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Great Lakes Region

OHIO SKILLED NURSING FACILITY

Elopement Compliance Toolkit



This toolkit provides Ohio nursing homes with practical, survey-ready resources to prevent elopement, ensure resident safety, and demonstrate compliance with Ohio Administrative Code (OAC) 3701-17, Centers for Medicare & Medicaid Services (CMS) F689 (Accidents/Supervision), and related reporting and Quality Assurance and Performance Improvement (QAPI) expectations. Materials are designed for front line staff, leadership, and interdisciplinary teams.

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Tools Included

- **Elopement Overview and Regulatory Foundation Quick Guide**
 - Definitions
 - Reporting requirements
 - Documentation
 - Policy language
- **Elopement Prevention Education and Training**

Format: PowerPoint (widescreen)
Use: Staff education, annual training, new hire orientation, leadership review
Includes: Definitions, regulatory expectations, prevention strategies, case studies, QAPI metrics, and survey pitfalls

 - Facilitator Talking Points (embedded within slide deck)
 - Case study discussion prompts for interdisciplinary teams
- **Post-test and Competency Validation Post-test**
 - Elopement Prevention and Response Knowledge Post-test
 - Answer key (educator use)
 - Suggested passing score and remediation guidance
- **Risk Assessment and Care Planning**
 - Elopement/Wandering Risk Assessment guidance
 - Identification of residents at risk
 - Individualized, person-centered care planning interventions
 - Care plan review and update expectations (quarterly and post-event)
- **Studies for Leadership and Professional Nursing Staff**
 - Ohio Statement of Deficiencies (SOD)-based case studies
 - Discussion questions and teaching points for staff and leadership
- **Auditing and Monitoring**
 - Supports ongoing observation and immediate feedback
 - Encourages early identification of risks and near misses
 - Promotes proactive intervention before adverse events occur

How to use this toolkit

Facilities may use this toolkit in whole or in part to support policy development, staff education, quality improvement activities, and survey readiness. Materials may be adapted to facility-specific policies and procedures while maintaining alignment with Ohio and the Centers for Medicare & Medicaid Services (CMS) requirements.

This toolkit is intended to support Ohio nursing homes in meeting federal CMS requirements and Ohio Department of Health (ODH) regulatory expectations related to resident supervision and elopement prevention. Facilities should review current CMS guidance and Ohio Administrative Code requirements to ensure ongoing compliance.

References

- [Ohio Administrative Code \(OAC\) 3701-17](#)
- [CMS State Operations Manual Appendix PP](#)
- [CMS 20127 Accidents Critical Care Pathway](#)

Ohio Elopement Overview and Regulatory Foundation Quick Guide

Definition: Ohio Administrative Code (OAC)

Elopement = A resident leaves the home or a safe area without the facility's knowledge or without supervision. If a resident with decision-making capacity chooses to leave, it is not considered an elopement unless the departure is unusual or atypical.

Immediate Actions and Reporting

- Activate facility elopement response protocol (announce, assign search zones, check exits/stairwells/restrooms).
- If not found within facility-defined timeframe (e.g., 15 minutes), call 911 and notify the resident representative.
- Operator immediately reports the elopement using the ODH-prescribed electronic reporting system currently to the email address of BLTCQ@odh.ohio.gov, ODH also reminds providers to follow all HIPAA requirements when submitting information, which may include encrypting the email to protect resident privacy.
- Notify physician and representative for injury or significant change; follow facility notification policy.

Care Planning and Supervision Requirements

- Assess elopement risk at admission and at least quarterly or with any change in condition.
- Reflect adequate supervision in the individualized plan of care (e.g., rounds frequency, observation level, wander management, activities).
- Review and update care plans at least quarterly and post-event (Root Cause Analysis (RCA)-driven revisions).

Records and Photos

- Maintain a current photograph in the medical record for each resident identified as an elopement risk; update at least annually.
- Ensure photos are accessible to staff responding to alarms to search efforts.

Documentation (After any Event or Near-miss)

- Timeline of events and staff actions.
- Search and recovery details; zones covered; time stamps.
- Notifications: physician, representative, law enforcement (if applicable), ODH report confirmation if reported/reportable. If you do not report to ODH, document rationale.
- Injury/status assessment; provider orders; observation period.
- RCA findings and corrective actions; care plan updates.

