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DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI) MS #17896 and CI MS 17899 from 07/19/2021 through 07/23/2021. The SA substantiated CI MS #17896 related to elopement. The facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiency M 640 cited. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 7/14/2021, when the facility failed to provide adequate supervision to prevent an elopement for Resident #1, who was identified on admission, 07/14/2021, as being at risk for elopement. Resident #1 was away from the facility unsupervised on 07/14/2021 from approximately 7:00 PM until the Resident's son was able to locate the Resident at her residence at approximately 9:00 PM. The facility's failure to provide adequate supervision to prevent an elopement placed Resident #1 and other residents with wandering behaviors at risk of elopement in a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 7/20/2021 at 7:00 PM. The IJ and SQC existed at: Rule 45.21.8, M640 - Accidents. Level IV. The facility submitted an acceptable Removal Plan on 7/22/2021, in which the facility alleged all corrective actions were completed to remove the IJ on 7/21/2021, and the IJ removed on	M 000		

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M 000	Continued From page 1 7/22/2021. The SA validated the Removal Plan on 7/23/2021, and determined the IJ was removed on 7/22/2021, prior to exit. Therefore, the scope and severity for Rule 45.21.8, M 640 - Accidents, was lowered to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The SA also investigated CI MS #17899 regarding resident rights related to no procedure to locate resident's lost clothes and personal items, quality of care related to responsible party not being notified of resident's change of condition and client services not performed, and dietary services related to food being cold and not cooked were not substantiated. At the time of the survey, the facility had a census of 88, and held a license of 120 beds.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on observation, staff interview, Resident interview, Resident Representative interview, record review, and facility policy review, the facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility	M 640	Resident #1 left the facility unattended on 7/14/2021 and did not return to the facility. On 7/20/21 & 7/21/21 an audit was completed by Director of Nursing	8/20/21

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M 640	Continued From page 2 for one (1) or four (4) residents reviewed for elopement risk. Resident #1. Resident #1 was admitted to the facility on 07/14/2021 at approximately 4:20 PM. Resident was observed by Licensed Practical Nurse (LPN) #1 to be pacing in the hallway and stating she was leaving and going home and required redirecting several times. LPN #1 reported she last saw Resident #1 a few minutes before 7:00 PM. Certified Nursing Assistant (CNA) #1 reported she last saw Resident #1 approximately 7:00 PM when dinner trays were picked up. At the end of LPN #1's shift, at approximately 7:20 PM, LPN #1 went to check on Resident #1 and the resident could not be located. Resident #1 was away from the facility unsupervised on 7/14/2021 from approximately 7:00 PM until the Resident's son was able to locate the Resident at her residence at approximately 9:00 PM. The facility's failure to provide adequate supervision to prevent an elopement placed Resident #1 and other residents with wandering behaviors and at risk of elopement in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality (SQC) that began on 07/14/2021, when Resident #1 eloped from the facility. The facility Administrator was notified of the IJ on 07/20/2021 at 7:00 PM. The facility provided an acceptable Removal Plan on 7/22/2021, in which the facility alleged all corrective actions were completed to remove the IJ on 7/21/2021, and the IJ removed on 7/22/20. The scope and severity for CFR(s): 42 CFR: 483.25(d)(1)(2), F 689, Free of Accidents/Hazards/Supervision/Devices, was	M 640	Services, Assistant Director of Nursing Services and Unit Managers of all current residents and updated elopement evaluations were completed to identify any other residents that could be affected by the identified deficient practice. Five residents were identified as elopement risk and none were found to be effected by the deficient practice. All staff were in serviced on 7/20/21 through 7/25/21 by the Director of Clinical Operations, regarding the Elopement guidelines & reporting expectations. Staff that had not received education by 7/25/21 were removed from the schedule and not allowed to work until education was completed. All doors and windows were checked on 7/14/21, 7/19/21 and 7/20/21 by Administrator and Maintenance Assistant. Door codes were changed by Maintenance Director on 7/20/21. A healthcare technologies company completed upgrades on all doors locking systems on 8/11/21. Nursing staff will monitor for signs of possible elopement of all admissions placing resident on elopement precautions immediately, alerting all team members of elopement risks, and initiating a plan of care immediately. Any newly identified elopement risk will be discussed in morning start up beginning 7/21/2021 with verification that all interventions were put in place for seven weeks and monthly X 3 or until sustained compliance can be reached. Audit findings will be reported to Quality Assurance Committee monthly for further interventions as needed and to	

