

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER St Sophia Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 936 Charbonier Road Florissant, MO 63031	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>30687</p> <p>Based on interview and record review, the facility failed to administer a medication prescribed for cancer treatment for one resident (Resident #5). The sample was six. The census was 177.</p> <p>Review of the facility's Medication Administration General Guideline, dated August 2014, showed the following:</p> <p>-Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;</p> <p>-Procedures:</p> <p>-Administration</p> <ol style="list-style-type: none"> 1. Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications; 2. Medications are administered in accordance with written orders of the prescriber. <p>Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/20/23, showed the following:</p> <p>-Moderate cognitive impairment;</p> <p>-No moods or behaviors;</p> <p>-Supervision with activities of daily living;</p> <p>-Diagnoses of anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), congestive heart failure, high blood pressure, dementia and depression.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's current care plan, showed the facility did not identify the resident's diagnosed cancer.</p> <p>Review of the resident's nurse's note, dated 11/16/23 at 12:49 P.M., showed the resident returned from his/her doctor's appointment with a new order for Capecitabine (Xeloda, an orally-administered chemotherapeutic agent used in the treatment of metastatic breast and colorectal cancers), 500 milligrams (mg) take four tablets twice a day for 14 days starting on 11/20/2023. The resident has a follow up appointment scheduled.</p> <p>Review of the resident's Medication Administration Record (MAR), dated November 20, 2023 through December 4, 2023, showed the following order:</p> <ul style="list-style-type: none"> -Capecitabine 500 mg take four tablets twice a day for cancer until 12/4/23; -Staff initialed administration of the medication. <p>Review of the resident's After Visit Summary, dated 11/16/23, showed a follow up appointment for 12/7/23.</p> <p>Review of the resident's physician's appointment note, dated 12/7/23, showed the following:</p> <ul style="list-style-type: none"> -Status: Appointment canceled; -Reason for cancellation: Resident tested positive for Coronavirus disease (COVID-19, an infectious disease caused by the SARS-CoV-2 virus). <p>Review of the resident's medical record, showed no documentation of the resident's COVID diagnosis and no documentation of the cancellation of the appointment.</p> <p>Review of the resident's After Visit Note, dated 12/14/23, showed the following:</p> <ul style="list-style-type: none"> -Order Source: Oncology Chemotherapy Treatment: Capecitabine 14 days on and seven days off; -Capecitabine (Xeloda) 500 mg oral tablet; -Take four tablets (2,000 mg) by mouth two times a day for 14 days; -Start date: 12/18/23; -End date: 01/01/24 after 28 doses. <p>Review of the resident's medical record, showed no documentation of this order and no documentation of the resident going or returning from this physician's appointment.</p> <p>Review of the resident's MAR, dated December 2023 and January 2024, showed no documentation of this order.</p> <p>Review of the resident's After Visit Summary, dated 1/25/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-7:44 P.M., the resident returned from hospital via ambulance and was transferred from the stretcher to his/her bed without incident. There were no new orders received.</p> <p>Review of the resident's medical record, showed no documentation of the resident going to the cancer center for an appointment and no documentation of the facility contacting the cancer center to reschedule the appointment or additional orders or instructions.</p> <p>During an interview on 5/10/24 at 9:14 A.M., the Social Worker at the cancer center said on 12/23 the resident had a Carcinoembryonic Antigen (CEA) blood Level of 5.7. On 5/9/24 the resident's blood level was 37.9. This test is a cancer marker.</p> <p>Review of the resident's CEA lab result, date 5/9/24, showed the following:</p> <p>-11/16/23, CEA level of 5.7;</p> <p>-3/14/24, CEA level of 36.2;</p> <p>-5/9/24, CEA level of 37.9.</p> <p>-Normal level 0.1-5.0 nanograms per milliliter (ng/mL)</p> <p>During an interview on 5/10/24 at 11:53 A.M., Licensed Practical Nurse (LPN) A said when a resident comes back from a doctor's appointment, the resident will have paperwork or the doctor will fax new orders. The information is given to the Assistant Director of Nursing (ADON). LPN A said he/she did not know what happens after it was given to the ADON.</p> <p>During an interview on 5/10/24 at 11:55 A.M., ADON B said the paperwork and orders are audited and any new appointments are transferred to the appointment sheet. He/She said he/she was behind getting the paperwork into the resident's medical record.</p> <p>During an interview on 5/10/24 at 12:00 P.M., the resident said he/she goes for cancer treatments and they are going fine.