QAPI Expectations

- Track all elopements and near-misses; trend by unit, time a day, contributing factors.
- Conduct RCA and implement corrective actions (environment, staffing, training, process redesign).
- Review effectiveness at QAPI and document follow-through.

Staff Training and Drills

- Educate on definition, triggers, and responsive roles for all departments (nursing, housekeeping, maintenance, activities).
- Run drills and/or training with case studies at least annually.
- Debrief meach drill; capture lessons learned and update policy and care processes.

Elopement Policy

Policy Language Snippets

- “An elopement occurs when a resident leaves a home or safe area without the facility’s knowledge or without supervision; residents with decision-making capacity who choose to leave are not considered elopements unless the departure is unusual or atypical.”
- “The operator will immediately report any elopement using the ODH-prescribed electronic reporting system.”
- “Residents identified as elopement risk will have adequate supervision reflected in the plan of care and a current photograph updated annually.”

Rule Anchors

For your policy footer.

- OAC 3701-17 (Nursing Homes): Definition, supervision/care planning, records, and reports.
- ODH reporting requirements: Use the ODH-prescribed electric reporting system for elopements.

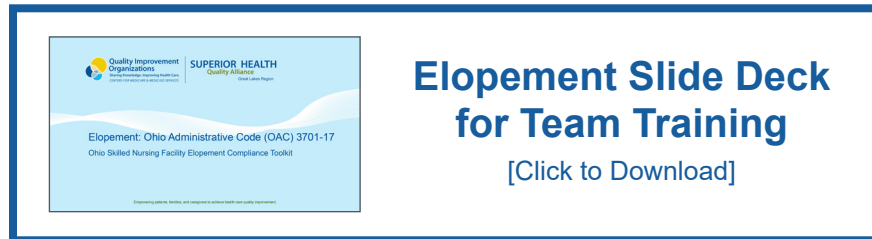
Practical Compliance Checklist

What surveyors expect to see.

- **Policy** defines elopement per 3701-17-01 and spells out **who reports, how, and when** (ODH system; internal chain).
- **Assessment** workflow flags elopement risk on admission and at least quarterly; **care plan** lists interventions (supervision level, door alarms, wander management, rounds, activities, sitter, family engagement).
- **Environment:** Functional door alarms; staff know alarm response and resident headcount process. (Supports “adequate supervision)
- **Resident photos** current (≤ 12 months) for all residents tagged as elopement risk.
- **Documentation** for each event: timeline, search and recovery actions, notifications, physician communication, ODH report confirmation, debrief/QAPI actions.

This guide is not a substitute for the Ohio Administrative Code or ODH directives.

Elopement Prevention Case Study Facilitator Guide (SNFs)



Purpose

This guide supports facilitated discussion of elopement scenarios to strengthen staff response, reporting, and survey readiness.

Facilitator Tips

- Encourage open discussion.
- Focus on systems, not blame.
- Tie responses back to Ohio reporting expectations.
- Identify at least one improvement action per case.

Expected Discussion Points

Case 1: Teaching/Survey Points

- Elopement definition applies even if the resident is found quickly.
- Immediate leadership, physician, and family notification required.
- ODH reporting required under OAC 3701-17-06.
- Care plan and supervision must be reassessed.
- Review through QAPI expected.

Case 2: Teaching/Survey Points

- Alarm and system failures = supervision failure.
- Law enforcement involvement triggers mandatory ODH reporting.
- Hospitalization increases survey severity.
- Equipment checks and monitoring must be documented.
- Surveyors will ask: "How do you know alarms are working?"

Case 3: Teaching/Survey Points

- Behavioral symptoms increase elopement risk.
- Staffing challenges do not excuse lack of supervision.
- Reporting required due to supervision failure.
- Person-centered care planning is critical.
- Surveyors will review staffing assignments and communication.

Elopement Prevention and Response Post-test

Ohio Nursing Homes

Name: _____

Date: _____

Unit/Role: _____

Instructions:

Answer all questions. Passing score = **80%**. Choose the single best answer unless noted.