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M 640	Continued From page 3 lowered to a "D", while the facility develops and implements a plan or correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: A review of the facility's policy, "Elopement," dated April 2017, revealed, "...Process: On admission, newly admitted or re-admitted residents are assessed for elopement risk. If an elopement risk is determined an individualized plan is established and intervention is initiated to mitigate that risk..." Record review of the written statement from the Director of Nursing (DON) revealed, "On July 14, 2021, I was called to (Proper Name of Facility) by Registered Nurse (RN) #1 stating that the nurse on B hall (LPN #1) was unable to locate her new resident, Resident #1. I informed her I would come immediately to center. After arriving to facility with the Interim Administrator, we spoke with several of the staff concerning how said resident could have left center undetected. Those staff members included: (Insert proper names for six (6) employees). All staff members stated they had not witnessed anyone leaving the center. Visitor log reviewed and no visitors were logged in during that time. The doors were tested to see if they would open when handle held down for 15 seconds. (sign on front door states it will). Front door did not open after 15 seconds." This was signed by the DON. Interview with the Director of Nursing (DON) on 7/19/2021 at 3:20 PM, the DON stated the facility has not had an elopement, but some residents did leave Against Medical Advice (AMA).	M 640	ensure compliance. First QAPI meetings was held on 7/20/21 and 7/26/2021.	

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M 640	Continued From page 4 Interview with the Administrator on 7/19/2021 at 3:20 PM, Administrator stated the facility has not had an elopement, and if they had, she would have reported it. Phone interviews with Resident #1's son on 7/19/2021 at 5:11 PM and 6:14 PM, revealed Resident #1 was discharged from the hospital and admitted to the facility on 7/14/2021. He stated on that same day, Resident #1 left the facility. The son stated he spoke with an employee of the facility around 7:00 PM - 8:00 PM, but he is uncertain of the time. He stated he was informed his mom left the facility and asked if he could help locate her. The son stated he left work and started searching for her and found her alone at her home. He stated he questioned her on how she got out of facility and got home and stated she told him, "I walked out the front door" and "I walked to the highway and someone picked me up and brought me home." The son does not know who picked her up and brought her home and his mother did not know the person who picked her up, but he believes that person may have known his mother. He called the facility to report he had found Resident #1 and asked about bringing her back, but the employee he spoke with said no. He stated the next day, his Mom had to go back to the Emergency Room due to arm pain. When she left the hospital the day after that, she was admitted to another nursing home facility. He stated Resident #1's memory is "decent", but she can not remember addresses or phone numbers. Interview with Administrator on 7/19/2021 at 5:40 PM, revealed she received a phone call from the Interim Administrator on 7/14/2021 between 9:30 PM - 10:00 PM. She was told that a resident had	M 640		

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left the facility and they had investigated the incident. She was told by the Interim Administrator that the resident did not want to be in the facility and somebody had picked her up and that Resident #1's son said a friend picked her up and took her home. She was informed by the Interim Administrator that this incident was Against Medical Advice (AMA) and not elopement.

Interview and record review with the Director of Nursing (DON) on 7/19/2021 at 6:00 PM, revealed she was notified of Resident #1 missing around 7:40 PM. The DON stated she could not find her documentation regarding the investigation of the elopement, but she knows she documented it. She stated the Corporate Nurse was present during the conversations of the incident, and she was documenting the information. The DON spoke with the Corporate Nurse concerning her notes and stated the Corporate Nurse documented, "Patient admitted, alcoholic with dementia, left AMA with a friend" and "Resident #1 left after about 4 hours. Called friend to pick her up." The DON stated Resident #1's son told her and the Interim Administrator that his mother was in (Insert Proper Name of Local Town) and that a friend picked her up and she is unsure how the resident got out of the facility. She stated "I was not here. Staff member had to let them in and out. Residents know the codes, also. They sit up front and learn the code. Sometimes staff hollers the code down the hall." The DON stated that no Against Medical Advice papers were signed and no staff members witnessed the resident leave the building.

