STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425140	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Moncks Corner	505 South Live Oak Drive Moncks Corner, SC 29461

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** 42424 Based on interview, record review, and facility policy the facility failed to ensure that Resident (R)1, a resident diagnosed with dementia, was free from neglect by failing to provide necessary care and services to prevent R1 from eloping from the facility which had the potential for serious bodily harm. On [DATE] at approximately 8:00 PM, R1 was found in the parking lot of the facility near a major U.S. Highway (Highway 17) by staff after they were unable to locate the resident for bedtime. On [DATE] at 5:51 PM, the Administrator was notified that the failure to ensure Resident (R)1 was free from neglect, which resulted in a successful elopement on [DATE] at approximately 8:00 PM, constituted Immediate Jeopardy (IJ) at F600. On [DATE] at 5:51 PM, the survey team provided the Administrator with a copy of the CMS IJ Template and informed the facility IJ existed as of [DATE], when a resident successfully eloped from the facility through the front door. F600 were related to 483.12 Freedom from Abuse, Neglect, and Exploitation. On [DATE] at 2:33 PM, the facility presented a successful plan of removal. The survey team validated the plan of removal and verified the facility put forth due diligence in addressing the noncompliance, indicating this IJ at Past Noncompliance as of [DATE]. An Extended Survey was conducted on [DATE], in conjunction with the Complaint Survey for non-compliance at F600 constituting substandard quality of care. Findings Include: Review of the facility policy titled Abuse Prevention and Reporting last revised on [DATE], documented, Neglect the failure to provide goods and services necessary to avoid harm, mental anguish or mental illness. Neglect may include instances of being left to sit or lie in urine, isolating a resident in their room or locations apart from other residents or supervision by the other staff, failure to answer requests for assistance and treatment. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnosis including but not limited to: vascular dementia without behaviors, cognitive communications deficit, altered mental status, and history of falling. (continued on next page)

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
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(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 R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R1 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated R1 had severe cognitive impairment. Review of R1's Nurses Notes dated [DATE] at 11:20 PM, documented, [R1] continuously attempting to leave facility throughout the day, redirected multiple times by staff, patient unable to tell staff where he is going or why he wants to go, speech very garbled. By the end of the day the patient became combative when staff was attempting to redirect. Resident refusing personal care and incontinent, unable to take vital signs however patient had no temperature, Nurse Practitioner notified and verbalized that resident should be send to the emergency room (ER), patient sent via 911 to hospital, manager, Director of Nursing (DON) and resident notified. Review of R1's Nurses Notes dated [DATE] at 5:03 AM, documented, Resident [R1] was at the door of the facility fighting with staff, yelling, argumentative and setting off the EMD alarm. Attempts by writer successful to remove/calm/redirect resident from the situation and the front of the building. Once [R1] was brought back to the unit, conversed with [R1] and reassured that all was well within the facility. [R1] was bathed, Activities of Daily Living (ADL) care provided, and he was then placed in his bed after sitting with writer at the nurses station approximately one hour. Once in bed, resident rested the remainder of the shift with no further behaviors/confusion episodes noted, no signs or symptoms or discomfort to report as bed remained low with call bell and bedside table within reach. Review of R1's Nurses Note dated [DATE] at 5:28 AM, documented, At approximately 8:00 PM [late entry from [DATE]] resident [R1] was observed to be missing from the facility. Certified Nursing Assistant (CNA) was looking for the resident to prepare him for bed was unable to find him. CNA went searching for the resident and found him outside the building wheeling himself towards the road. Nursing staff was able to wheel the resident back into the building and a body audit was completed with no problems noted. Resident assisted to bed and fell asleep shortly afterwards. Resident calmly asleep in bed for the rest of the night, call light within reach, all necessary documentation completed. Responsible party notified, headcount was done per protocol and every resident in the building accounted for. Review of R1's Quarterly assessment dated [DATE], revealed that R1 was high risk for elopement. Review of R1's Physician Orders revealed an order for an Electronic Monitoring Device to right ankle, dated [DATE]. Review of R1's Care Plan, last revised on [DATE], documented, R1 requires an Electronic Monitoring Device related to periods of disorientation and attempts of exit seeking looking for his spouse. Interventions include: provide increased supervision during periods of increased wandering and agitation; assess for psychosocial and cognitive changes; evaluate unit for possible safety hazards; develop an activities program to divert attention and meet needs for social and cognitive stimulation; check EMD for proper functioning and placement per facility protocol or manufacture's recommendation; re-direct provide diversional activities; assess/record/report to Medical Director risk factors for potential elopement such as wandering, repeat requests to leave the facility, statements such as I'm leaving I'm going home, attempts to leave facility or elopement attempts from previous facility or hospital; complete Elopement Risk Assessment. (continued on next page)