</p> <p>During an interview on 5/17/24 at 10:27 A.M., Pharmacy Representative (PR) C said he/she showed no documentation of an order for Capecitabine or Xeloda for 12/18/24 or 2/19/24. The last order for the medication was on 1/25/24, which was filled.</p> <p>During an interview on 6/3/24 at 1:07 P.M., the Director of Nursing (DON) said the Charge Nurse should transcribe the orders from the resident's after visit summary into the medical record and contact the responsible party and make them aware of the new orders. The DON said if the resident had a previous cancer treatment order, the Charge Nurse contacted the physician's office to ensure the order was discontinued. The DON said all of this information, including a resident going and returning from an appointment, should be documented in the resident's medical records.</p> <p>During an interview on 5/28/24 at 7:58 A.M., Primary Care Physician (PCP) D said he/she expected the resident's medication to be ordered in a timely manner and administered as ordered. PCP D said the medication is for the treatment of cancer. The resident's cancer has spread and the medication slows the spread of the cancer.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/14/24 at 2:05 P.M., the resident's Oncologist said the resident has colon cancer. The Capecitabine was a chemo therapy medication and was to prevent the reoccurrence of the cancer. The Oncologist said when the CEA numbers increase, they will do a CT scan to see if there was a reoccurrence of the cancer in other areas. The Oncologist said CT scans were completed in December 2023 and February 2024 and there were no concerns of reoccurrence. The Oncologist said he/she was not aware the resident did not get the medication as prescribed in December and February. He/She would have expected the facility to administer the medication as ordered or contact him/her with any concerns or questions.</p> <p>MO00235896</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34477</p> <p>Based on observation, interview and record review, the facility failed to provide protective oversight to one of three sampled residents identified by the facility as at risk for elopement. Resident #8, who resided on the facility's secured unit, had diagnoses of Alzheimer's disease and schizophrenia (a serious mental health condition that affects how people think, feel and behave) and was assessed to have moderate cognitive impairment. The resident had a known history of elopement and was admitted to the facility due to elopements while at home. During routine rounds, staff who were assigned to the resident failed to visibly check for confirmation of the resident's whereabouts. The resident left the building without staff knowledge and remained out of the building for approximately four hours before staff realized the resident was missing. The resident was found 12 hours later, approximately two miles away from the facility and had to cross a busy intersection to arrive at the location he/she was found. The census was 160.</p> <p>The Administrator was notified on 7/18/24, of the Immediate Jeopardy (IJ) past non-compliance which began on 7/12/24. The facility educated all nursing staff on visual checks during rounds, educated all staff on the facility's elopement policy and procedures, completed an audit of all residents at risk for elopement and updated care plans accordingly, performed an elopement drill, and audited all windows and alarmed doors. The deficiency was corrected on 7/15/24.</p> <p>Review of the facility's Essential Functions of Certified Nurse Aide (CNA), revised 1/2024, included:</p> <ul style="list-style-type: none"> -Notes observations of resident behavior, complaints, or symptoms and communicates immediately to nursing supervisors any known or suspected changes in residents' condition; -Follows all company policies and procedures; -Other duties as assigned. <p>Review of the facility's Missing Resident/Elopement policy, last revised on 4/26/24, showed:</p> <ul style="list-style-type: none"> -Policy: The Charge Nurse is responsible for knowing the location of their assigned residents. Residents who are participating in various programs such as Physical Therapy, Recreational Activities, Dining, etc., the employees in these programs will be responsible for the location of their participants; -Responsibility: All employees, interdisciplinary team (IDT) Members, Nursing Administration, Director of Nursing (DON) and Licensed Nursing Home Administrator; -Procedure: -It is the responsibility of all employees to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse immediately; <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-At any time in which a resident is determined missing, the following procedure will be followed:</p> <p>-The Supervisor/Charge Nurse will alert all personnel by all-paging Code Gray and location (including Unit and Room Number);</p> <p>-A search of the immediate area will be initiated under the direction of the Nursing Supervisor/Charge Nurse;</p> <p>-A search will be conducted of all rooms including locked rooms;</p> <p>-The Nursing Supervisor/Charge Nurse will designate employees to search the surrounding building as appropriate (patio, parking lot, etc.);</p> <p>-If the search of the immediate area (building) is unsuccessful, the Nursing Supervisor/Charge Nurse will immediately contact the Administrator and DON, local police department, family/responsible party, Regional Nurse and Director of Operations, attending physician and Department of Health and Senior Services (DHSS).