Multiple Choice:

1. In Ohio, an elopement is best defined as:
 - A. Any time a resident leaves their room without telling staff.
 - B. A resident leaving the home or safe area without the facility's knowledge or without supervision.
 - C. A resident going on a community outing with family.
 - D. Any resident leaving the building for any reason.
2. Which statement about residents with decision-making capacity is MOST accurate?
 - A. Any time they leave, it is an elopement.
 - B. It is never an elopement if they leave.
 - C. Not an elopement unless the departure is unusual or atypical.
 - D. It depends only on whether the alarm sounds.
3. For residents identified as elopement risk, Ohio requires:
 - A. A daily security escort.
 - B. A current photograph in the medical record updated at least annually.
 - C. A sitter 24/7.
 - D. Door alarms on all exits.
4. Adequate supervision for elopement risk should be:
 - A. The same for all residents to avoid discrimination.
 - B. Listed in the care plan and individualized based on assessment
 - C. Determined by maintenance
 - D. Only provided during day shift.
5. After an elopement event, the FIRST priority is
 - A. Complete the incident report.
 - B. Notify family.
 - C. Activate/search per protocol and ensure resident safety.
 - D. Update the QAPI dashboard.
6. When must the operator report an elopement to ODH?
 - A. Within 7 days.
 - B. Immediately using the ODH-prescribed electronic reporting system.
 - C. Only if the resident is injured.
 - D. Only if law enforcement is called.

7. Which best describes a strong environmental control practice?
 - A. Silencing door alarms promptly to reduce noise
 - B. Ensuring door alarms are audible and verified, and staff respond and document checks.
 - C. Posting "Do Not Exit" signs only
 - D. Relying on cameras instead of rounds

8. A near-miss (attempted elopement) should be:
 - A. Ignored since no harm occurred.
 - B. Handled by security only
 - C. Documented, analyzed (Root Cause Analysis), and used to update the care plan and training.
 - D. Reported to media.

True / False:

9. Staff should silence a door alarm and assume someone else is responding.
True False

10. Care plans for elopement risk must be reviewed at least quarterly and with any condition change.
True False

11. Photographs for residents at elopement risk must be updated every three years.
True False

12. QAPI should trend elopements and near-misses and document corrective actions.
True False

Scenarios (Short Answer):

13. A door alarm sounds on evening shift. What are your first three steps according to protocol?

14. A resident with decision-making capacity leaves after an argument with family and returns two hours later unharmed. What do you document and review?

15. A power outage disables the wander-management system for 10 minutes. What immediate contingency actions should staff take?

Elopement Prevention and Response Post-test

Answer Key - For Educator Use

Multiple Choice:

1-B, 2-C, 3-B, 4-B, 5-C, 6-B, 7-B, 8-C

True/False:

9-False, 10-True, 11-False, 12-True

Scenario Key Points:

13. Notify charge/lead; verify alarm & last-seen; initiate facility search with assigned zones; headcount/at-risk checks; escalate to 911/family per timeframe; document timeline.

14. Likely not an elopement if capacity & voluntary unless unusual/atypical; document circumstances and assessment on return; notifications; review/update care plan; consider social work support.

15. Increase manual rounds/visual exit monitoring; post staff at exits; communicate with maintenance/administrator; verify at-risk residents; document checks and restoration time; debrief for improvement.

Scoring:

12 questions worth 1 point each (MCQ + T/F) = 12 pts.

Scenarios (3 pts total: 1 pt each) = 15 pts max.

Pass ≥12/15 (≥80%).

Post-test Scoring and Remediation Guidance

A passing score of 80% or higher is required to demonstrate competency in elopement prevention and response.

Staff who do not achieve a passing score will receive targeted remediation and/or retake quiz until a passing score is achieved. Remediation may include a review of missed concepts, focused education using facility policy and training materials, and completion of a repeat post-test.

Successful completion of remediation and re-testing will be documented in the employee education record.

Case Studies for Leadership and Professional Nursing Staff

The following case studies are directly from Ohio provider SODs. Please use these for training and discussion with the leadership and/or professional nursing staff.

Case Study 1

For Professional Nursing Staff and Leadership

F 0689 SS=J 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and the facility failed to provide adequate supervision to prevent an elopement.

Resident (#45) who ambulated through a door on the Memory Care Unit (MCU) with a malfunctioning alarm and into the East side stairwell where Resident #45 fell down 11 cement stairs. This resulted in Immediate Jeopardy and the potential for serious-life threatening injuries, negative health outcomes and/or death for one resident when Resident #45 exited the third-floor MCU through a door with a malfunctioning alarm and into the East side stairwell and fell down the stairs without staff's knowledge.