Interview with LPN #2 on 7/19/2021 at 7:15 PM, revealed on 7/14/2021, she was working on D-Hall when Resident #1 left the building. LPN

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#2 stated she was passing medications around 7:20 PM when she received a text message from LPN #1 informing her that a resident could not be located. LPN #2 stated she notified RN #1 Nursing Supervisor, who notified the DON and the Interim Administrator. LPN #2 stated the building and outside was searched, and a head count was done and all other residents were located.

Interview with Licensed Practical Nurse (LPN) #1 on 7/20/2021 at 9:18 AM, revealed on 7/14/2021 at approximately 4:20 PM, she admitted Resident #1 to B-Hall from the hospital. LPN #1 stated the resident kept pacing back and forth in the hallway, saying she wanted to leave and go home and required redirecting several times. LPN #1 stated upon admission, Resident #1 was dressed in a hospital type gown, but the last time she saw her, a little before 7:00 PM, Resident #1 had changed into a t-shirt and pajama pants. LPN #1 stated at the end of her shift, around 7:15 PM - 7:20 PM, she counted medications with the oncoming nurse at the nurse's station and after counting the medications, she went to check on Resident #1 to see if she was calmer than she had been previously. LPN #1 stated Resident #1 was not in her room, so she looked around the hallway. She asked CNA #1 if she knew where Resident #1 was, and she also did not know. LPN #1 stated as she was searching the hall and rooms, she notified LPN #2 of the situation so other staff, the DON, Supervisor, and Interim Administrator could be contacted and a Code for elopement was called. LPN #1 stated each room inside the facility and outside the building was searched and Resident #1 could not be located. Concerning staffing on 7/14/2021, LPN #1 stated B-Hall had around 15 - 20 residents with two of those being new admissions, and it was only her

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and CNA #1 on that hall. LPN #1 stated, "when you have residents like (formal name of Resident #1), I would not say there was adequate staffing." LPN #1 stated she did not fill out an inventory list, but she looked through Resident #1's belongings to ensure there were no unsafe items and Resident #1 did not have a cell phone in her possessions. LPN #1 stated she did not make a phone call for the Resident #1, and she is unaware of anyone else making a phone call for the resident. LPN #1 revealed when she left the facility after work, it was not raining and had not rained that day.

Observation, interview, and tour with the Administrator on 7/20/2021 at 10:30 AM, of the doors on the end of B-Hall and front door revealed when the door latch was pressed, the alarm sounded and in 15 seconds the doors unlocked and were able to be opened. The alarm continued to sound until the keypad code was pressed. The Administrator stated, "In reality a resident could push the door and exit building."

Interview with the Maintenance Director #1 on 7/20/2021 at 10:35 AM, revealed he is changing the keypad codes on all the exterior doors. He stated the door alarms will sound if the lever is pushed or door is opened unless the code is entered.

Phone interview with the Interim Administrator on 7/20/2021 at 11:27 AM, revealed on 7/14/2021 at approximately 7:45 PM, she and the DON received a call from the facility informing them that Resident #1 could not be located. She stated they immediately went to the facility and RN #1 had attempted to contact Resident #1's son, but calls had not been returned. The Interim Administrator stated she and the DON spoke with

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Resident #1's son and he informed them that a family member had picked Resident #1 up and brought her home and he was going to pick her up. She stated the son asked about bringing Resident #1 back to the facility but stated she told him not to bring her back and they would try to get another placement the next day. The Interim Administrator said she spoke with the Corporate Nurse and told her what Resident #1's son had said and asked if she thought it was an elopement or AMA, and the Corporate Nurse said it sounds like AMA since a family member picked her up. As for how the resident left the facility, the Interim Administrator stated the resident could have leaned on the doors for 15-20 seconds and they would have unlock due to the fire code and an alarm would sound or she could have followed someone out. The Interim Administrator stated Resident #1 did leave the building and staff were unaware of her location.

Interview with Resident #1 on 7/20/2021 at 2:30 PM, revealed the resident stated she walked out of the facility. She walked halfway home and somebody stopped and picked her up. She stated she does not know who it was, but it was a man. Resident #1 stated, "everybody in (Proper Name of Local Town) knows me." Resident #1 stated the weather was fine when she left the building and it was not raining.

Interview with Certified Nurse Assistant (CNA) #1 on 7/20/2021 at 3:12 PM, revealed she was working on B-Hall when Resident #1 was admitted to the facility and stated that Resident #1 came into the facility saying, "it's time to go home." CNA #1 stated she was able to calm Resident #1, and the resident was able to eat dinner, and when the dinner tray was picked up around 7:00 PM, the resident was in her room.