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(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 the weather report revealed that on [DATE] at approximately 7:55 PM, the weather was 70 degrees Fahrenheit, sunset already occurred for the evening. During an interview on [DATE] at 11:28 AM, R1's Resident Representative (RR) revealed that they were informed that the resident eloped from the facility through the front door and was found by facility staff in the parking lot around 8:00 PM on [DATE]. However, they were not notified of the elopement until [DATE] around 6:00 AM by nursing staff. The RR had many concerns related to the elopement because this was not the resident's first time eloping from the facility and staff did not provide a lot of detail on how the elopement occurred. R1's RR further stated that R1 recently eloped about 2 months ago which prompted the facility to add an Electronic Monitoring Device (EMD) to the resident's leg ([DATE] according to the Physician Orders) but does not know much about that elopement because staff refused to go into detail about the incident. During an interview on [DATE] at 2:41 PM, Licensed Practical Nurse (LPN)1 revealed that during the day, R1 is easy to redirect but when the evening comes R1 exhibits sun-downing behaviors and can be combative with staff. LPN1 stated that they typically work first shift at the facility but has witnessed R1 be combative with other staff when attempting to exit seek. LPN1 was unaware of the resident eloping from the facility on [DATE]. During an interview on [DATE] at 2:45 PM, CNA2 revealed that during the day, R1 is agreeable to receiving care and easy to redirect when he attempts to exit seek. CNA2 stated that at times the resident can become combative but if left alone for a few minutes and reapproached, during the day the resident normally attends activities which keeps him occupied and his mind off his deceased wife who prior to passing also resided at the facility. CNA2 further stated when the resident is exit-seeking, he typically is looking for his wife, but with redirection will normally stop. CNA1 was unaware of the resident eloping from the facility on [DATE]. During a phone interview on [DATE] at 3:24 PM, RN1 revealed that they were the resident's assigned nurse on [DATE]. RN1 stated that she gave R1 the last of his bedtime medications around 8:00 PM and around 8:30 PM a CNA brought R1 back to the unit and explained that she found him outside. RN1 stated that she was still passing medications when the CNA informed her that she found the resident in the parking lot of the facility. RN1 further stated that she completed a body audit on R1, and he had no signs of harm or distress, and she informed the Director of Nursing and R1's daughter of the elopement. RN1 was unable to recall the last time they had elopement training or dementia training specifically but stated that they had general training a few weeks ago but was unable to provide details. RN1 finally stated that they did not hear any alarms going off during this time because they were in the room passing medications and the resident exited out of the front of the facility. (continued on next page)

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(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 phone interview on [DATE] at 4:00 PM, CNA1 revealed that they were R1's assigned CNA for the evening (of the elopement) and last saw the resident on [DATE] around 8:00 PM. CNA1 stated, [R1] was at the nurses station in his wheelchair and told me that he wasn't ready for bed yet. I went to go put another resident to bed which took about 10 minutes or so and when I went to find [R1] again to see if he was ready for bed, but I couldn't find him. I know [R1] likes to hang out in the day area near the kitchen in the front of the facility, so I headed there but still couldn't find him, something told me to look outside because I heard the alarm going off by the front door and that's when I found [R1] with another resident's family member in the middle part of the parking lot of the facility. I couldn't hear the alarm from the resident's unit because it is in the back portion of the facility and [R1] went out of the front door. It took me a while to convince [R1] to come back inside but he eventually was agreeable to returning. When I found the resident, he had on full clothes, but it was dark because the sun recently set for the evening. I didn't tell the nurse that he was missing, I just went to go look for him and brought him to the nurse and then I explained that I found him outside in the parking lot. Further interview with CNA1 revealed that the resident was missing for about 10 - 15 minutes before finding him in the parking lot. During an interview on [DATE] at 4:44 PM, the Director of Nursing (DON) revealed that they were made aware that the resident was found outside of the building on [DATE] at approximately 8:45 PM. The DON stated the facility was putting measures in place to ensure the resident did not elope again. Interventions that have initiated so far are checking the door to ensure it alarms appropriately, checking the resident's EMD to ensure it alarms by door correctly, and re-education of staff. The DON stated that this was still in the process at this time but the direct staff that were involved with the elopement were re-educated. During an interview on [DATE] at 5:08 PM, the Administrator revealed that they were informed the resident eloped from the facility on [DATE] and came to the facility to ensure that R1 did not elope again from the front door and other residents as well. The Administrator stated that when he arrived at the facility, they completed a head count to ensure all residents were in house and they began to try to find the cause of how the resident eloped. The Administrator stated, There had been on-going issues with the door, and we (Administrator and Maintenance Staff) examined the door and it was not properly aligned on it's hinges which is why the door did not lock when [R1] exited, even though he had an EMD. The alarms for the EMD were working appropriately but because the door was not aligned correctly which allowed the resident to exit. The Administrator further stated that he had been working to try and fix the door in the past, for other issues (not elopement) but it needs replacing because companies no longer make parts to fix that specific door. The facility is now in the process of replacing the door, along with other doors and EMD alarms at the facility because the facility is under renovation. On the night of [DATE], the Administrator had a staff member complete 1:1 of the front door to ensure no other residents or R1 could elope and did door monitoring from [DATE] - [DATE]. The door was able to be fixed and is now working and locking appropriately when residents with an EMD go near the door. Interventions that were put into place on [DATE] included: re-educating staff related to elopement and the process of what to do if a resident has eloped, education on EMD's and door alarms, and the notification process. (continued on next page)

