STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37781 Based on interviews, record reviews and review of the facility policy, the facility neglected to identify and acknowledge that Resident (R)3 was missing from the facility. The facility further failed to implement emergency protocol in a timely manner in order to locate the missing resident. On 11/18/24 at 3:15 PM, the Administrator was notified that the facility neglected to acknowledge a resident was missing from the facility and implement emergency protocol timely for locating the missing resident, which constituted IJ at F600. On 11/18/24 at 3:15 PM, the survey team provided the Administrator with a copy of the CMS IJ Templates, informing the facility IJ existed as of 11/04/24. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation. On 11/19/24 the facility provided an acceptable IJ Removal Plan for F600. On 11/19/24, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The IJ is considered at Past Non-Compliance as of 11/07/24. An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care. Findings Include: Review of the facility policy titled, Elopement, with a revision date of 11/1/17 states, to safely and timely redirect patients/residents to a safe environment. Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to: depression, cognitive communication deficit, acquired absence of left leg above knee, and unspecified psychosis not due to a substance or known physiological condition. Review of R3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating R3 had moderate cognitive impairment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R3's Elopement Risk Observation dated 11/07/24 revealed, Resident is not oriented to person, place and time. Resident is confused. Does not have safe decision-making capabilities. Wanderguard placed on right ankle. Review of R3's Decisional Making Capacity Form located in his Electronic Medical Record revealed an undated document with R3's name on it. There was a slash across the form. Review of the Facility's 5 Day Reportable revealed R3 was taken from the facility on 11/04/24 between 1:00 PM - 2:00 PM. R3 was last seen sitting in his wheelchair on the front porch of the facility after lunch, which is his usual routine. On 11/04/24 at 5:30 PM, R3 was noted to not be available for his afternoon medications or dinner. Staff assumed R3 was visiting friends in the facility. R3 was not reported as potentially missing to the Administrator or the Police within 30 minutes as required by the facility's policy. An attempt was made to interview R3 on 11/18/24 at 11:38 AM with no success. A second attempt was made to interview R3 on 11/19/24 at 9:15 AM and 11:00 AM, with no success. Observations of R3 during these times revealed a wanderguard bracelet in place to R3's ankle. During an interview with the Medical Records Clerk on 11/18/24 at 11:57 AM, she stated she is responsible for setting up transport for appointments. She stated on the day of the appointment, she called the transport company to verify because she noted the original resident who was to be transported was still in the facility. She was told that the call had been completed, meaning transport had taken someone. She stated she notified transport that no one had been taken because the intended resident was still in the building. At that time, she was told that an investigation would be taking place. During an interview with the Central Supply Clerk on 11/18/24 at 12:09 PM, she stated, I was covering the Receptionist's lunch break at approximately 12:30 PM - 1:00 PM that day. I did notice 2 transport vans, 1 black and 1 gray, but did not see anyone get into the vans. She stated she was not made aware of R3 being missing until the next morning when she returned to work. She stated the process for residents leaving for appointments is typically a resident with a wheelchair will sit in the lobby and wait for transport. However, if they need a stretcher, transport comes to their room to get them. During an interview with Licensed Practical Nurse (LPN)1 on 11/18/24 at 12:13 PM, she stated, I got on the [med] cart around 1:00 PM. I did not receive a report, the keys to the cart were left in the book. I started giving medications so I could catchup on anything that may have been late. I believe it was around dinner time when a Certified Nursing Assistant (CNA) stated [R3's] tray was still in his room, untouched. I knew this was unusual because he goes to other units looking for food. She stated she then made the Director of Nursing (DON) and Unit Manager (UM) aware and went on about her night. LPN1 said, There was no code white or sense of urgency to look to see if anyone knew where [R3] was. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/18/24 at 12:47 PM, the DON stated, [R3] left the facility with transport, instead of the resident that was intended to go. [R3] normally sits outside in the lobby but has never attempted to wander away from the facility. The Assistant DON (ADON) was supposed to go with the intended resident to the appointment, however, she left before him. Once it was noted that the intended resident was still in the building, transport was called and stated they had taken someone from the facility. Code [NAME] was not initiated because it was unknown that a resident was truly missing at that time. Later that day, the police notified the facility that [R3] was at a local Waffle House and a facility staff member went and picked him up. A telephone interview with the Lead Customer Service Supervisor of the Transport Driver on 11/18/24 at 1:24 PM, she stated, Driver asked and [R3] signed the letters BJ, so she took him. She stated that she is unaware of the drivers needing to go into the facility to verify who they are taking. She stated, I will reach out to our upper management to see if they will be putting a process in place so this doesn't happen again. During an interview on 11/18/24 at 1:30 PM, the ADON stated, I agreed to escort the original attendee to the appointment. She was sitting in the lobby of the facility with the original attendant and said she would meet him in there, so she left the facility to head to the doctor's office, which is approximately 18 minutes/13 miles away. The ADON stated she asked the Unit Manager (UM) to text or call when he (the intended resident) was picked up. The DON called and asked her to make a new appointment for him since there was an issue with transportation, but she was not made aware of what the issue was. When the ADON left the facility around 1:40 PM on 11/04/24, R3 was not outside of the facility at that time. She stated that when she was sitting at the doctor's office, there were no residents outside, nor was there a van. Since she was not made aware of the incident, she did not know to look for R3. During an interview with the Administrator on 11/18/24 at 2:07 PM, she stated, I was not made aware of the incident until Tuesday. I believe it was around 2:00 AM on 11/05/24 when [R3] returned to the facility with a staff member. [R3] told the workers at Waffle House that he was ready to go home. The workers then called the police and [R3] told the police his name and that he lived at Riverside. The police called the facility, and a staff member went and picked him up. When asked what her expectations were, the Administrator stated, If I had known he was missing or that transport had stated they had taken someone, I would have immediately locked the building down and completed a headcount, but unfortunately, that was not done. Multiple attempts were made to contact the staff member who returned R3 to the facility, for interview, with no success. During a telephone interview with R3's brother on 11/19/24 at 9:26 AM, he stated, The police called my mother stating my brother was at a Waffle House. My mother then told them to call me. When the police called, I told them that my brother is supposed to be at Riverside Nursing Home, so I don't know how he got to the Waffle House. The facility did not tell us all what happened, someone just called to say they were putting an ankle monitor on him. During an interview with the Administrator on 11/19/24 at 10:30 AM, she indicated that the form with the slash meant the resident has decisional making capabilities, but she would defer to the Social Services Director (SSD) for further clarification. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the SSD on 11/19/24 at 12:30 PM, he stated that the slash meant the resident does have decision making capacity, but there was not any documentation from a Physician to confirm it. He stated that he dropped the ball and R3's medical record is confusing because of conflicting information. During a follow-up interview with the Administrator and Administrator in Training on 11/19/24 at 1:15 PM, she stated that part of their audits was to ensure all residents were safely located in the building and residents who wish to be outside have now been provided with a courtyard that does not have access for them to be able to wander away from the facility unknown. On 11/19/24 the facility provided an acceptable IJ Removal Plan, which included the following: -What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #1 left facility via transport van without staff knowledge. The resident was out of the facility without staff knowledge for more than two hours. Staff re-educated on physically checking on every resident at least every two hours on 11/7/24. Resident #1 is without injury and elopement risk assessment repeated on 11/7/24 with interventions in place per plan of care. A resident count was conducted for all residents when Resident #1 returned to the facility. All residents were accounted for. AOC date is 11/07/24. -How other residents who have the potential to be affected by the alleged deficient practice are identified: Residents who socialize on the front porch or along the walkway may be affected by this alleged deficient practice. -How the corrective action will be monitored to ensure the deficient practice will not recur: (include re-education) 1. Check-in/Check-out (Porch Pass) process implemented for residents who desire to sit on the front porch- 11/7/24 2. Re-education for staff on Abuse, Neglect, or Mistreatment starting 11/7/24. 3. Re-education for staff on physically checking on residents at least every two hours on 11/7/24. 4. Continue a midnight census every night as a daily audit. 5. Safe area (courtyard) provided for residents to socialize. Residents informed 11/7/24. 6. Adhoc QAPI- 11/7/24. 