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M 640	Continued From page 9 CNA #1 stated she was outside B-Hall's exterior door around 7:00 PM with a resident that smokes for the smoke break, so she would have seen Resident #1 if she exited the building or attempted to exit the building through that door and the alarm would have sounded. CNA #1 stated when she was coming back into the building, LPN #1 told her Resident #1 was missing and a Code was called. CNA #1 stated there were about 15 residents in the isolation area of B-Hall on 7/14/2021. CNA #1 stated she checked Resident #1's inventory and she did not have a phone and she did not assist the resident to make a phone call. Interview with RN #2 on 7/20/2021 at 4:19 PM, revealed she is the Infection Control Nurse and the Director of Clinical Education. RN #2 stated if a resident is determined to be at high risk for elopement, the assessment should be done immediately and interventions should include wander guard use, one on one with the resident, monitor and frequent visual checks, and baseline care plan. Interview with Registered Nurse (RN) #1 on 7/20/2021 at 4:59 PM, revealed RN #1 stated she worked as A/B Hall Manager on 7/14/2021 when Resident #1 left the facility. RN #1 stated she was informed that Resident #1 could not be found so a Code 10 was called and this included searching inside the building, outside the building, driving on the road to search, and check of local stores. RN #1 stated she notified the Director of Nursing (DON) and the Interim Administrator at 7:59 PM of the elopement and that a Code 10 had been called. RN #1 stated the DON and the Interim Administrator came to the facility and the staff continued to search for Resident #1. RN #1 stated the DON was able to speak to Resident	M 640		

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#1's son and he said Resident #1 was at home. RN #1 stated she did not know Resident #1 was wandering until the last minute when she left facility. Since Resident #1 was wandering, an elopement assessment should have been done, a wander guard bracelet should have been placed on the resident, the family and doctor should have been notified, and the resident's information should have been placed in the elopement book.

Interview with the DON on 7/20/2021 at 5:23 PM, revealed LPN #1 did the assessment on Resident #1 and she signed off on LPN #1's assessment. Stated due to Resident #1 making repetitive statements about going home and her ability to leave the building on her own, a care plan and interventions to prevent elopement should have been done immediately. Interventions should have included a wander guard, frequent monitoring, and staff to maintain close visual contact with the resident. She thought a care plan was automatically generated when the assessment was completed. The DON stated elopement is when a resident gets out of the facility and staff does not know where they are, and Resident #1 was out of the facility and the staff did not know where she was so this would be elopement. The Interim Administrator informed Resident #1's son not to bring her back to the facility. The DON confirmed the facility failed to accurately assess and investigate this incident and that it was elopement and not AMA.

Interview with the Interim Administrator on 7/21/2021 at 4:50 PM revealed the decision to call this incident an AMA rather than an elopement was made by the Corporate Nurse based on inaccurate information that a family member picked up Resident #1.

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M 640	Continued From page 11 Interview with Dietary #1 on 7/21/2021 at 5:30 PM revealed she has known the resident all of her life. Dietary #1 stated she went to see Resident #1 when she arrived at the facility to encourage her to eat her dinner. Stated while she was cleaning kitchen before leaving for the evening, Resident #1 came into the dining room area and asked for Dietary #1 to take her home. Dietary #1 stated she informed Resident #1 she could not take her home and the resident left the dietary area and headed back to her room. Stated she left work around 7:00 PM - 7:15 PM and soon after arriving home, she received a call from facility staff asking if she knew anything about Resident #1's location and she informed them she did not know. Review of information from MapQuest revealed the distance from the Facility to the Resident's home is 15.2 miles. Review of weather conditions on 7/14/2021 at 7:00 PM revealed: Temperature 79 degrees, Humidity 79%, Wind 13 MPH, No precipitation. Information obtained on TimeAndDate.com. Observation on 7/21/2021 at 7:00 PM revealed the facility is located on a two-lane road. East of the facility on the next lot is an auto repair business that is completely fenced in. West of the facility is a small business. Across the street from the facility is a small community college. The Resident and the Resident ' s son stated the resident walked to a local highway (Insert Highway name), which is a two-lane highway located 0.5 miles from the facility. For the resident to walk to this highway, she left the facility and turned to the right and was walking east. The facility is on a two-lane road that runs east and	M 640		

