

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/14/2024
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF BILOXI			STREET ADDRESS, CITY, STATE, ZIP CODE 2279 ATKINSON ROAD BILOXI, MS 39531		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The State Agency (SA) conducted an investigation, MS #26122, a Facility Reported Incident (FRI), at the facility from 8/12/24 through 8/14/24 related to an elopement. During the survey, the SA determined the facility implemented corrective measures and was in compliance with the requirements for participation in Medicare and Medicaid. Based on the facility's implementation of corrective actions on 8/8/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 8/9/24, prior to the SA's entrance on 8/12/24. The facility's failure to provide supervision which resulted in Resident #1 exiting the facility unsupervised and unnoticed by facility staff. The facility had identified Resident #1 as a risk for wandering and elopement. Facility staff took Resident #1 to the therapy gym at approximately 9:50 AM on 8/8/24 and left the resident unattended to await therapy. Resident #1 was determined to be missing at approximately 9:55 AM and was found at 10:23 AM, about one (1) mile from the facility. During the investigation of the FRI, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 8/8/24. The IJ and SQC existed at: 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity "J."	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/20/2024

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.

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F 000	Continued From page 1 The IJ existed at: 42 CFR: 483.21(b)(1) Comprehensive Care Plans - F656 - Scope and Severity "J." This situation placed Resident #1 and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the past noncompliance at IJ and SQC on 8/13/24 at 3:00 PM and provided the Administrator with the IJ templates. At the time of survey, the facility was licensed for 180 beds and had a census of 134 residents.	F 000			
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656			

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F 656	Continued From page 2 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to implement care plan interventions related to wandering/elopement risk for one (1) of four (4) resident care plans reviewed. Resident #1. The facility's failure to implement care plan interventions resulted in Resident #1 exiting the facility unsupervised and unnoticed by facility staff. Facility staff took Resident #1 to the therapy	F 656	Past noncompliance: no plan of correction required.		

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F 656	Continued From page 3 gym at approximately 9:50 AM on 8/8/24. She was determined to be missing at 9:55 AM and was found at 10:23 AM, about one (1) mile from the facility. During the investigation, the SA identified an Immediate Jeopardy (IJ) which began on 8/8/24 and existed at 42 CFR: 483.21(b) Comprehensive Care Plans - F656 - Scope and Severity "J." This situation placed Resident #1 and other residents at risk for wandering and elopement, at risk for likelihood of serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ on 8/13/24 at 3:00 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 8/8/24, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed on 8/9/24, prior to the SA's entrance on 8/12/24. Findings Include: A review of the facility's policy, "Care Plans, Comprehensive Person-Centered," reviewed on 10/2022, revealed, "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ..." A record review of the Comprehensive Care Plan date initiated 6/28/24 revealed "Focus: I am an elopement risk/wanderer r/t (related to) impaired	F 656			

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F 656	Continued From page 4 safety awareness, I wander aimlessly ...Interventions/Tasks: Distract resident from wandering by offering pleasant diversions such as structured activities, food, conversation, television, book. Date initiated 06/28/2024 ..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 06/17/2024 with current diagnoses Altered Mental Status. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/24 revealed Section E identified that the resident wandered on one (1) to three (3) days, but the wandering was not considered to have a significant impact on the resident. A record review of the " ... Wander Evaluation" dated 06/28/2024 revealed the resident was at risk for wandering. A record review of the "Progress Notes" revealed that on 06/28/2024 at 3:48 PM, Social Services (SS) moved the resident to a new unit due to exit-seeking behavior on the Rehabilitation unit. A record review of the facility's investigation, "Resident Incident Timeline," revealed that on 08/08/24 at 9:55 AM, the staff identified that Resident #1 was not in the therapy gym where she had been escorted to receive therapy services. The staff were notified that the resident was missing. After searching the building and perimeter, it was determined that the resident had left the facility. The facility called a Code W (elopement) within the facility. The missing resident procedures were initiated, and the resident was located at 10:23 AM, approximately	F 656			