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(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	On [DATE] at 2:33 PM, the facility presented a plan of removal, which included the following: Immediate Action: R1 had the potential to be affected by the alleged isolated deficient practice as evidenced by nursing progress note dated [DATE] at 5:28 AM indicated R1 was observed missing from the facility and found outside the building with the front door alarming. R1 did not leave facility property, R1 was brought back into the facility immediately and safely by the Certified Nursing Assistant (CNA) and the Nurse. A body audit was completed which revealed no injuries. R1 was assisted to bed where he fell asleep and remained for the remainder of the night. R1 responsible party was notified, and a 100% resident head count was completed for all residents with all residents being accounted for, Medical Director/provider made aware. Facility Administrator was on-site within an hour of the reporting of the incident. Upon discovery of the front door in disrepair, the electronic medical device system was functioning properly despite the functionality of the latching of the door. The Maintenance Director was contacted and arrived at the facility minutes later to repair the front door. All other doors checked and verified for proper egress/ingress functioning to include alarming the electronic medical device system. The front door was monitoring continuously until the repairs were completed and appropriate functionality of the door was confirmed. The front door continued to be monitored for 24 hours after the event with no recurrence. No residents sustained any negative outcome related to the isolated event. Methods to identify any other residents who might be affected include all residents demonstrating exit-seeking behavior had the potential to be affected by the alleged deficient practice. Residents were protected by the timeliness of response to Code Pink and the repairs as well as the continual 24-hour monitoring of the front door post event. Systemic changes include all staff are to received education on Code Pink/ Missing Residents which include neglect of a resident; how to handle malfunctioning doors by the Administrator, Clinical Competency Coordinator (CCC), Director of Health Services (DHS), and/or licensed designated charge nurse initiated on [DATE]. All new hires will receive education in orientation. Any partner that is on leave will receive education prior to their next scheduled shift. Replacement of the front door has been approved and the work order has been requested by the vendor, awaiting date/time of replacement to be scheduled. However, all doors not limited to the front door is in working order to secure the facility properly and functioning properly. Monitoring includes the Maintenance Director or designee will verify the proper functioning of all doors twice daily times one month or until replacement of the door is complete. Results will be reviewed in the Quality Assurance and Performance Improvement (QAPI) monthly for three months and/or until substantial compliance is achieved.