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west. Traffic at 7:00 PM on a weekday consists of traffic going west to east were 46 vehicles in a 10 minute period. Traffic traveling east to west consisted of 32 vehicles in a 10-minute time frame. None of these were 18 wheelers, only personal vehicles and two (2) small trucks. Once the resident walked east for 0.5 miles, there is an intersection with a traffic light which crosses the facility road and a local 2-lane highway. At that intersection there are four businesses, one on each corner. There are two convenience stores, one on the northwest corner and one on the northeast corner. On the southeast corner there is a veterinarian clinic. On the southwest corner, there is an outpatient physical therapy clinic. To head to the Resident ' s home, she would have turned right at this intersection. No one is certain on how far the resident walked prior to being picked up and taken home.
Traffic flow on this highway at 7:10 PM on a weekday consisted of traffic flow traveling north and south. In a ten-minute time frame, the traffic traveling from north to south consisted of 58 vehicles, and traffic traveling from south to north consisted of 53 vehicles. None of these vehicles during this time were 18 wheelers, only personal vehicles and 3 small trucks.

The terrain on the road the facility is on is flat with no curves or hills from the facility to the intersection. The shoulder of the road heading east has a 10 - 12-foot-wide paved shoulder that runs approximately 0.4 miles of the distance between the facility and the intersection. After that section, there is a shoulder that is approximately 5-6 feet wide with a gradual decline to a small drainage ditch approximately 2-3 feet at the lowest point. The terrain of the highway south of the intersection is flat with no immediate curves and good visibility for approximately 4 miles.

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M 640	Continued From page 13 Approximately 200 yards past the intersection going south on highway is a small residential neighborhood road and approximately 0.5 miles past that is a small church on the west side of the highway. There are scattered and wide spaced houses on east and west side of road as well as open fields. The shoulder of the road for the first 4 miles of the road from intersection heading towards resident ' s home, consist of a grassy shoulder approximately 7 feet wide. Past the shoulder is a steady decline into a drainage ditch that is approximately 7-8 feet below road height. Interview with the Administrator on 7/22/2021 at 9:45 AM, revealed an assessment should have been done as well as implementing interventions such as wander guard use and frequent monitoring of resident by staff. Confirmed Resident #1 leaving the facility was an elopement and a reportable event, and the facility failed to report this to the proper agencies. Confirmed the facility failed to initiate a baseline care immediately when a problem/concern was identified for the risk of elopement and interventions to prevent an elopement were not initiated. Interview with DON on 7/22/2021 at 10:20 AM, confirmed the resident leaving the facility and away from the staff's supervision should have been considered elopement and should have been reported to the proper entities, including the SA. DON confirmed that due to the needs of the residents and a resident at risk for elopement had been identified, the staffing was insufficient on the hall Resident #1 was on. DON confirmed the discharge was inappropriate and the resident should have been allowed to return to the facility. DON confirmed an elopement care plan and interventions should have been initiated as soon	M 640		

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as the elopement risk was identified.

Telephone interview on 7/22/21 at 10:57 AM with Resident #1's son revealed the facility did call him when his mom was missing. When asked on the first phone call with the facility if he told the staff he knew where his mother was and that a family member picked her up, he responded, "No ma'am, I did not tell them that. I did not know where she was or who picked her up. I had to leave work to look for her." The Son stated when he found his mother, he called back to the facility to tell them he had located her.

Interview with Corporate Nurse on 7/22/2021 at 2:00 PM revealed the information she received initially led her to consider this incident an AMA. She stated once the situation was looked into more, it was apparent the situation was an elopement rather than AMA and confirmed the facility failed to report the elopement of Resident #1 and failure to use appropriate measures to prevent elopement put Resident #1 and other residents with wandering behaviors at risk.

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 7/14/21.

Record review of the Minimum Data Set (MDS), Section C had not been done due to the short period of time the resident was in the facility. Resident was admitted to facility at 4:20 PM on 7/14/2021 and left the facility around 7 PM on 7/14/2021.

