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Resident Elopement

Regulatory, Legal, and Risk Management Overview

OHCA 2025 Emergency Preparedness Leadership Summit | October 8, 2025

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Agenda

- What is Elopement?
- Regulatory Requirements
  - Federal
  - State
- Incident Reporting
- Case Law Review
- Risk Management Strategies

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Elopement

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What is Elopement?

- Elopement occurs when a resident leaves a home or safe area without the facilities knowledge or without supervision.
- A situation in which a resident with decision-making capacity leaves the home will not be considered an elopement unless the home has reason to suspect, or the circumstances surrounding the resident's departure indicate, that the departure is unusual or atypical.

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Why is this a critical issue?

- Resident Safety
- Regulatory Penalties
- Reputational Harm

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Common scenarios and risk factors

- Risk Factors:
  - Cognitive impairment
  - Dementia
  - History of wandering
  - Expressed desire to leave
- Common Scenarios:
  - Following visitors outside
  - Escaping through unsecured areas
  - Wandering unnoticed

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Regulatory Requirements

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Federal Requirements

42 CFR 483.20 Resident assessment.

- Each facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences, including residents' behavior patterns, physical functioning, customary routine, and psychosocial wellbeing.
- Comprehensive resident assessments are required:
  - Within 14 days after admission.
  - Within 14 days after facility determines or should have determined that there has been significant change in resident's physical or mental condition.
  - No less than once every 12 months.

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Federal Requirements

42 CFR 483.21 Comprehensive person-centered care planning.

- Care plans must consider and record the resident's preference and potential for future discharge.
- This could be an opportunity to note whether the resident is eager for discharge such that they may try to leave without authorization.

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Federal Requirements

42 CFR 483.71: Facility assessment.

- The LTC facility must conduct and document a facility-wide assessment. Must review and update as necessary and at least annually.
- Relevant requirements include:
  - The resident population
  - The number of residents and resident capacity
  - The care required by the resident population
  - The staff competencies and skill sets necessary to provide necessary care
  - The physical environment, equipment, services, and other physical plant considerations necessary to care for the resident population.
- The facility resources:
  - All buildings and other structures/vehicles
  - Equipment
  - Services provided
  - All personnel and their education/training/competencies related to resident care.
  - A facility-based and community-based risk assessment, utilizing an all-hazards approach

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Federal Requirements

42 CFR 483.73 Emergency preparedness.

- The LTC facility must have an emergency preparedness program. Relevant requirements include:
  - Emergency plan that must be reviewed at least annually. "Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents."
  - Policies and procedures based on the emergency plan, the risk assessment, and communication plan. Must review and update at least annually.
  - Must include a system to "track the location of on-duty staff and sheltered residence in the LTC facility's care during and after an emergency."
  - Communication plan, updated at least annually, must include the names, contact information, and means of communication for LTC facility staff; residents' physicians; volunteers; other LTC facilities; and various federal, state, tribal, regional, and local emergency preparedness staff and other agencies. It must also include a means for providing information about the location of residents under the facility's care.

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State Requirements

3701-17-10 Resident assessments; advanced care planning.

- Each nursing home must conduct written initial and periodic resident assessments. Must be performed by licensed health care professionals and be based on personal observation or judgement.
- Prior to admission, the facility will obtain each resident's medical history, which must be updated no more than five days prior to admission.
- Upon admission, the nursing home will conduct a detailed resident assessment, including their risk for elopement.
- A comprehensive assessment must be performed within 14 days after a new resident joins the facility, and at least annually thereafter, within thirty days of the anniversary date of the completion of the resident's last comprehensive assessment.
  - The comprehensive assessment must include the resident's risk of elopement.
- The facility must reassess each resident at least every three months, including a reassessment of the resident's risk of elopement.

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State Requirements

3701-17-14 Plan of care.

- A plan of care must be completed and implemented for each resident within 7 days of completion of the initial comprehensive assessment. It must be prepared by an interdisciplinary team. It must be reviewed whenever there is a change in a resident's condition, needs, or preferences, and at least quarterly.
- Each nursing home will provide adequate supervision of residents who are assessed for risk of falls, or elopement, or both.