Resident #45 was missing for approximately one hour before the staff determined the resident was missing, and the resident was found lying on the landing between the second and third floors. Nine-one-one (911) was called, and Resident #45 was sent to the hospital for evaluation and treatment of multiple fractures.

Resident #45 who was cognitively impaired due to diagnosis of dementia, was assessed as being at high risk for elopement; however, no care plan was implemented for the resident being cognitively impaired or at risk for elopement.

Question 1: What specific failures contributed to this event being cited as Immediate Jeopardy?

Question 2: Which regulatory requirements under F689 were not met in this case?

Question 3: At what points could this event have been prevented?

Question 4: What care planning interventions should have been in place for this resident?

Question 5: What immediate actions are required once an elopement or missing resident is identified?

Question 6: What corrective actions would surveyors expect to see to remove Immediate Jeopardy?

Question 7: What system-level changes should leadership consider to prevent recurrence?

Case Study 1 Key Takeaway

For Staff and Leadership

Elopement is not a single-failure event. It is almost always a system failure. High-risk assessments without intervention, combined with environmental hazards and supervision gaps, can rapidly escalate to Immediate Jeopardy.

Question 1: What specific failures contributed to this event being cited as Immediate Jeopardy?

Talking Points / Expected Answer:

- **Environmental hazard:**
 - Malfunctioning door alarm on the MCU exit.
- **Supervision failure:**
 - Resident was missing for approximately one hour without staff awareness.
- **Risk assessment failure:**
 - Resident was identified as high risk for elopement, yet:
 - No individualized interventions were implemented.
 - No care plan addressed cognitive impairment or elopement risk.
- **System failure:**
 - Lack of alarm monitoring checks and/or documentation.
 - Inadequate staff rounding or accountability.
- **Outcome severity:**
 - Resident fell 11 cement stairs, resulting in multiple fractures and hospitalization.
- **Immediate Jeopardy threshold met because:**
 - The situation created a likelihood of serious injury, harm, impairment, or death.

Question 2: Which regulatory requirements under F689 were not met in this case?

Talking Points / Expected Answer:

- Failure to maintain a resident environment as free of accident hazards as possible.
- Failure to provide adequate supervision for a cognitively impaired, high-risk resident.
- Failure to ensure safety devices (alarms) were:
 - Functioning properly.
 - Routinely tested.
 - Promptly repaired.
- Failure to implement person-centered care planning based on assessed risk.

Question 3: At what points could this event have been prevented?

Talking Points / Expected Answer:

- Admission / Assessment Phase
 - High elopement risk identified → required immediate interventions.

- Care Planning
 - Missing care plan addressing:
 - Dementia-related behaviors.
 - Elopement risk.
 - Supervision needs.
- Environmental Rounds
 - Routine alarm testing could have identified malfunction.
- Staff Monitoring
 - Timely rounding and headcounts may have identified the resident's absence sooner.
- Leadership Oversight
 - Failure to verify compliance with safety checks and high-risk resident protocols.

Question 4: What care planning interventions should have been in place for this resident?

Talking Points / Expected Answer:

- **Elopement prevention care planning**, including:
 - Functioning door alarms with daily checks.
 - Increased supervision or visual monitoring.
 - Wander-guard or electronic monitoring (if appropriate and consented).
 - Staff education on resident-specific behaviors.
 - Environmental modifications (secured stairwells, delayed-egress doors).
- Documentation reflecting:
 - Ongoing reassessment.
 - Staff awareness.
 - Resident response to interventions.

Question 5: What immediate actions are required once an elopement or missing resident is identified?

Talking Points / Expected Answer:

- Initiate **missing resident / elopement protocol immediately**.
- Conduct a **facility-wide search**.
- Notify:
 - Administrator / leadership.
 - 911 (per policy and risk level).
- Document:
 - Timeline of events.
 - Staff actions.
- Ensure **medical evaluation** once the resident is located.
- Begin **Immediate Jeopardy removal actions** if applicable.

Question 6: What corrective actions would surveyors expect to see to remove Immediate Jeopardy?

Talking Points / Expected Answer:

- Immediate repair or replacement of malfunctioning alarms.
- Temporary safety measures implemented until permanent fixes are complete.
- Re-assessment of **all residents** at risk for elopement.
- Updated and implemented care plans.
- Staff re-education on:
 - Elopement prevention.
 - Alarm monitoring.
 - Missing resident procedures.
- Leadership oversight with monitoring and auditing.

