

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Parkview Northwest Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3875 East Galbraith Road Cincinnati, OH 45236	

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** 37101</p> <p>Based on observations, medical record review, staff interview, review of the facility's investigation, review of the witness statements, review of the facilities self-reported incidents (SRIs), review of an emergency medical services (EMS) report, review of hospital records, review of emergency room (ER) notes, review of the local weather report, and review of a facility policy, the facility failed to provide adequate supervision and implement timely interventions for exit-seeking behaviors for Resident #39, who was cognitively impaired, had a history of recent exit-seeking behaviors, and who resided in a secured unit, to prevent his elopement from the facility without staff knowledge. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or death on [DATE] when Resident #39 broke the window in his room using a fire extinguisher and later returned to the room and exited the secured building by jumping out of the second story window, approximately 13 feet from the ground level. Resident #39 was missing from the facility for approximately 12 hours before staff found the resident being cared for by police and EMS six miles from the facility. This affected one (#39) of three residents reviewed for elopement risk. The facility identified twenty-seven residents (#01, #03, #04, #05, #08, #09, #10, #11, #12, #14, #15, #16, #18, #24, #25, #27, #33, #34, #36, #38, #40, #43, #44, #44, #45, #46, and #47) at risk for elopement on the secured unit. The facility census was 47.</p> <p>On [DATE] at 3:46 P.M., the Administrator, the Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #314, and Regional Director of Operations (RDO) #315, were notified Immediate Jeopardy began on [DATE] at 6:30 A.M., when Resident #39 eloped from the facility, without staff knowledge due to the failure of the facility to provide adequate supervision. On [DATE] at 6:30 A.M., State tested Nursing Assistant (STNA) #300 discovered Resident #39 had broken out his room window with a fire extinguisher and reported it to Licensed Practical Nurse (LPN) #220. Staff then moved Resident #39 from his room to the common area. LPN #220 who was assigned to monitor Resident #39, allowed the resident to return to the room with the broken window and then left the resident's room to check on another resident. LPN #220 was aware the resident broke his window and had STNAs take him and roommate to the dining room. At 6:45 A.M., in an interview with LPN #220, she stated she observed the resident returning to his room and he refused to leave the room. LPN #220 was observing him from the door when she left to care for another resident leaving the resident unsupervised and by himself in his room. On [DATE] at 7:30 A.M., STNA # 265 could not locate Resident #39. Staff looked out Resident #39's broken window and saw the following items on the ground below: a pillow, unused gloves, wipes, a flat sheet, and a bedspread. On [DATE] at approximately 7:40 P.M., STNA #265 was off duty and observed Resident #39 with the police and EMS personnel in a heavily trafficked area approximately six miles away from the facility. Resident #39 was taken to the hospital for evaluation.</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
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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>The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions:</p> <p>On [DATE] at 6:30 A.M., LPN #220 was informed the window in Resident #39's room was broken. At 7:00 A.M., LPN #220 was stationed outside the resident's room to supervise and ensure the safety of Resident #39 and to prevent re-entrance and access to the resident's room. At 7:25 A.M., LPN #220 stationed outside of the resident's room responded to another resident screaming and went to check on the resident.</p> <p>On [DATE] At 7:30 A.M., STNA #265 checked the resident's room for the resident and noted him missing. Resident #39 was believed to have exited through the broken second floor window and landed 13 feet below on the exterior ground which consisted of grass and concrete and was unsecured. On the ground there was a pillow, unused gloves, wipes, a flat bed sheet and a bed spread. A head count was conducted immediately and there was a total of 45 residents present in-house out of a census of 47 (there was one resident on a Leave of Absence (LOA) with family and Resident #39 was unaccounted for).</p> <p>On [DATE] at 7:30 A.M., upon discovering the Resident #39 could not be located, STNAs #218, #217, #312, #265 and LPN # 251 began searching the facility.