The facility provided an acceptable Removal Plan on 7/22/2021. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

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M 640	Continued From page 15 Removal Plan On 7/20/21, at 7 PM the State Agency (SA) surveyors notified the facility's Administrator of an Immediate Jeopardy (IJ) which began on 7/14/21 related to the facility's failure to supervise, provide adequate staffing, failed to report, and failed to implement a care plan when Resident # 1 left the facility unsupervised without staff knowledge and unnoticed on 7/14/21, resulting in an elopement. IJ templates were provided to the Administrator. Resident #1 (R1) was admitted to facility on 7/14/21 at 4:20PM. The resident was walking up and down the hall and License Practical Nurse #1 (LPN 1) redirected her several times. LPN #1 stated she saw the resident at 7:10 PM and redirected the resident to her room. At 7:30 PM the LPN was getting ready to leave her shift and went to R1's room to check on her and resident was not in her room. LPN 1 notified Charge Nurse # 1 and an elopement exercise was initiated. The resident was not found in the center so the search was extended to the outside of the center and a team member got in her car and drove around the surrounding streets. Administrator and Director of Nursing (DNS) was notified of missing resident. Unit Manager made several attempts to contact the Responsible Party (RP) without success. Director of Nursing attempted to contact the RP upon arrival to the center without success. The RP returned call to center at 8:27PM. RP left work and went home. RP called DNS back @ 8:59 PM and stated that he was with his mother at she was fine. Windows and doors were checked. The facility never determined how the resident got out. Facility completed an elopement evaluation and	M 640		

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determined the resident to be at risk for elopement. The facility did not initiate a care plan immediately, therefore staff were not aware the resident was an elopement risk. The facility failed to provide interventions to prevent elopement, nor provide adequate staffing to monitor the resident, therefore the resident left the facility without notifying any staff she was leaving. The resident did not return to the center for further assessment after elopement. The family was given a verbal discharge over the phone. The facility failed to do proper discharge planning. The facility failed to report the elopement to the appropriate entities.

Measures immediately taken to achieve compliance with prevention of elopement, adequate discharge, and staffing expectation, and to aide in preventing future elopements and possible harm were:

* Quality Assurance meeting was completed on 7/20/21 @ 9 PM. Discussion and an immediate plan including initiation of 100% head count. There were 89 residents on census that day. After a head count was completed there was only 88 residents accounted. All doors were checked. The egress doors did not open. The Quality Assurance meeting was held via telephone conference and included: Medical Director; Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and Regional Director of Clinical Operations.

* An initial investigation was started the evening of 7/14/21 by the Interim - Administrator and Director of Nursing, including interviews of team member's that were in the center at that time.

* Doors were checked by the

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M 640	Continued From page 17 Interim-Administrator on 7/14/21. Doors were checked on 7/19/21 by the Administrator. Doors and windows were checked on 7/20/21 by the Maintenance Assistant. Door codes were change on 7/20/21 by the Maintenance Director. * Facility had census of 90 residents, elopement evaluations were completed on 7/20/21 & 7/21/21 for all 90 residents by the Director of Nursing and MDS nurse. Five residents were identified at risk for elopement and reviewed. Three residents were previously at risk for elopement and already had wander guards in place. Two additional residents were identified that voiced desire to leave the center that had not previously made those comments. Wander guards were placed on them at that time. * Care plans for those five residents identified at risk for elopement were reviewed and updated as appropriate by the Minimum Data Set Nurse #1 (MDS1) and Director of Clinical Operations #1 (DCO1). All 5 were identified to have appropriate interventions in place to prevent elopement. * On 7/20/21, one resident was admitted Res # 98150 and he was assessed and was not at risk for elopement. * Beginning on 7/20/21, Director of Nursing/Assistant Director of Nursing/Unit managers to review the Baseline Care plan for 100% of new admissions on the day of admission to ensure that all high risk areas have an appropriate care plan in place. * The Director of Care Coordination reviewed discharge planning with Resident #98150 on admission on 7/20/21, and will update as needed throughout residents stay in the facility.	M 640		