Question 7: What system-level changes should leadership consider to prevent recurrence?

Talking Points / Expected Answer:

- Standardized **alarm testing and documentation.**
- Routine environmental safety audits.
- Clear accountability for monitoring high-risk residents.
- Interdisciplinary review of elopement risks.
- Incorporation of elopement events into **QAPI.**
- Use of **RCA** to address:
 - Process gaps.
 - Training gaps.
 - Equipment failures.

Case Study 2

For Professional Nursing Staff and Leadership

F 0689 SS=J 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and the facility failed to provide adequate supervision to prevent an elopement

Based on observation, closed medical record review, review of the local police report, staff interviews, review of the National Weather Service forecast, review of the facility Elopement Policy and Procedure, review of Abuse, Neglect and Misappropriation Policy and Procedure, and review of camera footage, the facility failed to provide adequate supervision to prevent Resident #95, who had diagnoses of metabolic encephalopathy, malnutrition, and adult failure to thrive and severe cognitive impairment, from leaving the facility without staff knowledge. This resulted in Immediate Jeopardy and actual harm leading to death beginning on 12/23/24 at approximately 8:40 P.M. when Resident #95 was last seen inside the facility. On 12/23/24 at 9:30 P.M., 12/24/24 at 12:36 A.M. and 12/24/24 at approximately 4:00 A.M. staff identified Resident #95 was not in the facility but failed to take sufficient action to determine her whereabouts.

On 12/24/24 at 6:09 A.M., Licensed Practical Nurse (LPN) #500 began phoning nursing management regarding Resident #95 missing from the facility. At 6:22 A.M., LPN via phone and informed her Resident #95 was missing. A “code purple” (facility code for an elopement) was called and a search of the facility and property began. Registered Nurse (RN) #484 arrived at the facility at approximately 7:30 A.M. and assisted with search efforts. The local police department was then called, responded to the facility and assisted in search efforts. On 12/24/24 at approximately 8:10 A.M., RN #484 was informed a wheelchair was observed in the stairwell of the lower level. RN #484 observed the chair, continued up the stairs near where the wheelchair was found and opened the door which exited to the outside, where she met resistance. RN #484 observed Resident #95 lying on the patio outside the exit door to the facility.

Resident #95 was observed cold to touch, wet, and without respirations or a heart rate. RN #484 screamed for help and initiated cardiopulmonary resuscitation (CPR). Additional staff responded to the area. Emergency Medical Services (EMS) was contacted, and Resident #95 was transported to a local hospital where she was unable to be resuscitated and was pronounced deceased on 12/24/24 at 8:57 A.M.

An interview on 01/07/25 at 1:20 P.M. with Corporate Director of Clinical Services #508 revealed the facility was informed Resident #95’s preliminary cause of death was “environmental exposure and hypothermia”. Resident #95’s official death certificate remained pending at the time of the on-site investigation. Review of the undated facility policy titled “Abuse Prohibition” revealed each resident has the right to be free from abuse and neglect. The policy defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All allegations of abuse, neglect, and misappropriation of property are immediately reported, thoroughly investigated and appropriate actions taken. Review of the facility policy titled “Elopement” revised

10/2022 revealed a situation in which a resident leaves the premises or a safe area without the facility’s knowledge and supervision should be immediately be reported to Administrator and Director of Nursing (DON) and a search initiated per policy.

Question 1: Why did this event rise to Immediate Jeopardy with actual harm leading to death?

Question 2: What specific supervision failures occurred in this case?

Question 3: How does this event meet the regulatory definition of neglect?

Question 4: What actions should have occurred at the FIRST indication the resident was missing?

Question 5: How did delays and repeated inaction compound risk in this case?

Question 6: What environmental and system hazards are evident from this case?

Question 7: What corrective actions are required to remove Immediate Jeopardy?

Question 8: What long-term system changes should leadership implement?

Case Study 2 Key Takeaway

For Staff and Leadership

Elopement with delayed response is not a single error; it is neglect through inaction. When a cognitively impaired resident is missing, time equals life. Policies must be activated immediately, without hesitation.

Question 1: Why did this event rise to Immediate Jeopardy with actual harm leading to death?