</p> <p>On [DATE] at 7:30 A.M., all other windows were checked by STNAs #216 and #312 and validated as being secured, and all exits/entrances were validated as being secured by STNA # 218.</p> <p>On [DATE] at 7:45 A.M., STNAs #218 and #312 searched the perimeter of the facility until 8:10 A.M.</p> <p>On [DATE] at approximately 8:00 A.M., LPN #293 notified the local Police Department Resident #39 was missing. Resident #39's Guardian, Psychiatric (Psych) Physician #316 and Medical Director (MD) #317 were notified by LPN #251.</p> <p>On [DATE] at 8:00 A.M., Maintenance Technician (MT) #318 arrived at the facility.</p> <p>On [DATE] at 8:10 A.M., the DON and Administrator were notified that Resident #39 could not be located. LPN #293 was placed on door watch outside of Resident #39's room to ensure the resident's room was not entered due to the broken window where she remained until the window was fixed around 10:12 A.M. by MT #318.</p> <p>On [DATE] at approximately 9:00 A.M., the DON, Business Office Manager (BOM) #207, Therapy Manager #258, Activities Director (AD) #305, MT #318, Administrator, RDO #315, Minimum Data Set (MDS) Coordinator #256 and Social Services Designee (SSD) #271 arrived at the facility and conducted an additional neighboring community search to locate the missing resident.</p> <p>On [DATE] at 9:30 A.M., calls were made to all local hospitals by SSD #271 and Resident #39 was not located.</p> <p>On [DATE] at approximately 10:12 A.M., the Administrator conducted a second audit of all door alarms and the elevator keypads to check for proper function and locking mechanism. No concerns were identified.</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>On [DATE] at approximately 10:15 A.M., MT #318 conducted a second window audit to ensure all windows were secured and in proper function. There were no concerns identified.</p> <p>On [DATE] at 12:00 P.M., the DON and RDO #315 reviewed/completed wandering observation tools for each resident. No new residents were identified as an elopement risk.</p> <p>On [DATE] at 12:30 P.M., MDS Coordinator #256 reviewed/updated all care plans to identify residents who were at risk for wandering and elopement. No new residents identified.</p> <p>On [DATE] at approximately 1:00 P.M., the DON reviewed the elopement binder, the elopement policy, pictures, and face sheets of all at risk residents and no corrections were needed.</p> <p>On [DATE] at 2:30 P.M., the search for Resident #39 was concluded by the facility staff.</p> <p>On [DATE] at 3:00 P.M., the DON and Administrator initiated education on elopement management with all facility staff. There were 108 educated out of 108 total staff and completed by 9:00 P.M. and the facility utilized no agency staff. All 108 staff were educated electronically and any staff member not present was instructed to sign off on the education prior to the next scheduled shift.</p> <p>On [DATE] at approximately 3:30 P.M., education was provided to the Administrator by RDO #315 on elopement management and elopement prevention.</p> <p>On [DATE] at approximately 3:30 P.M., education was provided to the Administrator and DON by RDO #315 on management of potential risks and hazards to prevent accidents that include but not limited to safeguarding identified risks/hazards to avoid exposure to residents.</p> <p>On [DATE] at approximately 3:30 P.M., education was provided to the Administrator and DON by RDO #315 on supervision of residents when known risks or hazards are identified that include but not limited to one-on-one (1:1) supervision.</p> <p>On [DATE] at approximately 7:40 P.M., Resident #39 was located in a neighboring community six miles away by STNA #265 who was heading home and familiar with the area. STNA #265 observed the resident with the police and EMS. STNA #265 notified the DON Resident #39 had been located.</p> <p>On [DATE] at 7:55 P.M., RDO #315 was notified by the Administrator that Resident #39 had been located by STNA #265.</p> <p>On [DATE] at 8:08 P.M., an unknown Dispatcher at the local Police Department (PD) called the Administrator to provide an update on the status of Resident #39. The PD Dispatcher was instructed to have EMS transport Resident #39 to the local hospital for a psychological evaluation.</p> <p>On [DATE] at 8:12 P.M., Resident's #39's Guardian was notified by the DON and Administrator Resident #39 had been located and was being transported to the local hospital for a medical and psychological evaluation.</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>On [DATE] at approximately 8:14 P.M., Psych Physician #316 was updated by the Administrator and DON on the status of the resident being transitioned to the hospital's Psychiatric Unit. Psych Physician #316 reported the hospital would evaluate the resident and determine if he was appropriate for a 72-hour hold (psychiatric admission).