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State Requirements

3701-17-19 Records and reports.

- Nursing homes must keep and maintain individual medical records for each resident. If a resident has been identified as being an elopement risk, the record for that resident must include a photograph of the resident, which must be updated annually.

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Incident Reporting

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Incident Reporting Requirements

- Facilities must investigate and document all incidents and subsequent investigations. In addition to being documented in the resident record, there must also be separate incident logs that include the time, place, and date of the incident; a general description; and the care response or action taken. (Ohio Administrative Code 3701-16-12(B).
- The operator must immediately report (via an electronic system prescribed by the director) resident elopement.
- As part of the required quality assurance and performance improvement (QAPI) program, each nursing home facility must track, conduct a root cause analysis, investigate, and monitor incidents, accidents, and events that occur in the home. (Ohio Administrative Code 3701-17-06).

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Incident Reporting

- If the elopement results in serious injury, harm, or a significant risk to the resident, the incident must be reported immediately to the Ohio Department of Health (ODH) and other relevant authorities. Immediate reporting typically means within 2 hours of the incident.
- For incidents that do not result in serious injury or harm but still pose a risk to the resident, the nursing home must report the elopement within 24 hours of the incident.
- The nursing home must document the incident, including the circumstances of the elopement, the actions taken to locate and return the resident, and any measures implemented to prevent future occurrences.

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Case Review

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Facts

- "R1" was admitted to Glenoaks for her "progressive confusion with dementia" and "occasional wandering and restless behavior." She was diagnosed with Alzheimer's along with anxiety, delusions, and behavioral disturbance; she was ambulatory and alert with impaired decision-making skills. All of this was known upon her admittance, even noted in her psychological services initial evaluation note.

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Facts

- Her plan of care, modified December 17, 2010, noted that she was at risk of elopement and included the following staff interventions:
  - monitoring doors for complete closure; frequently checking door alarms for proper working order; indicating to staff that R1 was at risk for elopement by putting a green identification bracelet on her; ensuring that R1 wore the green identification bracelet at all times; placing green stickers on the spine of R1's chart and Activities of Daily Living (ADL) record to identify her as an elopement risk; and including R1's name and photograph in the facility's elopement book, which was kept at the nurses' station.

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Facts

- On December 24, 2010, R1 exited the facility unauthorized and unsupervised. Some on-break staff members noticed her outside and notified two licensed practical nurses, who secured her. On December 27, Glenoaks discharged R1 to a senior care unit at a hospital because Glenoaks was not a "lockdown Alzheimer's unit" and did not have the capacity to deal with R1's behavior. Glenoaks reported the elopement to the state survey agency, prompting a January investigatory survey.

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Findings

- It was reasonably foreseeable that R1 would attempt to elope. Entries in the facility's nursing and social services notes and records and R1's care plan, from her arrival through her attempted elopement, noted her confused state and increasing signs of elopement behavior. She also repeatedly expressed a desire or reason to leave the facility. Some of the notes expressly recognized that "she is an elopement risk."
- The facility failed to take all reasonable measures to mitigate the reasonably foreseeable risk that residents would elope. Glenoaks primarily relied on a keycode lock system on its exit doors to prevent residents from eloping; however, it freely disseminated the door code to visitors so that they could leave the facility on their own. In addition to relying only on the keycodes and a bracelet system to prevent and detect elopements, Glenoaks failed to effectively and consistently utilize those tools. The keycode lock system was rendered an inadequate intervention because it was not secure and confidential.

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Findings

- In addition to being negligent, Glenoaks was also neglectful by failing to have policies that addressed the keycode locks, who had access to the codes, or how often the codes needed to be changed. "The lack of written policies and procedures addressing the keypad lock codes that they did not function as intended to deter residents from exiting the facility without supervision."
- Specific to R1, the facility failed to take preventative measures. Glenoaks put R1's name and photograph in an elopement book kept at the nurses' station and put a green bracelet on R1's wrist to visually label her as an elopement risk. Her care plan required staff to monitor exits for complete closure and check that she wore her bracelet at all times. Facility policy only required weekly bracelet checks, which is insufficient. Regardless of whether R1 was wearing her bracelet at the time, staff was not monitoring the exit doors or R1s whereabouts, and the facility only checked the locks and doors once per shift.
- Additionally, the posting of signs outside doors asking visitors not to let residents out is inadequate to mitigate the foreseeable risk of resident elopement. A resident could be taken as a visitor or could slip out behind a delivery person.