Talking Points / Expected Answer:

- Resident vulnerability:
 - Severe cognitive impairment.
 - Diagnoses including metabolic encephalopathy, malnutrition, and adult failure to thrive.
 - Dependent on staff for safety and supervision.
- Multiple missed opportunities:
 - Resident last seen at 8:40 p.m.
 - Identified missing at 9:30 p.m., 12:36 a.m., and 4:00 a.m.
 - No timely escalation or comprehensive response.
- Failure to act promptly:
 - Code Purple not initiated until approximately 6:22 a.m.
- Environmental exposure:
 - Resident found outdoors, cold, wet, unresponsive.
 - Preliminary cause of death: hypothermia and environmental exposure.
- Immediate Jeopardy determination:
 - Facility actions (and inaction) created a situation likely to cause serious harm or death, which did occur.

Question 2: What specific supervision failures occurred in this case?

Talking Points / Expected Answer:

- Failure to recognize resident absence as an emergency.
- Failure to initiate an immediate, facility-wide search upon first discovery.
- Failure to notify leadership and emergency services promptly.
- Failure to follow facility elopement policy.
- Inadequate monitoring of a high-risk cognitively impaired resident.
- Failure to secure or monitor exit points effectively.

Question 3: How does this event meet the regulatory definition of neglect?

Talking Points / Expected Answer:

- Facility policy defines neglect as: Failure to provide goods and services necessary to avoid physical harm.
- In this case, neglect included:

- Failure to provide adequate supervision.
- Failure to respond appropriately when the resident was known to be missing.
- Failure to protect the resident from environmental hazards.
- Neglect does not require intent—failure to act is sufficient.

Question 4: What actions should have occurred at the FIRST indication the resident was missing?

Talking Points / Expected Answer:

- Immediate activation of Code Purple.
- Facility-wide and grounds search.
- Immediate notification of:
 - Administrator.
 - Director of Nursing.
- Assessment of:
 - Door alarms.
 - Stairwells.
 - Outdoor exits.
- If not rapidly located:
 - Immediate 911 and law enforcement notification.
- Continuous documentation of timeline and actions.

Question 5: How did delays and repeated inaction compound risk in this case?

Talking Points / Expected Answer:

- Each delay increased exposure to:
 - Cold temperatures.
 - Weather conditions.
 - Physical injury.
- Failure to act after multiple identifications of absence represents:
 - Systemic breakdown.
 - Leadership and staff accountability failure.
- Surveyors view patterned inaction as stronger evidence of neglect.

Question 6: What environmental and system hazards are evident from this case?

Talking Points / Expected Answer:

- Stairwell access not adequately monitored.
- Exit doors not effectively secured or alarmed.
- Lack of real-time awareness of resident movement.
- Inadequate overnight staffing awareness and escalation.
- Absence of environmental risk mitigation during inclement or cold weather.

Question 7: What corrective actions are required to remove Immediate Jeopardy?

Talking Points / Expected Answer:

- Immediate securing and monitoring of all exits and stairwells.
- Re-education of all staff on:
 - Elopement policy.
 - Code Purple activation.
 - Abuse/neglect reporting.
- Re-assessment of all residents for elopement risk.
- Immediate care plan updates with documented interventions.
- Leadership oversight and auditing.
- Demonstration of sustained compliance, not one-time fixes.

Question 8: What long-term system changes should leadership implement?

Talking Points / Expected Answer:

- Standardized missing resident response protocol with timelines.
- Clear escalation thresholds (minutes—not hours).
- Routine drills for elopement scenarios.
- Environmental risk assessments during extreme weather.
- Integration of elopement events into QAPI and RCA.
- Clear accountability for overnight supervision.