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M 640	Continued From page 18 Discharge planning will include the resident, their representative and the administrative team. Education has been provided to the Social Services Director and Director of Care Coordination by the Director of Clinical Operations regarding daily monitoring expectations regarding Discharge notification education provided on 7/21/21 @ 9:00 am. * Administrator was educated on expectations of Reporting of any violation of Centers for Medicare and Medicaid (CMS) regulations per CMS guidance on 7/21/21 by the Director of Clinical Operations. * An Elopement drill was completed on 7/21/21 @ 6:20PM by the Administrator. Staff were observed to appropriately respond to the elopement drill. * Elopement books on each unit were updated on 7/21/21 with photos of all identified at risk residents by the Social Service Director. * All staff education began on 7/20/21 @ 9:30 PM by the Director of Clinical Operations regarding the following areas: Elopement process and monitoring to prevent elopement, adequate staffing to prevent elopement, expectations of reporting to State and Federal regulations, discharge process with timely notification of discharge guidelines, and process and implementation of baseline care plan for all high risk areas identified. Education to be completed by 7/21/21. Any staff who have not received the education will be removed from the schedule after 7/21/21 and will not be allowed to work until education is completed. * Beginning on 7/21/21, all new	M 640		

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admissions/readmissions will be reviewed in Daily Clinical Start up by the DNS/ADNS to assess elopement risk and to ensure appropriate interventions in place.

* On 7/21/21 @ 5:22 PM, the Administrator called the elopement in to the Mississippi State Department of Health.

* Facility will ensure adequate staffing to ensure proper monitoring of residents through scheduling of additional staff and use of extra shift bonus program as needed for any additional shift worked. Daily work force management meeting was held on 7/20/21 and staffing was reviewed. Staffing will be held daily Monday through Friday by Administrator, Director of Nursing, and Human Resources Coordinator to review and ensure staffing is adequate and address as needed. DNS receives all call outs and will adjust staffing as needed with use of shift bonus offerings and utilization of PRN staff when needed.

* The facility's corrective actions were initiated on 07/20/2021. All actions to remove the Immediate Jeopardy were completed on 7/21/21. The facility alleged immediate jeopardy removal as of 7/21/21.
(Proper Name)Administrator

On 7/23/21, the SA validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign in sheets. The SA verified the facility had implemented the following measures to remove the IJ:

* The SA validated through interview with the Administrator and DON and record review of the sign-in sheet and agenda that a Quality Assurance meeting was completed on 7/20/21 @

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M 640	Continued From page 20 9PM. Discussion and an immediate plan including initiation of 100% head count. There were 89 residents on census that day. After a head count was completed there was only 88 residents accounted. All doors were checked. The egress doors did not open. The Quality Assurance meeting was held via telephone conference and included: Medical Director; Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and Regional Director of Clinical Operations. * The SA validated through a record review that the initial investigation was started the evening of 7/14/21 by the Interim - Administrator and Director of Nursing, including interviews of team member's that were in the center at that time. * The SA validated through interview with the Administrator and Maintenance Director that doors were checked by the Interim-Administrator on 7/14/21. Doors were checked on 7/19/21 by the Administrator. Doors and windows were checked on 7/20/21 by the Maintenance Assistant. Door codes were change on 7/20/21 by the Maintenance Director. * The SA validated through interview with the DON and record review that elopement evaluations were completed on 7/20/21 & 7/21/21 for all 90 residents by the Director of Nursing and MDS nurse. Five residents were identified at risk for elopement and reviewed. Three residents were previously at risk for elopement and already had wander guards in place. Two additional residents were identified that voiced desire to leave the center that had not previously made those comments. Wander guards were placed on them at that time.	M 640		

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M 640	Continued From page 21 * The SA validated through interview with the Minimum Data Set Nurse (MDS) and record review that care plans for those five residents identified at risk for elopement were reviewed and updated as appropriate by the Minimum Data Set Nurse #1 (MDS1) and Director of Clinical Operations #1 (DCO1). All 5 were identified to have appropriate interventions in place to prevent elopement. * The SA validated through record review that on 7/20/21, one resident was admitted Res # 98150 and he was assessed and was not at risk for elopement. * The SA validated through record review and interview with the MDS nurse that beginning on 7/20/21, Director of Nursing/Assistant Director of Nursing/Unit managers to review the Baseline Care plan for 100% of new admissions on the day of admission to ensure that all high risk areas have an appropriate care plan in place. * The SA validated through record review and interview with the A Level IV Based on observation, staff interview, Resident interview, Resident Representative interview, record review, and facility policy review, the facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility for one (1) or four (4) residents reviewed for elopement risk. Resident #1. Resident #1 was admitted to the facility on 07/14/2021 at approximately 4:20 PM. Resident was observed by Licensed Practical Nurse (LPN) #1 to be pacing in the hallway and stating she was leaving and going home and required	M 640		

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redirecting several times. LPN #1 reported she last saw Resident #1 a few minutes before 7:00 PM. Certified Nursing Assistant (CNA) #1 reported she last saw Resident #1 approximately 7:00 PM when dinner trays were picked up. At the end of LPN #1's shift, at approximately 7:20 PM, LPN #1 went to check on Resident #1 and the resident could not be located. Resident #1 was away from the facility unsupervised on 7/14/2021 from approximately 7:00 PM until the Resident's son was able to locate the Resident at her residence at approximately 9:00 PM.