</p> <p>Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 5/18/24, showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Wandering behaviors not exhibited;</p> <p>-Frequently incontinent of bowel and bladder;</p> <p>-Once standing, ability to walk 150 feet in a corridor or similar space: Supervised or touching assistance. Helper provides verbal cues or touch/steadying assistance;</p> <p>-Diagnoses included: Alzheimer's disease, schizophrenia, high blood pressure, and diabetes.</p> <p>Review of the resident's undated care plan, in use during the investigation, showed:</p> <p>-Focus: Resident has impaired cognitive function/dementia. Resident carries a baby doll around;</p> <p>-Goal: Will maintain current level of cognitive function;</p> <p>-Interventions: Administer meds as ordered. Identify self at each interaction. Face resident when speaking;</p> <p>-Focus: At risk for elopement as evidenced by: History or wandering;</p> <p>-Goal: Will not leave the facility unattended;</p> <p>-Interventions: Identify pattern of elopement. If resident exits the building, do not leave unattended, walk with resident and/or keep within eye sight. Monitor location closely.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's April, May, and June 2024 Elopement Risk Evaluations, showed:</p> <ul style="list-style-type: none"> -At risk; -Does the resident have a history of elopement or an attempted elopement while at home? Yes; -Does the resident have a history of attempting to leave the facility without informing staff? Yes; -Does the resident wander? Yes; -Is the wandering behavior a pattern, goal directed (i.e. specific destination in mind, going home, etc.)? Yes. <p>Review of the resident's progress notes, showed:</p> <ul style="list-style-type: none"> -Nursing note on 4/17/24 at 7:19 P.M., Resident actively exit seeking and pushing on doors. Resident becoming increasingly agitated. Resident redirected to his/her room. Medical doctor notified; -Nursing note on 7/12/24 at 5:41 P.M., Resident refused medications this evening x 3, family member informed; -Administration note on 7/12/24 at 11:27 P.M., Received a call that resident was not in his/her room upon rounds at approximately 10:45 P.M. Facility conducted facility wide and surrounding area checks with no results. Resident noted to refuse medication today. Resident belongings noted on his/her bed and covered with blanket and remain in his/her room at this time. Resident's Power of Attorney (POA, a legal document that allows someone to act on the behalf of someone else), medical doctor, and local police notified and search continued; -Nursing note on 7/13/24 at 6:15 A.M., Resident returned to facility accompanied by local police officer. Resident currently sitting in TV area waiting for family to arrive, family stated they're going to take him/her to the hospital for observation. Police officer is still waiting with resident until family arrives. Management made aware of resident return. <p>Review of the facility's completed investigation, dated 7/13/24, included:</p> <ul style="list-style-type: none"> -On 7/12/24 at approximately 10:15 P.M., staff reported they entered the resident's room, called out to him/her with no reply they then approached the bed and pulled back the covers and noticed the resident was not in his/her bed. Staff searched his/her room as well as the unit and immediately initiated a Code Gray. The Administrator, DON and Assistant Director of Nursing (ADON) were notified. Staff then initiated a facility wide search including the grounds and surrounding community. The doctor, POA and police were made aware of the situation; -Weather report checked (which was 73 degrees); <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Upon completion of the investigation, the window in the dining room appeared tampered with (retaining screws removed and screen torn) therefore, it was determined the resident exited the facility through the dining room window of the unit. During an interview Licensed Practical Nurse (LPN) C reported he/she observed the resident in the dining room with another resident at approximately 6:00 P.M. LPN C indicated he/she did not observe the resident exit seeking during the shift. LPN C recalled the resident ambulating between his/her room and the dining room, cleaning tables. During an interview with CNA D, he/she explained he/she last saw the resident in his/her room between 5:45 P.M. and 5:55 P.M. According to CNA D, the resident did not exhibit exit seeking behaviors during his/her shift;</p> <p>-During staff interview with CNAs B and A, they said at approximately 8:30 P.M., they were making their rounds and noticed what appeared to be the resident lying in bed with his/her blanket covering