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F 656	Continued From page 5 1 mile from the facility, walking in a residential area. On 08/13/2024 at 1:30 PM, during an interview with Licensed Practical Nurse (LPN) #1, who was also the Care Plan Coordinator, she confirmed that Resident #1 was not identified as an elopement risk upon admission. However, following the 06/28/2024 Wander Evaluation, the resident was identified as being at risk. LPN #1 confirmed that Resident #1's care plan was individualized to ensure the resident's safety. She explained that care plans are designed to provide individualized care for residents and summarize a person's health condition, treatment, and care. She added that she expected all nursing staff in the facility to implement care plan interventions for the residents' safety. During an interview on 08/13/2024 at 2:00 PM with the Director of Nursing (DON), she confirmed that care plans are very important and should be individualized for each resident. She emphasized that care plans tell the story of the resident's condition and treatment plan. The DON stated that she expected the care plan nurse to perform correctly and individualize each resident's care plan, and for all care staff to follow the care plans. She confirmed that the facility staff failed to follow the care plan by not distracting and monitoring the resident as required. The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 8/12/24: On 8/13/2024 at 3:00 PM, the State Agency presented an IJ template which notified the	F 656			

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F 656	Continued From page 6 Administrator that the facility failed to provide supervision necessary to prevent an elopement for Resident #1, a vulnerable resident, who left the facility unnoticed and unsupervised and failed to implement care plan interventions related to wandering/elopement risks. On 8/8/2024 at 9:55 AM, the staff identified that the resident was not in the therapy gym where she was escorted to receive therapy services. The staff were notified that the resident was missing, after searching the building and perimeter, it was determined that the resident had left the facility. Missing resident procedures were initiated and the resident was located at 10:23 AM by the facilities FNP (Family Nurse Practitioner) and the SDC (Staff Development Coordinator) approximately 1 mile from the facility walking in a residential area. On 8/8/24 at 9:55 AM, RCNA (Rehabilitation Certified Nursing Assistant) noted that resident was not sitting in the chair by the rehab door. The CNA searched the therapy gym area then went back to the Serenity Unit to see if resident was there. Rehab CNA asked staff if resident had returned to the unit: staff noted resident had not returned. All staff immediately began to search for resident on the Serenity Unit. At this time the LPN #1 (Licensed Practical Nurse) on the unit directed all staff to conduct a search of all areas of the building and perimeter. On 8/8/24 at 10:00 AM, code W (elopement) initiated protocols which notified all staff to begin searching. Staff members were assigned by Administrator and DON (Director of Nursing) to search inside and outside of building. Staff members were directed to search the outside	F 656			

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F 656	Continued From page 7 perimeters in the direction of the woods and surrounding residential areas. On 8/8/24 at 10:23 AM, LPN #2 and the NP called DON to report the resident safely walking in a residential area about 1 mile east of the facility. Resident was returned to the facility at 10:30 AM. On 8/8/24 at 10:25 AM, staff completed a headcount compared to the daily census and accounted for all residents. On 8/8/24 at 10:30 AM, the Nursing Home Administrator notified state agency of the elopement. On 8/8/24 at 10:35 AM, the resident was returned to her unit, assessed by LPN #1 and a full body audit was completed. No signs or symptoms of injury, face was noted to be flushed, and resident took fluids cooperatively. NP assessed resident on unit, ordered labs, and UA (result negative). NP contacted the psychological NP for medication after ruling out acute episode. Resident is own Resident Representative (RR) and there was no next of kin to notify. On 8/8/2024 at 10:45 AM, the resident was assessed by the LSW (Licensed Social Worker) with no psychosocial harm found. On 8/8/24 at 11:00 AM, the Administrator and DON checked all doors and keypads for proper functioning. All were secure with no issues found. On 8/8/24 at 11:15 AM, the inside door code was changed and will be used for emergency exit only. Entrance and exit through therapy door are now restricted to visitors and staff. All visitors	F 656			