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Decision

- Upheld CMS and ALJ's decision to impose a CMP of $3,550 per day for the immediate jeopardy noncompliance period of December 24, 2010 – January 27, 2011) and $150 per day for the period of non-immediate jeopardy noncompliance (through February 17, 2011).
- Proposed additional/alternative measures Glenoaks should have instituted: nurse/staff desk near the primary exit, electronic monitoring/tracking, video surveillance, audible door alarms.

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Glenoaks Nursing Center, DAB 2522, at 3 (2013)

Key Takeaways

- If a facility is going to rely on keycodes for door security, codes must be confidential, and doors should be monitored at all times.
- If bracelets are used for identifying risk of elopement, staff must check that residents are wearing them at all times (as much as is reasonable).
- It is unwise to rely on only a few preventative measures.
- For all measures implemented, the facility should have written policies and procedures pertaining to how the measures will be utilized, maintained, and secured.

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Aase Haugen Homes, Inc., DAB 2013 (2006).

Facts

- Two instances of resident elopement involving residents who had been identified as "having a propensity for wandering and who had been provided with bracelets designed to trigger an alarm system if they exited the facility."
- First instance, facility was on generator power after a storm, the alarm was not triggered with Resident 22 eloped; found by a neighbor about 180 feet from the facility, who called the facility.
- Second instance, Resident 15 found across the street from the facility by another neighbor; the front door alarm had sounded but had been turned off after staff members checked the system and the surveillance monitor, failing to investigate further.

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Aase Haugen Homes, Inc., DAB 2013 (2006).

Findings

- Resident 22 – By identifying R22 as a "high risk" for elopement and assigning him a wrist alarm, Aase Haugen could not reasonably argue that they did not recognize that "given the opportunity, R22 would attempt an elopement." Additionally, this identification and use of alarm system created a duty for the facility to ensure that the system would be functional in the aftermath of a power failure.
- Resident 15 - The staff's silencing of the alarm and failure to investigate whether a resident had eloped beyond looking at the surveillance monitor were not reasonable responses "in light of the purpose of the alarms and the known risk of elopement they addressed." No staff members actually checked the front door, and Aase Haugen could not account for who turned off the alarm. A reasonable person faced with the situation would have known that it was necessary to take further steps to determine whether any resident had existed and whether the alarm was indeed false or not.

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Aase Haugen Homes, Inc., DAB 2013 (2006).

Decision

- Upheld ALJ's decision to impose a per instance CMP of $2,000.
- Aase Haugen has since implemented new policies requiring nursing staff to cover each other's breaks when monitoring wandering residence, instructing staff to respond to all alarms and to ensure that a resident triggering the alarm has been accounted for before doing "another thing." The new policies "were reasonable measures that could have been implemented earlier and would have greatly reduced the likelihood of staff responding inadequately to an alarm."

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Aase Haugen Homes, Inc., DAB 2013 (2006).

Key Takeaways

- ❖ Have adequate staff and procedures to monitor residents at risk of elopement
- ❖ Ensure the systems in place to monitor residents at risk for elopement actually work and have backup plans for technology failures.

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Woodstock Care Center v. U.S. Dept of Health & Human Services, 363 F.3d 583 (6th Cir 2003)

Facts

- Woodstock was an Ohio long term care facility. Half of its 43 residents were diagnosed with dementia and more than two-thirds displayed symptoms of dementia. After a survey and four site visits by inspectors from the Ohio Department of Health, the Health Care Financing Administration within HHS determined that Woodstock had allowed risky conditions to persist and was out of compliance.
- Woodstock had several instances of resident elopement.