</p> <p>On [DATE] at 8:25 P.M., an unknown ER Nurse at the local hospital called and spoke with the Administrator and DON and informed them Resident #39 would be assessed psychologically and medically.</p> <p>On [DATE] at 8:59 P.M., Medical Director #317 was updated on Resident #39's status by the Administrator.</p> <p>On [DATE] at 9:00 A.M., the DON and Administrator reported to the Quality Assurance Performance Improvement (QAPI) committee the findings related to compliance. The QAPI committee consists of the Administrator, DON, SSD #271, RD #252, BOM #207, MDS Coordinator #256, RDO #315, Therapy Manager #258, and MD #317 (via telephone).</p> <p>On [DATE] at approximately 3:15 P.M., the DON called the local hospital for an update on Resident #39. The hospital noted Resident #39 was assessed, and no new discoveries or diagnoses were determined, thus the resident was set for discharge back to the facility at 5:00 P.M.</p> <p>On [DATE] at 5:32 P.M., an elopement drill was conducted by the DON and Administrator. No issues were identified.</p> <p>On [DATE] at 6:02 P.M., Resident #39 returned to the facility. The resident's Guardian and MD #317 were notified of the resident's return with no new orders given.</p> <p>On [DATE] at 6:02 P.M., Resident #39 was immediately placed on 1:1 observation and will remain until determined by the Interdisciplinary Team (IDT) and MD #317 that 1:1 observation was no longer required. All staff were educated on expectations of the resident being on 1:1 observation by the DON and Administrator.</p> <p>On [DATE] at 6:29 P.M., an admission assessment was completed (including skin, pain, and a Braden Scale) on Resident #39. A care conference with the facility's IDT and Resident #39's Guardian/mother was scheduled for [DATE] at 12:45 P.M.</p> <p>Beginning [DATE], to monitor for ongoing compliance, elopement drills will be completed twice weekly for four weeks, then monthly. The drills will be conducted by the DON or Administrator on day shifts and night shifts.</p> <p>On [DATE] at 12:45 P.M., A 72-hour care conference was held with the facility's IDT which included SSD #271, DON, Administrator, Therapy Manager #258, MD #317, RDO #315, Registered Dietitian (RD) #252, BOM #275 and Resident #39's Guardian/mother. The Guardian was okay with the new interventions of a room move, 1:1 observation, and a psychiatric consultation. A Brief Interview Mental Status (BIMS) assessment was completed on Resident #39 and noted to be a 12 which indicated the resident was cognitively intact. Resident #39's care plan was updated to show the resident eloped and new interventions include 1:1 observation, educate the resident to speak with staff if he would like to take a walk outside, provide diversionary activities, notify the physician of behavior changes, and offer additional snacks and hydration.</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>On [DATE] 3:30 P.M., Resident #39's room change was conducted. Resident remains on 1:1 observation close to the nurse's station.</p> <p>On [DATE], the surveyor completed review of the medical records for residents (#03, #09, #24, and #38) identified as elopement risks and revealed no concerns related to actual elopement from the facility, elopement risk assessments were current and accurate, and care plans were initiated and updated with appropriate interventions to prevent elopement.</p> <p>On [DATE] from 11:00 A.M. to 12:30 P.M. and on [DATE] from 12:00 P.M. to 3:36 P.M., interviews with STNAs #216, #265, #218, Registered Nurse (RN) #210, LPNs #220 and #293, Central Supply (CS) #282, AD #215, and Activities Assistant (AA) #321, revealed all staff were educated and verbalized knowledge of the facility's elopement policies and procedures and guidelines for monitoring residents who have been placed on 1:1 supervision.</p> <p>Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #39 revealed an admitted [DATE] with diagnoses including schizoaffective disorder, Tourette's disorder, schizophrenia, dementia, bipolar disorder, seizures, suicidality, myocardial infarction, attention deficit hyperactivity disorder (ADHD) combined type, and history of falling.</p> <p>Review of a Guardianship Order dated [DATE] for Resident #39 revealed the resident was assigned a guardianship due to being incompetent, and a mental disability related to schizoaffective disorder and schizophrenia.</p> <p>Review of the physician's order dated [DATE] for Resident #39 revealed the resident was ordered to be admitted to a secured unit.