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F 656	Continued From page 8 must enter and exit through facility's main entrance. All staff must enter and exit through back door of facility. On 8/8/2024 at 12:00 PM, the Administrator notified the Attorney General's office of the incident. On 8/8/24 at 12:30 PM, Quality Assessment and Performance Improvement (QAPI) committee meeting was held involving missing resident. Staff in attendance were Medical Director, Administrator, Director of Nursing (DON), Assistant DON (ADON)/Infection Preventionist, Housekeeping Supervisor, Regional Nurse Consultant, Business Office Manager, Certified Dietary Manager, Social Services Director, Social Services Assistant, Admissions, Staff Development Coordinator, Medical Records. It was determined through staff interviews and resident interview that the resident exited the facility through the Rehabilitation (gym) door as visitors and staff frequently enter and exit these doors. Through root cause analysis by the DON and Administrator, we determined that the resident exited by following another person out the door before the door was able to close completely; the resident was sitting in a chair five feet from the door. The resident has been known to wander on her unit and exit seek. The resident also stated to the Social Worker on 8/8/24 during their interview that she "went for a walk" and exited the door. On 8/8/24 the QAPI committee reviewed the incident, actions taken, and the policy was reviewed with no recommendations for change. On 8/8/24, 100% facility staff in-service	F 656			

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F 656	Continued From page 9 completed by Staff Development Coordinator, ADON, and Housekeeping Supervisor began regarding elopement/missing resident policies prior to returning to work. On 8/8/24, 100% of all residents assessed for elopement risk by ADON and Staff Development. Twenty-seven new residents were added to elopement/wandering list. On 8/8/24, 100% audit performed of care plans for those identified for elopement risk to include visual monitoring and arm bands conducted by Regional Nurse Consultant. Twenty-seven new residents added to elopement/wandering list. On 8/8/24, 100% audit of wandering residents book completed by Social Services to ensure all pictures are current. On 8/8/24, Elopement drills were performed on all shifts (7A-3P, 3P-11P, 11P-7A) by the Director of Nursing and the Staff Development Coordinator. On 8/8/24, outside keypad to therapy door disabled and removed. Inside door code changed and will be used for emergency exit only. On 8/8/24, entrance and exit through therapy door is restricted to visitors and staff. All visitors must enter and exit through facility's main entrance. All staff must enter and exit through back door of facility. All corrective actions were completed on 8/8/24 and the facility alleges the IJ was removed on 8/9/24. Validation:	F 656			

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F 656	Continued From page 10	F 656			
F 689 SS=J	The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #26122 through record review and interviews on the 8/14/24. The SA determined all corrective actions were completed on 8/8/24 and the IJ was removed on 8/9/24. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, facility policy reviews, and the facility's investigation, the facility failed to provide adequate supervision to prevent Resident #1, who was identified as an elopement and wandering risk, from exiting the facility unnoticed and unsupervised for one (1) of four (4) residents reviewed. The facility's failure to provide supervision resulted in Resident #1 exiting the facility unsupervised and unnoticed by facility staff. Resident #1 was brought to the therapy gym at approximately 9:50 AM on 8/8/24 and left unattended. She was determined to be missing at 9:55 AM and was found at 10:23 AM, about one (1) mile from the facility. During the investigation, the SA identified an	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 11 Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 8/8/24 and existed at 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity "J." This situation placed Resident #1 and other residents at risk for wandering and elopement, likely for serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 8/13/24 at 3:00 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 8/8/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 8/9/24, prior to the SA's entrance on 8/12/24. Findings Include: A review of the facility's policy, "Accidents and Incidents," dated August 7, 2013, revealed, "Policy: It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and that residents receive supervision and assistance devices to prevent accidents whenever possible ..." A review of the facility's policy, "Emergency Procedure-Missing Resident," reviewed 03/2023, revealed, "Policy Statement: Resident elopement resulting in a missing resident is considered a facility emergency. Policy Interpretation and Implementation 1. Residents at risk for wandering and/or elopement will be monitored and staff will	F 689			