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(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** 42424 Based on interview, record review, and review of the facility policy, the facility failed to ensure that adequate supervision was in place to prevent Resident (R)1 from eloping from the facility. Specifically, on 10/02/24 at approximately 8:00 PM, R1 was found in the parking lot of the facility near a major U.S. Highway (Highway 17), by staff after they were unable to locate the resident for bedtime. On 10/04/24 at 5:51 PM, the Administrator was notified that the failure to ensure Resident (R)1 was free from neglect, which resulted in a successful elopement on 10/02/24 at approximately 8:00 PM, constituted Immediate Jeopardy (IJ) at F689. On 10/04/24 at 5:51 PM, the survey team provided the Administrator with a copy of the CMS IJ Template and informed the facility IJ existed as of 10/02/24, when a resident successfully eloped from the facility through the front door. F689 were related to 483.25 Quality of Care . On 10/07/24 at 2:33 PM, the facility presented a successful plan of removal. The survey team validated the plan of removal and verified the facility put forth due diligence in addressing the noncompliance, indicating this IJ at Past Noncompliance as of 10/03/24. An Extended Survey was conducted on 10/07/24, in conjunction with the Complaint Survey for non-compliance at F689 constituting substandard quality of care. Findings include: Review of the facility policy titled Occurrences last revised on 01/11/24, documented, The healthcare center recognizes that due to the frailty of the patients/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. To prevent occurrences, each patient/resident will be observed to and assessed for risk. Appropriate, realistic interventions will be implemented in accordance with their plan of care. Definitions include occurrence hazards are physical feature in the healthcare center environment which may pose a risk to a patient/residents safety, including but not limited to any event, accident, or incident on or off healthcare center property which results in an injury or has the potential for injury; elopement from healthcare center property regardless of whether there was an injury associated with the elopement. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE], with diagnosis including but not limited to: vascular dementia without behaviors, cognitive communications deficit, altered mental status, and history of falling. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/24, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated R1 had severe cognitive impairment. (continued on next page)

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(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	Review of R1's Nurses Notes dated 07/26/24 at 11:20 PM, documented, [R1] continuously attempting to leave facility throughout the day, redirected multiple times by staff, patient unable to tell staff where he is going or why he wants to go, speech very garbled. By the end of the day the patient became combative when staff was attempting to redirect. Resident refusing personal care and incontinent, unable to take vital signs however patient had no temperature, Nurse Practitioner notified and verbalized that resident should be send to the emergency room (ER), patient sent via 911 to hospital, manager, Director of Nursing (DON) and resident notified. Review of R1's Nurses Note dated 10/03/24 at 5:28 AM, documented, At approximately 8:00 PM [late entry from 10/02/24] resident was observed to be missing from the facility. Certified Nursing Assistant (CNA) was looking for the resident to prepare him for bed was unable to find him. CNA went searching for the resident and found him outside the building wheeling himself towards the road. Nursing staff was able to wheel the resident back into the building and a body audit was completed with no problems noted. Resident assisted to bed and fell asleep shortly afterwards. Resident calmly asleep in bed for the rest of the night, call light within reach, all necessary documentation completed. Responsible party notified, headcount was done per protocol and every resident in the building accounted for. Review of R1's Quarterly assessment dated [DATE], revealed that R1 was high risk for elopement. Review of R1's Physician Orders revealed an order for an Electronic Monitoring Device to right ankle, dated 07/23/24. Review of R1's Care Plan, last revised on 07/24/24, documented, R1 requires an Electronic Monitoring Device related to periods of disorientation and attempts of exit seeking looking for his spouse. Interventions include: provide increased supervision during periods of increased wandering and agitation; re-direct provide diversional activities. During a phone interview on 10/04/24 at 3:24 PM, RN1 revealed that they were the resident's assigned nurse on 10/02/24. RN1 stated that she gave R1 the last of his bedtime medications around 8:00 PM and around 8:30 PM a CNA (Certified Nursing Assistant) brought R1 back to the unit and explained that she found him outside. RN1 stated that she was still passing medications when the CNA informed her that she found the resident in the parking lot of the facility. RN1 further stated that she completed a body audit on R1, and he had no signs of harm or distress, and she informed the Director of Nursing and R1's daughter of the elopement. RN1 finally stated that they did not hear any alarms going off during this time because they were in the room passing medications and the resident exited out of the front of the facility. (continued on next page)