7. ADON/designee will audit midnight census five times weekly x4 weeks, then three x weekly for 4 weeks, then monthly x 1 until compliance is achieved. -What quality assurance program will be put into place: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Results of the monitoring will be presented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37781 Based on interviews, record review and review of the facility policy, the facility failed to provide adequate supervision for Resident (R)3, who successfully eloped from the facility. On 11/18/24 at 3:15 PM, the Administrator was notified that the failure to provide adequate supervision to prevent an elopement constituted Immediate Jeopardy (IJ) at F689. On 11/18/24 at 3:15 PM, the survey team provided the Administrator with a copy of the CMS IJ Templates, informing the facility IJ existed as of 11/04/24. The IJ was related to 42 CFR 483.25 - Quality of Care. On 11/19/24 the facility provided an acceptable IJ Removal Plan for F689. On 11/19/24, the survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance. The IJ is considered at Past Non-Compliance as of 11/07/24. An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care. Findings Include: Review of the facility's policy titled, Elopement, with a revision date of 11/01/17 states, to safely and timely redirect patients/residents to a safe environment. Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE], with diagnoses including but not limited to: depression, cognitive communication deficit, acquired absence of left leg above knee, and unspecified psychosis not due to a substance or known physiological condition. Review of R3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating R3 had moderate cognitive impairment. Review of R3's Decisional Making Capacity Form located in his Electronic Medical Record revealed an undated document with R3's name on it. There was a slash across the form. Review of the Facility's 5 Day Reportable revealed R3 was taken from the facility on 11/04/24 between 1:00 PM - 2:00 PM. R3 was last seen sitting in his wheelchair on the front porch of the facility after lunch, which is his usual routine. On 11/04/24 at 5:30 PM, R3 was noted to not be available for his afternoon medications or dinner. Staff assumed R3 was visiting friends in the facility. R3 was not reported as potentially missing to the Administrator or the Police within 30 minutes as required by the facility's policy. An attempt was made to interview R3 on 11/18/24 at 11:38 AM with no success. A second attempt was made to interview R3 on 11/19/24 at 9:15 AM and 11:00 AM, with no success. Observations of R3 during these times revealed a wanderguard bracelet in place to R3's ankle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Medical Records Clerk on 11/18/24 at 11:57 AM, she stated she is responsible for setting up transport for appointments. She stated on the day of the appointment, she called the transport company to verify because she noted the original resident who was to be transported was still in the facility. She was told that the call had been completed, meaning transport had taken someone. She stated she notified transport that no one had been taken because the intended resident was still in the building. At that time, she was told that an investigation would be taking place. During an interview with the Central Supply Clerk on 11/18/24 at 12:09 PM, she stated, I was covering the Receptionist's lunch break at approximately 12:30 PM - 1:00 PM that day. I did notice 2 transport vans, 1 black and 1 gray, but did not see anyone get into the vans. She stated she was not made aware of R3 being missing until the next morning when she returned to work. She stated the process for residents leaving for appointments is typically a resident with a wheelchair will sit in the lobby and wait for transport. However, if they need a stretcher, transport comes to their room to get them. During an interview with Licensed Practical Nurse (LPN)1 on 11/18/24 at 12:13 PM, she stated, I got on the [med] cart around 1:00 PM. I did not receive a report, the keys to the cart were left in the book. I started giving medications so I could catchup on anything that may have been late. I believe it was around dinner time when a Certified Nursing Assistant (CNA) stated [R3's] tray was still in his room, untouched. I knew this was unusual because he goes to other units looking for food. She stated she then made the Director of Nursing (DON) and Unit Manager (UM) aware and went on about her night. LPN1 said, There was no code white or sense of urgency to look to see if anyone knew where [R3] was. During a telephone interview on 11/18/24 at 12:47 PM, the DON stated, [R3] left the facility with transport, instead of the resident that was intended to go. [R3] normally sits outside in the lobby but has never attempted to wander away from the facility. The Assistant DON (ADON) was supposed to go with the intended resident to the appointment, however, she left before him. Once it was noted that the intended resident was still in the building, transport was called and stated they had taken someone from the facility. Code [NAME] was not initiated because it was unknown that a resident was truly missing at that time. Later that day, the police notified the facility that [R3] was at a local Waffle House