 was not there at that time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/15/24 at 11:10 am with the Social Services Designee (SSD), the SSD stated Resident 1's pick-up time for the ophthalmologist's appointment was scheduled for 8/13/24 at 7 am and AA 1 needed to be in the facility by 7 am.</p> <p>During an interview on 8/15/24 at 11:13 am with LVN 2, LVN 2 stated all residents in the secured unit were at risk for elopement and had to be accompanied by a facility staff for any outside appointment. LVN 2 stated any staff in the secured unit must not unlock the door to let any resident and any rideshare driver out without a staff helper. LVN 2 stated only facility staff knew the passcode to open doors in the secured unit.</p> <p>During an interview on 8/15/24 at 11:36 am with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated all residents in the secured unit were at risk for elopement and needed a chaperone when a resident (any resident) goes out for any appointment. RNS 1 stated staff in the secured unit must not unlock the door until the chaperone or helper was with Resident 1.</p> <p>During an interview on 8/15/24 at 11:52 am with LVN 3, LVN 3 stated all residents in the secured unit needed constant supervision and monitoring because they wandered and at risk for elopement. LVN 3 stated residents in the secured unit were not allowed to go out without a staff helper to ensure residents' safety and to prevent elopement.</p> <p>During a concurrent review of the facility's secured unit's video surveillance and interview on 8/15/24 at 12:05 pm with the Director of Maintenance (DOM) and the DON, the surveyor reviewed the facility's secured unit's video surveillance dated 8/13/24 and timed at 7:07 am to 7:08 am with the DOM and the DON. The video surveillance showed a male staff entering the passcode to unlock the door to allow Resident 1 and the rideshare driver to go outside the secured unit on 8/13/24 at 7:07 am. The DON stated the male staff who unlocked the door was [DATE].</p> <p>During a concurrent review of the facility's secured unit's video surveillance and interview on 8/15/24 at 12:32 pm with [DATE], [DATE] stated the doors to the secured unit were always locked with a passcode and staff (any staff in general) could not let residents out without a staff chaperone/helper. [DATE] watched the recorded video surveillance, dated 8/13/24 timed at 7:07 am to 7:08 am, and stated the male staff on the video surveillance who let Resident 1 and the rideshare driver leave the secured unit was [DATE]. [DATE] stated [DATE] thought the rideshare driver with Resident 1 was a facility staff.</p> <p>During an interview on 8/15/24 at 2:46 pm with LVN 3, LVN 3 stated on 8/13/24 at 7:40 am, the SSD informed LVN 3 that Resident 1 left the facility with the rideshare driver and without a staff chaperone. LVN 3 stated on 8/13/24, unable to recall time, LVN 3 asked LVN 7 to call the ophthalmologist's office to verify if Resident 1 checked in for Resident 1's appointment, but LVN 7 was unable to speak with anyone at the ophthalmologist's office (on 8/13/24 at 8:20 am). LVN 3 stated the ADM informed LVN 3 at 8:51 am (on 8/13/24) that Resident 1 never made it to Resident 1's appointment.</p> <p>During an interview on 8/15/24 at 3:10 pm with the DON, the DON stated Resident 1 had an eye appointment on 8/13/24 (at 8 am). The rideshare driver arrived at the facility's secured unit to pick up Resident 1 (on 8/13/24 at 7:07 am) but AA 1, who was the assigned helper to accompany Resident 1, was not in the facility yet. The DON stated LVN 1 told the rideshare driver to wait for AA 1 to arrive, but the rideshare driver did not wait and left the facility with Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/15/24 at 3:36 pm with AA 1, AA 1 stated on 8/13/24 (at 7 am) AA 1 was supposed to go with Resident 1 to the ophthalmologist's office but AA 1 did not wake up on time and was running late. AA 1 stated DRV 1 called AA 1 at 7 am to remind AA 1 of Resident 1's appointment, and AA 1 informed DRV 1 that AA 1 was running late. AA 1 stated as soon as AA 1 arrived at the facility on 8/13/24, unable to recall time, DRV 1 told AA 1 they had to follow Resident 1 to the ophthalmologist's office. AA 1 stated as soon as they (DRV 1 and AA 1) got to the ophthalmologist's office on 8/13/24 at 8:20 am, the receptionist told them Resident 1 did not check in for Resident 1's appointment. AA 1 checked all the offices in the building and DRV 1 drove around the streets near the ophthalmologist office. AA 1 stated when they (DRV 1 and AA 1) could not find Resident 1 they notified the SSD and an LVN (unidentified). AA 1 stated AA 1 usually accompanied residents to their appointments and that was the first time AA 1 was late.</p> <p>During an interview on 8/15/24 at 4:29 pm with the SSD, the SSD stated on 8/13/24 at 7:30 am LVN 3 called the SSD and informed the SSD that Resident 1 left the facility to go to the ophthalmologist's office with the rideshare driver without a staff helper. The SSD stated the SSD called Resident 1's insurance company, on 8/13/24 at 7:35 am, to find out how to get a hold of the rideshare driver because Resident 1's insurance company was the one who arranged the rideshare service. The SSD stated Resident 1's insurance representative informed the SSD that Resident 1 was dropped off by the rideshare driver at the ophthalmologist's office at 7:58 am. The SSD stated the receptionist at the ophthalmologist's office verified Resident 1 had an appointment but Resident 1 never checked in. The SSD stated residents in the secured unit were not allowed to go outside the building without a staff chaperone/helper or a family member.</p> <p>During a phone interview on 8/16/24 at 11:30 am with LVN 1, LVN 1 stated Resident 1 had a doctor's appointment on 8/13/24 (at 8 am) and the rideshare driver arrived to pick up Resident 1 between 7:05 am to 7:10 am. LVN 1 told the rideshare driver to wait inside the secured unit so LVN 1 could find out where AA 1 was. LVN 1 stated Resident 1 and the rideshare driver were standing in the hallway by the secured unit's door between the Manor and the Center, while LVN 1 called the supervisor's office to find out where AA 1 was. LVN 1 stated when LVN 1 hung up the phone, Resident 1 and the rideshare driver were no longer standing in the hallway by the door. LVN 1 stated LVN 1 alerted LVN 3 and LVN 2. LVN 1 stated this happened during shift change, and nurses were coming in and out of the secured unit's door. LVN 1 stated Helper (HLP) 1 looked outside the facility for Resident 1 and the rideshare driver, but HLP 1 did not find Resident 1 and the rideshare driver. LVN 1 stated staff were not supposed to let residents out without staff supervision. LVN 1 stated residents in the secured unit were at risk for elopement and it was important to have a staff helper with them whenever the residents went outside so they would not wander away.</p> <p>During a review of the facility policy and procedure (P&P) titled, Elopements and Wandering Residents, dated 2/2020, the P&P indicated, the facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate (sufficient/enough) supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The P&P indicated, the facility established and utilized a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The P&P indicated, adequate supervision would be provided to help prevent accidents or elopement.</p>		