</p> <p>Review of a Wandering Tool Evaluation dated [DATE] for Resident #39 revealed the resident had a past history of wandering, elopement attempts, had expressed anxiety/apprehension to leave the facility, the family/responsible party voiced concerns that would indicate the resident may have wandering tendencies or try to leave, and the resident wandered without sense of purpose, i.e., confused, may enter others rooms and explore belongings. The assessment identified Resident #39 as being at risk for elopement or unsafe wandering. A follow- up evaluation was completed on [DATE] which revealed Resident #39 remained at risk for elopement and unsafe wandering.</p> <p>Review of the care plan dated [DATE] and revised on [DATE] for Resident #39, revealed the resident resided on a secured unit related to elopement risk, and poor cognition. Interventions included educate the resident/resident's representative of the need for a secured unit to maintain the resident's safety, notify the medical provider/resident's representative of any behavior changes, provide diversionary activities as needed and redirect when appropriate.</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>Review of a progress note dated [DATE] at 1:04 P.M. for Resident #39, revealed the resident was seen by laundry staff trying to remove the ceiling tiles as an escape route. The resident was redirected and accompanied to the dining room for lunch. The vital signs were within normal limits, the resident denied pain, the skin was intact, and the resident was calm. Fifteen (15)-minute checks were initiated, and Resident #39 remained on 15-minute checks from [DATE] until [DATE].</p> <p>Review of the quarterly MDS assessment dated [DATE] for Resident #39 revealed the resident was cognitively impaired and required supervision for activities of daily living (ADLs). Resident #39 was assessed to have the presence of wandering behaviors.</p> <p>Review of a progress note dated [DATE] at 8:45 A.M. for Resident #39 revealed at approximately 7:30 A.M., Resident #39 was noted to not be in his room. The Physician, DON, the resident's Guardian, and the local police were notified.</p> <p>Review of the EMS run report dated [DATE] revealed EMS was dispatched at 7:37 P.M. for unknown problem/person down. The report indicated the patient (Resident #39) broke out of a long care facility this morning. He has a history of mental health. There are no medical issues that he was complaining of and needs transportation back to the facility. Cincinnati Police Department (CPD) notified and responded to transport patient. The patient was turned over to law enforcement.</p> <p>Review of a progress note dated [DATE] at 9:00 P.M. for Resident #39 revealed the resident was located by a staff member (identified as STNA #265) earlier this evening. The police responded and EMS. The resident was transported to a psychiatric hospital for a psychological and medical evaluation. The resident was placed on 72-hour hold and the resident's Guardian was notified. The Facility Psychiatrist #316, Medical Director #317, the RDCO# 314, and RDO #315 were notified. The residents room change will be initiated prior to returning to the facility.</p> <p>Review of the hospital ER notes dated [DATE] at 9:40 P.M. for Resident #39 revealed the resident presented to the ER for foot pain after going missing from a nursing home. The notes revealed the nursing home found evidence that the resident had broken a window out and jumped out of the second story window around 7:30 A.M. The resident was reported to have a shuffled gait; however, refused to participate in the medical care team's examination. The resident did not express discomfort with palpation of the extremities or examination of the spine and due to history, imaging was ordered to rule out trauma. The resident had various imaging studies which were all negative for any acute fractures or abnormalities. Resident #39 was medically cleared, diagnosed with fall, schizophrenia with acute exacerbation, discharged from the ER on [DATE] at 6:08 A.M. and immediately readmitted to psychiatry unit at the same hospital. The psychiatry notes indicated the resident was well known to the psychiatry team and the resident was originally placed in a Skilled Nursing Facility (SNF) due to injuries he sustained after breaking out a window at home and jumping. The resident received comprehensive psychiatric evaluation and therapeutic management in accordance Psychiatric Emergency Services (PES) guidelines for dangerous behavior while he was at his SNF. Resident #39 was monitored for 10 hours and discharged back to the SNF at 5:32 P.M. with no new orders.</p> <p>Review of STNA #306's written statement dated [DATE], revealed she had clocked out and was about to leave when someone said they couldn't find Resident #39 for his breakfast tray. They started looking for the resident and she stayed and waited.