Case Study 3

For Professional Nursing Staff and Leadership

F609 SS=D 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: **§483.12(c)(1)** Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. **§483.12(c)(4)** Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Review of a nursing progress note, dated 04/21/25, revealed Resident #53 exited the building around 5:30 P.M. and went to the carryout store. Resident #53 sat on the floor and refused to get up, stated she was being kidnapped. Extensive effort was required as the resident refused to get up until store clerk told her she had to leave. Emergency services (911) were called to help. Resident #53 was delusional and stated she wanted to take a cab to Secor Road. Resident #53 was encouraged to talk to her doctor that helped her with her voices and behaviors. Resident #53 finally got into the car with staff and returned to the facility. Emergency services were canceled due to prolonged wait. Facility management was aware, the physician was notified, and attempted to call family three times with no answer. Psychiatric Nurse Practitioner (PNP) to visit with the resident this week. Review of the facility video surveillance, dated 04/21/25, revealed at 6:55 P.M. Resident #53 was seated in her wheelchair in the front lobby. At 6:56 P.M. an unknown visitor entered the code from outside of the facility and entered. Upon the visitor passing, Resident #53 abruptly stood up and walked out the front doors, without staff present with her. Review of the EIDC system from 04/21/25 through 05/05/25 revealed no evidence the facility submitted a self-reported incident (SRI) to the State Survey Agency (SSA) related to Resident #53's elopement on 04/21/25. Interview on 05/05/25 at 11:48 A.M. with the Administrator revealed she was not notified Resident #53 had eloped on 04/21/25 and verified an SRI was not completed to report Resident #53's elopement to the SSA.

F610 D 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: **§483.12(c)(2)** Have evidence that all alleged violations are thoroughly investigated. **§483.12(c)(3)** Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. **§483.12(c)(4)** Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This STANDARD is not met as evidenced by: Based on medical record review, staff interview and review of the facility policy, the facility failed to investigate an incident of resident elopement. Findings include: Review of the medical record revealed refused to get up until the store clerk told her she had to leave. 911 was called to help. Resident #53 was delusional and stated she wanted to take a cab to Secor Road. Facility management was aware, the physician was notified, and attempted to call family three times

with no answer. Psychiatric Nurse Practitioner (PNP) to visit with resident this week. Review of video surveillance, dated 04/21/25, revealed at 6:55 P.M. Resident #53 was seated in her wheelchair in the front lobby. At 6:56 P.M., an unknown visitor entered the code from outside of the facility and entered. Upon the visitor passing, Resident #53 abruptly stood up and walked out the front doors, without staff. Resident #53 returned to the facility at 7:59 P.M. with staff.

A follow up interview on 05/06/25 at 8:09 A.M. with the DON revealed she was not aware until 05/05/25 that Resident #53 had eloped from the facility without staff knowledge on 04/21/25. The DON verified an investigation was not initiated until 05/05/25. Review of the facility policy titled, "Abuse, Neglect, and Exploitation", dated 2024, revealed the facility would complete an immediate investigation when there was suspicion or reports of abuse, neglect, or exploitation.

Question 1: Why did this incident trigger F609 (Reporting) requirements?

Question 2: What specific reporting failures occurred under F609?

Question 3: Why does this event also meet F610 (Investigate / Prevent / Correct)?

Question 4: What investigation steps should have occurred immediately on 04/21/25?

Question 5: What environmental and system failures are evident in this case?

Question 6: Why is leadership awareness critical in elopement and neglect cases?

Question 7: What corrective actions should have been implemented to prevent recurrence?

Question 8: What are the key lessons for staff regarding reporting and investigations?

Case Study 3 Key Takeaway

For Staff and Leadership

Failure to report and investigate can be cited separately and just as seriously as the event itself.
Elopement without reporting and investigation reflects systemic breakdown, not isolated error.

Question 1: Why did this incident trigger F609 (Reporting) requirements?

Talking Points / Expected Answer:

- Resident #53 eloped from the facility without staff knowledge.
- Resident exhibited:
 - Delusional behavior.
 - Paranoia (“being kidnapped”).
 - Impaired judgment and decision-making.
- 911 was called due to behavioral instability.
- Elopement constitutes potential neglect and injury of unknown source.
- F609 requires reporting of:
 - Alleged neglect.
 - Injuries of unknown source.
 - Events placing resident safety at risk.
- SSA notification (SRI) was required but not completed.

Question 2: What specific reporting failures occurred under F609?

Talking Points / Expected Answer:

- Failure to notify:
 - Administrator.
 - SSA.
- No SRI submitted.
- Administrator unaware of the elopement until surveyor interview
- Reporting timelines violated:
 - Immediate (≤ 2 hours) if serious risk.
 - ≤ 24 hours if not involving serious bodily injury.
- Failure to escalate despite:
 - Law enforcement involvement.
 - Community exposure.
 - Documented mental status changes.

Question 3: Why does this event also meet F610 (Investigate / Prevent / Correct)?

Talking Points / Expected Answer:

- Facility failed to:
 - Initiate an immediate investigation.