him/her. According to the CNAs, the resident is continent of bowel and bladder and appeared to be comfortable; without disturbing the resident they went to assist the other residents on the unit. During staff interviews with CNAs B and A, they explained they work together on their assignments and during their first rounds they noticed what they thought was the resident lying in his/her bed and it was not until their second round at approximately 10:15 P.M., they realized what they thought was the resident was actually his/her pillow and his/her multiple baby dolls covered with the resident's blanket. Upon searching, the resident was not in his/her room or on the unit, therefore a Code Gray was initiated;</p> <p>-On 7/13/24 the resident was located safely and escorted back to the facility at 6:15 A.M. Attempted to interview the resident regarding leaving the facility, however the resident was unable to provide any information.</p> <p>Observation of the facility's surveillance video on 7/17/24 at 10:52 A.M., showed:</p> <p>-The surveillance camera faced the back of the facility;</p> <p>-At approximately 6:11 P.M. on 7/12/24, the resident could be seen walking into the line of sight of the camera;</p> <p>-The resident quickly walked past the back of the building and continued up the driveway towards the front of the building, outside of the camera's line of sight;</p> <p>-The resident wore jeans, a t-shirt, a hoodie, and shoes.</p> <p>Review of www.timeanddate.com for temperatures in Florissant, MO on 7/12/24 and 7/13/24, showed:</p> <p>-At 6:51 P.M. on 7/12/24, the temperature was 86 degrees Fahrenheit (F);</p> <p>-At 5:51 A.M. on 7/13/24, the temperature was 76 degrees F.</p> <p>Review of the resident's progress notes, showed:</p> <p>-Nursing note on 7/13/24 at 6:54 A.M., No injuries noted, no signs/symptoms of acute distress. Resident was in good spirits, upbeat, smiling and seemed happy to be back;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Social Services (SS) note on 7/13/24 at 11:23 A.M., SS met with resident to see how he/she was doing and to discuss recent behaviors. Due to illness resident gets confused at times. Resident was able to state he/she was well and appeared in a positive mood. Resident was unable to discuss recent behaviors. Resident did not appear to be displaying any exit seeking behaviors at this time. Resident is currently on 1:1 with staff. SS will continue 1:1 three times a week for four weeks. There were no further concerns with resident at this time per nurse. Resident will be monitored accordingly.</p> <p>Observation and interview of the resident, showed:</p> <p>-On 7/17/24 at 9:25 A.M., the resident sat in a wheelchair in the doorway of his/her room. The resident had two baby dolls on his/her lap. He/She appeared calm and engaged with the baby dolls;</p> <p>-On 7/28/24 at 9:18 A.M., the resident sat in a chair by the nurse's station. He/She was rocking a baby doll back and forth. The resident introduced his/her baby to the surveyor. The resident said he/she had lived at the facility here and there two times. The resident said he/she had siblings. The resident's brother took the resident out and was coming later that day. The resident said it wasn't easy being at the facility. He/She denied ever leaving the facility alone. The resident said he/she would tell them, and pointed to the nurse's station, if he/she was going to leave.</p> <p>During an interview on 7/17/24 at 11:53 A.M., LPN C said he/she worked the 7:00 A.M. to 7:00 P.M. shift on 7/12/24. The last time LPN C saw the resident, was at approximately 5:50 P.M. The resident was in the dining room with his/her hands on the table and holding his/her baby dolls. LPN C was surprised when he/she heard the resident eloped. The resident had not displayed exit seeking behavior in the last 30 days. LPN C did not know the window could be lifted all the way up. There was an elopement book at the nurse's station that lists residents at risk for elopement. If a resident could not be found, they were to call a Code Gray. LPN C said staff were expected to complete rounds every two hours and lay eyes on the residents assigned to staff. The resident is now on 1:1 with staff and staff are also completing 15 minute checks.</p> <p>During an interview on 7/17/24 at 12:19 P.M., CNA D said he/she was familiar with the resident. The resident was always quiet and to himself/herself. The resident liked to stay in his/her room, at a chair by the nurse's station or in the dining room. CNA D had observed the resident fiddle with the blinds in his/her room and look outside, but had never observed the resident mess with the window. CNA D worked the 7:00 A.M. to 7:00 P.M. shift on 7/12/24. CNA D was aware the resident was exit seeking. He/She last saw the resident on 7/12/24 between 5:50 P.M. and 5:55 P.M. The resident was in his/her room with his/her baby dolls. When staff completed rounds, they should lay eyes on every resident on their assignment. If a resident wasn't in their room, CNA D would go look for them.