</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>Interview with LPN #220 on [DATE] at 1:32 P.M., revealed she was assigned as Resident #39's nurse on [DATE] during the night shift and into the morning of [DATE]. LPN #220 stated she was informed by STNA #208 of the broken glass in the resident's room and instructed the STNA to move the resident and his roommate to the dining room and stay with them. LPN #220 stated she did not hear breaking of any glass in the resident's room during the shift and could not be certain when the glass was broken. LPN #220 stated STNA #300 assisted her with cleaning up the glass and she remained in the hallway near Resident #39's room. LPN #220 stated at approximately 6:45 A.M. she saw Resident #39 return to his room and the resident refused to leave his room. LPN #220 stated she left the facility at approximately 7:15 A.M. when the day shift nurse, LPN #293, arrived.</p> <p>Interview with STNA #265 on [DATE] at 1:37 P.M., revealed she was assigned to care for Resident #39 on [DATE] during the day shift (7:00 A.M. to 7:00 P.M.). STNA #265 stated Resident #39 was on 15-minute checks and she was informed the resident's room window was broken earlier in the morning but never informed the resident was not supposed to be in his room or be on 1:1 observation. STNA #265 stated she checked on the resident at 7:15 A.M. and he was lying in his bed, and she did not want to disturb him and when she checked on him again at 7:30 A.M. the resident was not in his room. STNA #265 stated she looked out the resident's window and saw a pillow and some bed linens lying on the ground and the gate was open. STNA #265 stated she immediately informed LPN #293 and all staff started searching for the resident. STNA #265 stated after her shift at 7:00 P.M., she decided to search the neighboring community because she had heard the resident talk about the area. STNA #265 stated at approximately 7:40 P.M. she located Resident #39 with EMS and notified the Administrator. STNA #265 stated the resident was dressed in hoodie, jeans, and tennis shoes. STNA #265 left when the resident was transported to the hospital.</p> <p>Interview with LPN #293 on [DATE] at 1:44 P.M., revealed she was assigned to care for Resident #39 on [DATE] during the day shift. LPN #293 stated she was informed by LPN #220 that Resident #39's room window had been broken out. LPN # 293 stated she was getting report from the previous shift and did not see the resident and at 7:30 A.M., STNA #265 informed her the resident was not in his room and when she looked out the window, she saw a pillow and blankets and assumed the resident had eloped through the broken window. LPN #293 stated she initiated a head count which ended at approximately 8:15 A.M. and Resident #39 was not in the facility. LPN #293 stated she closed the door to the resident's room and stayed by the door from 8:15 A.M. until 10:12 A.M. when MT #318 repaired the window.</p> <p>Observation of Resident #39 on [DATE] at 1:57 P.M., revealed the resident was on a 1:1 observation by RN #210. Interview with Resident #39 at the same time, revealed the resident reported he couldn't remember what happened on [DATE] but stated he wanted to leave the facility.</p> <p>Telephone interview with the Administrator on [DATE] at 3:33 P.M., revealed on [DATE] at 8:00 A.M., LPN #293 notified the local police Resident #39 was missing and the police put out a statewide be on the lookout ([NAME]). The Administrator stated she was contacted by the local police on [DATE] at 8:08 P.M., that the resident had been found and asked if she wanted him held at the police station or returned to the facility. The Administrator instructed the police to take him to the hospital for a psychiatric and medical evaluation. The Administrator stated a fire extinguisher was found on the floor of the resident's room and the facility had determined he used the fire extinguisher to break the window. The Administrator stated after the resident returned to the facility on [DATE], she interviewed the resident and he stated he used the fire extinguisher to break the window and jumped out of the window because he wanted to go home.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Parkview Northwest Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3875 East Galbraith Road Cincinnati, OH 45236	
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>Review of the online weather report at the website https://www.wunderground.com/history/daily/us/oh/cincinnati/KCVG/date/[DATE] revealed the air temperature on [DATE] at 7:52 A.M. was 39 degrees Fahrenheit, there was no precipitation, and the wind speed was approximately twelve miles per hour.</p> <p>Review of the facility's undated policy titled, Elopement Management revealed failure to provide adequate supervision for cognitively impaired residents who leave the facility or safe area and are unaccounted for is considered an elopement.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153232.</p>		