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Woodstock Care Center v. U.S. Dept of Health & Human Services, 363 F.3d 583 (6th Cir 2003)

Facts

- R11 suffered from organic brain disorder, alcohol dependency, and seizures, and wore an electronic tracking device that triggered an alarm when it passed through external facility doors. He eloped twice. The first time he was missing for at least 80 minutes after he was determined missing; he was found in a ditch two miles away. After that, Woodstock installed a camera on a fence over which R1 escaped. Two weeks later, he was caught climbing the fence at 1am and returned when asked; he then attempted to climb the fence again at 2am; called the police at 2:40 am; and successfully climbed the fence and eloped at 4:45 am. He was found by staff wandering the streets at 5:30 am without shoes or coat. An alarm was installed on the fence on February 17 or 19 but did not become operational until March 15.
- R3, 81 years old and diagnosed with Alzheimer's and dementia, eloped when a visitor to the facility remembered R3 from when she had been a visitor of her husband and held open the door for her. She was on the streets for 45 minutes before staff found her.
- R5, 74 years old, diagnosed with Alzheimer's and dementia, and heavily medicated, became severely agitated when his medication was lowered to allow him to return to an active mental state. After demanding to leave, he escaped through an unlocked window opening to an unfenced area. He was returned thirty minutes later, with scratches.

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Woodstock Care Center v. U.S. Dept of Health & Human Services, 363 F.3d 583 (6th Cir 2003)

Findings

- Because Woodstock failed to enact heightened supervision of and other security precautions for residents at risk of elopement, "immediate injury" occurred. The eloping residents suffered minor injuries and "suffered the risk of more serious injuries."
- Woodstock argued that the elopements were intentional acts by the residents that cannot be characterized as accidents that the facility is at fault for. It is irrelevant whether they should be characterized as intentional or accidental, because the issue is whether Woodstock adequately supervised its residents – when a resident is able to elope, they are left without any supervision, so repeated elopements showcase inadequacy.
- Woodstock failed to take all reasonable precaution and was negligent for failing to restrain R11 after several escape attempts in one night and for keeping R5 in a room with a large unlocked window even though he was known to be at risk of elopement.

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Woodstock Care Center v. U.S. Dept of Health & Human Services, 363 F.3d 583 (6th Cir 2003)

Decision

- Affirmed HHS, the ALJ, and DAB's imposition of a $33,650 CMP.

Key Takeaways

- Immediate jeopardy does not require a showing of actual harm, only a likelihood of serious harm.
- Case mentions restraint:
  - Aside from emergency situations, nursing homes may not physically or chemically restrain a resident without a detailed written order of an attending physician, which must include a medical reason for restraint. (Ohio Administrative Code 3701-17-15(B).

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Overview of Standards

- 42 CFR 483.25(h)(2) Quality of Care: Facilities must provide "adequate supervision and assistance devices" to prevent accidents.
  - Standard: "the regulation obligates the facility to provide supervision and assistance devices adequate to meet the residents' assessed needs and to mitigate foreseeable risks of harm from accidents."
- Neglect: failure to implement reasonable measures to protect residents at risk of elopement has been found to constitute neglect, in violation of 42 CFR 483.13(c).
  - "Neglect" is the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 CFR 483.301.
  - "Noncompliance with section 483.13(c) can be based on either failure to develop policies or procedures adequate to prevent neglect, or failure to implement such policies.

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Overview of Standards

- CMS may impose a civil money penalty (CMP) for the number of days the facility is not in substantial compliance or for each instance of noncompliance. The amount of the CMP is in part based on the "seriousness" of the noncompliance. Both in "scope (whether it is "isolated," constitutes a "pattern," or is "widespread") and severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy")."
- The per-instance CMP can range from $1,000 to $10,000.
- If CMS imposes a per-day CMP, the CMP can range from $3,050 to $10,000 per day for noncompliance causing "immediate jeopardy" or from $50 to $3,000 per day for noncompliance that does not constitute "immediate jeopardy."

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Risk Management

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Discussion

- What are you using in your facilities?
- What has worked best for you?
- Any new technologies you are utilizing?

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Best Practices

- Comprehensive staff training
- Secure environments
- Resident monitoring
- Structured activities
- Clearly marked boundaries
- Advanced technologies
- Building structure
- Up to date policies and procedures
- Family education
- Back-up plans in emergencies

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Questions?

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