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(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 a phone interview on 10/04/24 at 4:00 PM, Certified Nursing Assistant (CNA)1 revealed that they were R1's assigned CNA for the evening (of the elopement) and last saw the resident on 10/02/24 around 8:00 PM. CNA1 stated, [R1] was at the nurses station in his wheelchair and told me that he wasn't ready for bed yet. I went to go put another resident to bed which took about 10 minutes or so and when I went to find [R1] again to see if he was ready for bed, but I couldn't find him. I know [R1] likes to hang out in the day area near the kitchen in the front of the facility, so I headed there but still couldn't find him, something told me to look outside because I heard the alarm going off by the front door and that's when I found [R1] with another resident's family member in the middle part of the parking lot of the facility. I couldn't hear the alarm from the resident's unit because it is in the back portion of the facility and [R1] went out of the front door. It took me a while to convince [R1] to come back inside but he eventually was agreeable to returning. When I found the resident, he had on full clothes, but it was dark because the sun recently set for the evening. I didn't tell the nurse that he was missing, I just went to go look for him and brought him to the nurse and then I explained that I found him outside in the parking lot. Further interview with CNA1 revealed that the resident was missing for about 10 - 15 minutes before finding him the parking lot. During an interview on 10/04/24 at 4:44 PM, the Director of Nursing (DON) revealed that they were made aware that the resident was found outside of the building on 10/02/24 at approximately 8:45 PM. The DON stated the facility was putting measures in place to ensure the resident did not elope again. Interventions that have initiated so far are checking the door to ensure it alarms appropriately, checking the resident's EMD to ensure it alarms by door correctly, and re-education of staff. The DON stated that this was still in the process at this time but the direct staff that were involved with the elopement were re-educated. During an interview on 10/04/24 at 5:08 PM, the Administrator revealed that they were informed the resident eloped from the facility on 10/04/24 and came to the facility to ensure that R1 did not elope again from the front door and other residents as well. The Administrator stated that when he arrived at the facility, they completed a head count to ensure all residents were in house and they began to try to find the cause of how the resident eloped. The Administrator stated, There had been on-going issues with the door, and we (Administrator and Maintenance Staff) examined the door and it was not properly aligned on it's hinges which is why the door did not lock when [R1] exited, even though he had an EMD. The alarms for the EMD were working appropriately but because the door was not aligned correctly which allowed the resident to exit. The Administrator further stated that he had been working to try and fix the door in the past, for other issues (not elopement) but it needs replacing because companies no longer make parts to fix that specific door. The facility is now in the process of replacing the door, along with other doors and EMD alarms at the facility because the facility is under renovation. On the night of 10/02/24, the Administrator had a staff member complete 1:1 of the front door to ensure no other residents or R1 could elope and did door monitoring from 10/02/24 - 10/03/24. The door was able to be fixed and is now working and locking appropriately when residents with an EMD go near the door. Interventions that were put into place on 10/02/24 included: re-educating staff related to elopement and the process of what to do if a resident has eloped, education on EMD's and door alarms, and the notification process. (continued on next page)

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(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	The facility's removal plan for F689 included Immediate Action: R1 had the potential to be affected by the alleged isolated deficient practice as evidenced by nursing progress note dated 10/03/24 at 5:28 AM indicated R1 was observed missing from the facility and found outside the building with the front door alarming. R1 did not leave facility property, R1 was brought back into the facility immediately and safely by the Certified Nursing Assistant (CNA) and the Nurse. A body audit was completed which revealed no injuries. R1 was assisted to bed where he fell asleep and remained for the remainder of the night. R1 responsible party was notified, and a 100% resident head count was completed for all residents with all residents being accounted for, Medical Director/provider made aware. Facility Administrator was on-site within an hour of the reporting of the incident. Upon discovery of the front door in disrepair, the electronic medical device system was functioning properly despite the functionality of the latching of the door. The Maintenance Director was conducted and arrived at the facility minutes later to repair the front door. All other doors checked and verified for proper egress/ingress functioning to include alarming the electronic medical device system. The front door was monitoring continuously until the repairs were completed and appropriate functionality of the door was confirmed. The front door continued to be monitored for 24 hours after the event with no recurrence. No residents sustained any negative outcome related to the isolated event. Methods to identify any other residents who might be affected include all residents demonstrating exit-seeking behavior had the potential to be affected by the alleged deficient practice. Residents were protected by the timeliness of response to Code Pink and the repairs as well as the continual 24-hour monitoring of the front door post event. Systemic changes include all staff are to received education on Code Pink/ Missing Residents which include neglect of a resident; how to handle malfunctioning doors by the Administrator, Clinical Competency Coordinator (CCC), Director of Health Services (DHS), and/or licensed designated charge nurse initiated on 10/02/24. All new hires will receive education in orientation. Any partner that is on leave will receive education prior to their next scheduled shift. Replacement of the front door has been approved and the work order has been requested by the vendor, awaiting date/time of replacement to be scheduled. However, all doors not limited to the front door is in working order to secure the facility properly and functioning properly. Monitoring includes the Maintenance Director or designee will verify the proper functioning of all doors twice daily times one month or until replacement of the door is complete. Results will be reviewed in the Quality Assurance and Performance Improvement (QAPI) monthly for three months and/or until substantial compliance is achieved.