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NAME OF PROVIDER OR SUPPLIER THE PILLARS OF BILOXI				STREET ADDRESS, CITY, STATE, ZIP CODE 2279 ATKINSON ROAD BILOXI, MS 39531			
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F 689	Continued From page 12 take necessary precautions to ensure their safety ..." A record review of the facility's investigation, "Resident Incident Timeline," revealed that on 08/08/24 at 9:55 AM, the staff identified that Resident #1 was not in the therapy gym where she had been escorted to receive therapy services. The staff were notified that the resident was missing; after searching the building and perimeter, it was determined that the resident had left the facility. The facility called a Code W (elopement) within the facility. The missing resident procedures were initiated, and the resident was located at 10:23 AM, approximately 1 mile from the facility, walking in a residential area. Upon returning the resident to the facility, the Nurse Practitioner (NP) performed a thorough assessment, with labs and urinalysis performed. The resident's face was noted to be flushed, and the resident took fluids cooperatively. It was determined through staff and resident interviews that Resident #1 exited the facility through the Rehabilitation door, as visitors and staff frequently enter and exit through these doors. During an interview with the Administrator on 08/12/24 at 10:10 AM, it was confirmed that on 08/08/24 at approximately 10:00 AM, Resident #1 exited the facility through the rehabilitation unit and was located approximately 1 mile from the facility at 10:23 AM. The resident had been assisted to the therapy gym at approximately 9:50 AM by a Certified Nurse Aide (CNA) and she was sitting in her favorite chair looking outside the double doors. The NP and Licensed Practical Nurse (LPN) #2 found Resident #1 with a flushed face and brought her back to the facility. Resident #1 was calm while entering the automobile and			F 689			

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F 689	Continued From page 13 spoke about "robbing a bank." Upon returning to the facility, she was evaluated by the NP, with labs and urinalysis performed. Resident #1 drank water cooperatively. The weather on 08/08/24 at 10:00 AM was clear skies and a temperature of 92 degrees with no rain. The resident wore a cap, jeans, a short-sleeved shirt, a cardigan, and open-toe slides. Following the incident, all residents were accounted for, checked for any problems, and assessed for elopement risk. The resident had no family and was her own Responsible Representative (RR). The facility immediately notified the State Agency (SA) and Attorney General's Office (AGO). The facility began in-services for all staff on "Elopement." The Administrator confirmed they held an emergency Quality Assurance and Performance Improvement (QAPI) meeting and began implementing corrective actions. The Administrator stated the facility began to have additional elopement drills and in-serviced all employees on elopement and supervision of residents. The Administrator provided the SA with copies of the statements received regarding the investigation and the sign-in page of the QAPI meeting that was held on the afternoon of the incident to discuss the incident and steps needed to prevent this from happening again. The facility conducted an investigation and submitted it to the SA and AG office. Following their investigation, they determined there were no signs of abuse or neglect. Through a root cause analysis by the Director of Nursing (DON) and Administrator, it was determined that the resident exited by following another person out the door before the door was able to close completely; the resident was sitting in a chair five feet from the door. The resident had been known to wander on her unit and exhibit exit-seeking behavior.	F 689			

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F 689	Continued From page 14 During an interview with the DON on 08/12/24 at 10:20 AM, it was confirmed that Resident #1 was admitted to the facility on 06/17/24, was very weak, and was not initially identified as an elopement risk. She was admitted to the rehabilitation unit for therapy. During her stay, Resident #1 showed signs of improvement and began entering other residents' rooms, carrying laundry, and making/remaking beds. On 06/28/24, a second wandering evaluation was performed, and she was deemed a wandering risk. On 08/12/24 at 10:30 AM, during an interview and observation drive-through with LPN #2 of the route from the facility to the location where Resident #1 was found, the distance was determined to be 1.1 miles. LPN #2 pointed out where Resident #1 was found at the end of the sidewalk, and stated the resident was dressed in pants, a shirt, and a gray sweater with open-toe shoes. During the observation, there were sidewalks on either side of the road, but not on both sides. There were 3-4 cars on the road at the time of the observation. A large waterway was observed along one side of the route, with two signs indicating "Caution Alligators and Snakes May Be Present." It was confirmed that when Resident #1 was found, the NP assessed her and observed no injuries. LPN #2 confirmed that when it was determined that Resident #1 was missing from the facility, a Code "W" was called throughout the entire facility. All staff began to search for Resident #1, and the NP and LPN #2 started driving in search of her. LPN #2 drove west of the building for approximately one mile and found her at the end of the sidewalk.	F 689			