and a facility staff member went and picked him up. During an interview on 11/18/24 at 1:30 PM, the ADON stated, I agreed to escort the original attendee to the appointment. She was sitting in the lobby of the facility with the original attendant and said she would meet him in there, so she left the facility to head to the doctor's office, which is approximately 18 minutes/13 miles away. The ADON stated she asked the Unit Manager (UM) to text or call when he (the intended resident) was picked up. The DON called and asked her to make a new appointment for him since there was an issue with transportation, but she was not made aware of what the issue was. When the ADON left the facility around 1:40 PM on 11/04/24, R3 was not outside of the facility at that time. She stated that when she was sitting at the doctor's office, there were no residents outside, nor was there a van. Since she was not made aware of the incident, she did not know to look for R3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator on 11/18/24 at 2:07 PM, she stated, I was not made aware of the incident until Tuesday. I believe it was around 2:00 AM on 11/05/24 when [R3] returned to the facility with a staff member. [R3] told the workers at Waffle House that he was ready to go home. The workers then called the police and [R3] told the police his name and that he lived at Riverside. The police called the facility, and a staff member went and picked him up. When asked what her expectations were, the Administrator stated, If I had known he was missing or that transport had stated they had taken someone, I would have immediately locked the building down and completed a headcount, but unfortunately, that was not done. During an interview with the Administrator on 11/19/24 at 10:30 AM, she indicated that the form with the slash meant the resident has decisional making capabilities, but she would defer to the Social Services Director (SSD) for further clarification. During an interview with the SSD on 11/19/24 at 12:30 PM, he stated that the slash meant the resident does have decision making capacity, but there was not any documentation from a Physician to confirm it. He stated that he dropped the ball and R3's medical record is confusing because of conflicting information. During a follow-up interview with the Administrator and Administrator in Training present on 11/19/24 at 1:15 PM, she stated that part of their audits was to ensure all residents were safely located in the building and residents who wish to be outside have now been provided with a courtyard that does not have access for them to be able to wander away from the facility unknown. On 11/19/24 the facility provided an acceptable IJ Removal Plan, which included the following: -What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #1 left facility via transport van without staff knowledge. The resident was out of the facility without staff knowledge for more than two hours. Staff re-educated on physically checking on every resident at least every two hours on 11/7/24. Resident #1 is without injury and elopement risk assessment repeated on 11/7/24 with interventions in place per plan of care. A resident count was conducted for all residents when Resident #1 returned to the facility. All residents were accounted for. AOC date is 11/07/24. -How other residents who have the potential to be affected by the alleged deficient practice are identified: Residents who socialize on the front porch or along the walkway may be affected by this alleged deficient practice. -How the corrective action will be monitored to ensure the deficient practice will not recur: (include re-education) 1. Elopement drill conducted 11/7/24. 2. Check-in/Check-out (Porch Pass) process implemented for residents who desire to sit on the front porch-11/7/24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425082	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehab	2375 Baker Hosp Blvd Charleston, SC 29405

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Re-education for staff on Elopement Policy and Process and Abuse, Neglect, or Mistreatment starting 11/7/24. 4. Elopement risk assessments completed on residents who reside in the facility on 11/7/24. 5. A review of residents who are assessed as an elopement risk was completed on 11/7/24 and care plans updated as appropriate. 6. Safe area (courtyard) provided for residents to socialize. Residents informed 11/7/24. 7. Adhoc QAPI- 11/7/24. 8. Continue a midnight census every night as a daily audit. 9. ADON/designee will audit for elopement assessments completed and accurate within 24 hours or admission/readmission five times weekly for 4 weeks, then three x weekly for 4 weeks, then monthly x 1 until compliance is achieved. 10. ADON/designee will audit 24-hour report and new nurses' notes (facility activity report) for documentation of elopement risks five times weekly x 4 weeks, then three x weekly for 4 weeks, then monthly x 1 until compliance is achieved. -What quality assurance program will be put into place: Results of the monitoring will be presented to the Quality Assurance Performance Improvement (QAPI) Committee for a period of 3 months or until substantial compliance is achieved and maintained. Any areas of concern identified will be addressed at time of discovery.