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER St Sophia Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 936 Charbonier Road Florissant, MO 63031	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/18/24, CNA B said he/she had worked the 7:00 P.M. to 7:00 A.M. shift and the resident was usually on his/her assignment. The resident usually stayed in his/her room, sat by the nurse's station or sat in the dining room. CNA B had never known the resident to try to get out. He/She had never seen the resident fiddle with the windows at all. CNA B was shocked when he/she found out the resident left through a window. The CNAs who work the day shift are always gone when the night shift CNAs begin work. The nurse provided information about the residents during report at shift change. CNA B did not see the resident at the start of his/her shift on 7/12/24. All of the residents were up at the beginning of the shift. The first time he/she checked on the resident, CNA B peeked his/her head into the resident's room. The resident appeared to be asleep. The second time CNA B checked on the resident, he/she thought maybe the resident needed a drink, so CNA B pulled back the cover and saw the resident wasn't there. The first time CNA B checked on the resident, he/she did not go in the room. Once the resident was discovered to be missing, a Code Gray was called. They checked all resident rooms, bathrooms, shower rooms and opened all doors. He/She checked the windows in resident rooms, but did not check the windows in the dining room. The ADON then called the police. CNA B did not know what the resident was wearing because he/she had not seen the resident at all during his/her shift.</p> <p>During an interview on 7/18/24 at 6:33 A.M., CNA A said he/she was familiar with the resident and said the resident was pretty independent. When he/she started his/her shift, the CNAs from the earlier shift had already left. CNA A would get report from the nurse or the Certified Medication Technician (CMT). That night, the CMT came to the hall at 10:30 P.M., but should have been there at 7:00 P.M. CNA A and CNA B usually completed rounds together. The resident's routine varied in the evening. He/She usually sat by the nurse's station. The night of 7/12/24, the resident appeared to be asleep, so he/she did not wake the resident. The second time they completed rounds, they were going to offer the resident water and snacks. They pulled back the covers and the resident was not there. After checking resident rooms, bathrooms and the dining room, a Code Gray was called. CNA A had not seen the resident all shift and did not know what the resident wore. CNA A asked a CMT what the resident had on and was told blue jeans and a black shirt. CNA A was aware he/she should do visual checks on residents when completing rounds.</p> <p>During an interview on 7/18/24 at 9:12 A.M., the Maintenance Director said the maintenance team checks the windows throughout the facility on a monthly basis. He said sometimes when lifting up and down, the screws in place to prevent the window from opening more than four inches are worn down. He may have missed this window during the monthly checks. The resident had torn the blinds down in his/her room in the past, but had not ever messed with the window or the screen.</p> <p>During an interview on 7/17/24 at 10:52 A.M., the Administrator said the resident was admitted to the facility after he/she tried to elope from home while living with a family member. She was not aware of the resident exhibiting any exit seeking behaviors at the facility. Staff knew the resident was an elopement risk, and his/her room was nearest to the nurse's station as an added prevention. They assumed the resident left the building through a window in the dining room on the secured unit. This was based on what the camera showed, and an opened window with torn screen in the dining room. Staff did not realize the resident was out of the building until 10:15 P.M. The resident was found by police near a hospital, approximately two miles away. The resident returned to the facility at 6:15 A.M. on 7/13/24. The Administrator said she never told staff specifically to visually verify a resident when making rounds, but that was the expectation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/24 at 2:43 P.M., the Medical Director said he was made aware of the resident's elopement immediately. This incident was very out of the ordinary. He expected staff to visually check on residents when doing rounds.</p> <p>During an interview on 7/23/24 at 12:47 P.M., the resident's POA said prior to coming to the facility, the resident lived alone. After the resident had moved into the facility, the POA took the resident out on a visit and the resident walked away. He/She had been made aware of the resident's elopement by the facility on 7/12/24 between 10:30 P.M. and 11:00 P.M. The POA thought the resident was at the facility in a locked unit for his/her safety. The POA and another family member came to the facility the night of 7/12/24 and helped search for the resident. Law enforcement informed him/her the resident had been found between 5:30 A.M. and 6:00 A.M. on 7/13/24.</p> <p>MO00238922</p> <p>MO00238924</p> <p>-</p>