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F 689	Continued From page 15 On 08/12/24 at 10:52 AM, during an interview with Rehabilitation Certified Nurse Assistant #1 (R-CNA #1), she revealed that she learned Resident #1 was missing when walked from Resident #1's unit to the Rehabilitation unit and the Speech Therapist (ST) questioned if she had seen Resident #1, but she had not. After not locating Resident #1 in her unit, she immediately reported to the Administrator, and "Code W" was called, initiating a search for Resident #1. R-CNA #1 confirmed that Resident #1 always sat in the Rehabilitation Unit facing the double doors. She also confirmed that outpatients, staff, and families frequently used the rehab door. On 08/12/24 at 1:05 PM, during an interview with the Maintenance Director, it was revealed that he checked all doors daily, and all doors closed and locked as required. All doors to enter or exit the building required a code. Since the incident with Resident #1, the facility removed the numeric keypad from outside the door to prevent staff and visitors from entering unless a staff member inside the facility let them in. On 08/13/24 at 1:01 PM, during an interview with the Social Worker (SW), it was confirmed that on 06/28/24, when Resident #1 showed signs of wandering, a second wandering evaluation was performed, and the facility then placed Resident #1 in another unit. On 8/13/24 at 1:59 PM, during an interview with CNA #2, she confirmed she assisted Resident #1 to the therapy gym on 8/8/24 at approximately 9:50 AM. She was aware the resident was an elopement risk, and she advised the therapy staff the resident was sitting in her favorite chair waiting for therapy services.	F 689			

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F 689	Continued From page 16 A record review of the weather report from the website https://www.wunderground.com/calendar/us/ms/biloxi/KGPT revealed that it was 92 degrees on 08/08/24 at 10:00 AM. A record review of the "Admission Record" revealed that the facility admitted Resident #1 on 06/17/24 with current diagnoses including Altered Mental Status. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/24 revealed a Brief Interview for Mental Status (BIMS) score was five (5), indicating that the resident was cognitively impaired. A review of Section E, which addressed behavior, showed that the resident wandered on one (1) to three (3) days, but the wandering was not considered to have a significant impact on the resident. A record review of the "Progress Notes" revealed that on 06/28/24 at 3:48 PM, social services moved Resident #1 to a new unit due to exit-seeking behavior on the Rehabilitation Unit. A record review of the "Wander Evaluation" dated 06/17/24 revealed the Resident #1 was not at risk for wandering. A record review of the "Wander Evaluation dated 06/28/24 revealed Resident #1 was identified as at risk for wandering as she had grown stronger and was able to ambulate independently on the unit. She expressed a desire to "go home which formerly was Tent city for homeless."			F 689			

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F 689	Continued From page 17 The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 8/12/24: On 8/13/2024 at 3:00 PM, the State Agency presented an IJ template which notified the Administrator that the facility failed to provide supervision necessary to prevent an elopement for Resident #1, a vulnerable resident, who left the facility unnoticed and unsupervised and failed to implement care plan interventions related to wandering/elopement risks. On 8/8/2024 at 9:55 AM, the staff identified that the resident was not in the therapy gym where she was escorted to receive therapy services. The staff were notified that the resident was missing, after searching the building and perimeter it was determined that the resident had left the facility. Missing resident procedures were initiated and the resident was located at 10:23 AM by the facilities FNP (Family Nurse Practitioner) and the SDC (Staff Development Coordinator) approximately 1 mile from the facility walking in a residential area. On 8/8/24 at 9:55 AM, RCNA (Rehabilitation Certified Nursing Assistant) noted that resident was not sitting in the chair by the rehab door. The CNA searched the therapy gym area then went back to the Serenity Unit to see if resident was there. Rehab CNA asked staff if resident had returned to the unit: staff noted resident had not returned. All staff immediately began to search for resident on the Serenity Unit. At this time the LPN #1 (Licensed Practical Nurse) on the unit directed all staff to conduct a search of all areas of the building and perimeter.	F 689			