- Preserve and review evidence in a timely manner.
- Prevent recurrence while investigation was pending.
- DON confirmed investigation did not begin until 05/05/25, nearly two weeks later.
- Policy required immediate investigation upon suspicion of neglect or elopement.
- Delayed investigation undermines:
 - Root cause identification.
 - System corrections.
 - Regulatory compliance.

Question 4: What investigation steps should have occurred immediately on 04/21/25?

Talking Points / Expected Answer:

- Initiate investigation the same day.
- Secure and review:
 - Video surveillance.
 - EIDC access log.
- Interview:
 - Staff involved.
 - Witnesses.
- Assess:
 - Door code access controls.
 - Lobby supervision practice.
- Notify:
 - Administrator.
 - SSA.
- Implement immediate protective actions (enhanced supervision, door monitoring).

Question 5: What environmental and system failures are evident in this case?

Talking Points / Expected Answer:

- Unknown visitor able to enter facility using door code.
- No staff monitoring the lobby at time of exit.
- Lack of safeguards preventing residents from following visitors out.
- Failure to recognize unsupervised lobby access as a risk area.
- Breakdown in communication between:
 - Frontline staff.
 - Nursing leadership.
 - Administrator.

Question 6: Why is leadership awareness critical in elopement and neglect cases?

Talking Points / Expected Answer:

- Administrator and DON must:
 - Ensure timely reporting.
 - Oversee investigations.
 - Implement corrective actions.
- Leadership unawareness signal:
 - Breakdown in reporting culture.
 - Failure of escalation processes.
- Surveyors expect leadership to:
 - Know about serious incidents.
 - Demonstrate active oversight.
 - Ensure regulatory timelines are met.

Question 7: What corrective actions should have been implemented to prevent recurrence?

Talking Points / Expected Answer:

- Immediate supervision of Resident #53.
- Reassessment of:
 - Elopement risk.
 - Behavioral health needs.
- Care plan updates with documented interventions.
- Review and restrict door code access.
- Staff re-education on:
 - Reporting requirements (F609).
 - Investigation expectations (F610).
- Monitoring compliance through audits.

Question 8: What are the key lessons for staff regarding reporting and investigations?

Talking Points / Expected Answer:

- Documentation alone is not reporting.
- Leadership must be notified—always.
- When in doubt, report.
- Elopement = potential neglect until proven otherwise.
- Investigations must begin immediately, not after surveyor discovery.
- Policies must be followed exactly as written.

Elopement and Wandering Prevention

Routine Safety Checks Auditing Tool

Daily Controls

(Frontline, every-shift accountability.)

- Door alarms tested and **audible** on all secured exits.
- Exits and stairwells **secured and unobstructed**.
- Rounding and/or head counts completed on **at-risk residents** per care plan.
- Alarm response times observed and **monitored for timeliness**.

Weekly Controls

(System reliability and environmental safety.)

- Wander-guard / electronic monitoring **battery checks** completed.
- Security lighting functioning (interior and exterior).
- Camera views verified for **clear visibility of exits and stairwells**.

Monthly Controls

(Compliance documentation and leadership oversight.)

- Resident photographs reviewed and updated (**≤ 12 months**).
- Door code access reviewed and **audited**.
- Night/evening environmental safety walk-round completed.
- Staff review of **safe-area boundaries** (units, courtyards, lobby access).

As Needed / Event-driven Actions

(Immediate risk mitigation.)

- Immediate corrective action for **any alarm or device malfunction**.
- Visitor and lobby access **actively monitored** during peak traffic times.
- Weather-related risk mitigation implemented (cold exposure, heat exposure, storms, power outages).

QAPI Oversight

(Quality monitoring, system learning, and leadership oversight.)

- Findings are trended through QAPI, including elopements and near-misses.
- Corrective actions are tracked for effectiveness and sustainability over time.
- Root Cause Analysis (RCA) completed for all elopements and near-misses.
- Resident elopement/wandering risk assessments completed (admission, quarterly, and with change in condition).
- Residents identified at risk have individualized, person-centered care plans.
- Care plans are updated after elopement events, near-misses, or condition changes.
- Staff education provided based on QAPI trends, events, or identified gaps.

Auditor Summary

Overall Compliance:

- Compliant
- Needs Improvement
- High Risk

Key Risks Identified:

Immediate Actions Required:

Administrator / DON Review:

Name: _____

Signature: _____

Date: _____



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