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F 689	Continued From page 18 On 8/8/24 at 10:00 AM, code W (elopement) initiated protocols which notified all staff to begin searching. Staff members were assigned by Administrator and DON (Director of Nursing) to search inside and outside of building. Staff members were directed to search the outside perimeters in the direction of the woods and surrounding residential areas. On 8/8/24 at 10:23 AM, LPN #2 and the NP called DON to report the resident safely walking in a residential area about 1 mile east of the facility. Resident was returned to the facility at 10:30am. On 8/8/24 at 10:25 AM, staff completed a headcount compared to the daily census and all residents were accounted for. On 8/8/24 at 10:30 AM, the Nursing Home Administrator notified state agency of the elopement. On 8/8/24 at 10:35 AM, the resident was returned to her unit, assessed by LPN #1 and full body audit was completed. No signs or symptoms of injury, face was noted to be flushed, and resident took fluids cooperatively. NP assessed resident on unit, ordered labs, and UA (resulted negative). NP contacted the psychological NP for medication after ruling out acute episode. Resident is own Resident Representative (RR) no next of kin to notify. On 8/8/2024 at 10:45 AM, the resident was assessed by the LSW (Licensed Social Worker) with no psychosocial harm found. On 8/8/24 at 11:00 AM, the Administrator and DON checked all doors and keypads for proper			F 689			

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F 689	Continued From page 19 functioning, all were secure with no issues found. On 8/8/24 at 11:15 AM, inside door code changed and will be used for emergency exit only. Entrance and exit through therapy door are now restricted to visitors and staff. All visitors must enter and exit through facility's main entrance. All staff must enter and exit through back door of facility. On 8/8/2024 at 12:00 PM, the Administrator notified the Attorney General's office of the incident. On 8/8/24 at 12:30 PM, Quality Assessment and Performance Improvement (QAPI) committee meeting was held involving missing resident. Staff in attendance were Medical Director, Administrator, Director of Nursing (DON), Assistant DON (ADON)/Infection Preventionist, Housekeeping Supervisor, Regional Nurse Consultant, Business Office Manager, Certified Dietary Manager, Social Services Director, Social Services Assistant, Admissions, Staff Development Coordinator, Medical Records. It was determined through staff interviews and resident interview that the resident exited the facility through the Rehabilitation (gym) door as visitors and staff frequently enter and exit these doors. Through root cause analysis by the DON and Administrator, we determined that the resident exited by following another person out the door before the door was able to close completely; the resident was sitting in a chair five feet from the door. The resident has been known to wander on her unit and exit seek. The resident also stated to the Social Worker on 8/8/24 during their interview that she "went for a walk" and exited the door.	F 689			

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F 689	Continued From page 20 On 8/8/24 the QAPI committee reviewed the incident, actions taken, and the policy was reviewed with no recommendations for change. On 8/8/24, 100% facility staff in-service completed by Staff Development Coordinator, ADON, and Housekeeping Supervisor began regarding elopement/missing resident policies prior to returning to work. On 8/8/24, 100% of all residents assessed for elopement risk by ADON and Staff Development. Twenty-seven new residents added to elopement/wandering list. On 8/8/24, 100% audit performed of care plans for those identified for elopement risk to include visual monitoring and arm bands conducted by Regional Nurse Consultant. Twenty-seven new residents added to elopement/wandering list. On 8/8/24, 100% audit of wandering residents book completed by Social Services to ensure all pictures are current. On 8/8/24, Elopement drills were performed on all shifts (7A-3P, 3P-11P, 11P-7A) by the Director of Nursing and the Staff Development Coordinator and will continue for 4 weeks then monthly for QAPI review and recommendations. Any findings will be addressed immediately by the Administrator or DON. On 8/8/24, outside keypad to therapy door disabled and removed. Inside door code changed and will be used for emergency exit only. On 8/8/24, entrance and exit through therapy			F 689			

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F 689	Continued From page 21 door is restricted to visitors and staff. All visitors must enter and exit through facility's main entrance. All staff must enter and exit through back door of facility. All corrective actions were completed on 8/8/24 and the facility alleges the IJ was removed on 8/9/24. Validation: The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #26122 through record review and interviews on the 8/14/24. The SA determined all corrective actions were completed on 8/8/24 and the IJ was removed on 8/9/24.	F 689			