The facility's failure to provide adequate supervision to prevent an elopement placed Resident #1 and other residents with wandering behaviors and at risk of elopement in a situation that was likely to cause serious injury, harm, impairment, or death.

The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality (SQC) that began on 07/14/2021, when Resident #1 eloped from the facility. The facility Administrator was notified of the IJ on 07/20/2021 at 7:00 PM. The facility provided an acceptable Removal Plan on 7/22/2021, in which the facility alleged all corrective actions were completed to remove the IJ on 7/21/2021, and the IJ removed on 7/22/20. The scope and severity for CFR(s): 42 CFR: 483.25(d)(1)(2), F 689, Free of Accidents/Hazards/Supervision/Devices, was lowered to a "D", while the facility develops and implements a plan or correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings Include:

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A review of the facility's policy, "Elopement," dated April 2017, revealed, "...Process: On admission, newly admitted or re-admitted residents are assessed for elopement risk. If an elopement risk is determined an individualized plan is established and intervention is initiated to mitigate that risk..."

Record review of the written statement from the Director of Nursing (DON) revealed, "On July 14, 2021, I was called to (Proper Name of Facility) by Registered Nurse (RN) #1 stating that the nurse on B hall (LPN #1) was unable to locate her new resident, Resident #1. I informed her I would come immediately to center. After arriving to facility with the Interim Administrator, we spoke with several of the staff concerning how said resident could have left center undetected. Those staff members included: (Insert proper names for six (6) employees). All staff members stated they had not witnessed anyone leaving the center. Visitor log reviewed and no visitors were logged in during that time. The doors were tested to see if they would open when handle held down for 15 seconds. (sign on front door states it will). Front door did not open after 15 seconds." This was signed by the DON.

Interview with the Director of Nursing (DON) on 7/19/2021 at 3:20 PM, the DON stated the facility has not had an elopement, but some residents did leave Against Medical Advice (AMA).

Interview with the Administrator on 7/19/2021 at 3:20 PM, Administrator stated the facility has not had an elopement, and if they had, she would have reported it.

Phone interviews with Resident #1's son on 7/19/2021 at 5:11 PM and 6:14 PM, revealed

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M 640	Continued From page 24 Resident #1 was discharged from the hospital and admitted to the facility on 7/14/2021. He stated on that same day, Resident #1 left the facility. The son stated he spoke with an employee of the facility around 7:00 PM - 8:00 PM, but he is uncertain of the time. He stated he was informed his mom left the facility and asked if he could help locate her. The son stated he left work and started searching for her and found her alone at her home. He stated he questioned her on how she got out of facility and got home and stated she told him, "I walked out the front door" and "I walked to the highway and someone picked me up and brought me home." The son does not know who picked her up and brought her home and his mother did not know the person who picked her up, but he believes that person may have known his mother. He called the facility to report he had found Resident #1 and asked about bringing her back, but the employee he spoke with said no. He stated the next day, his Mom had to go back to the Emergency Room due to arm pain. When she left the hospital the day after that, she was admitted to another nursing home facility. He stated Resident #1's memory is "decent", but she can not remember addresses or phone numbers. Interview with Administrator on 7/19/2021 at 5:40 PM, revealed she received a phone call from the Interim Administrator on 7/14/2021 between 9:30 PM - 10:00 PM. She was told that a resident had left the facility and they had investigated the incident. She was told by the Interim Administrator that the resident did not want to be in the facility and somebody had picked her up and that Resident #1's son said a friend picked her up and took her home. She was informed by the Interim Administrator that this incident was Against Medical Advice (AMA) and not	M 640		

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elopement.

Interview and record review with the Director of Nursing (DON) on 7/19/2021 at 6:00 PM, revealed she was notified of Resident #1 missing around 7:40 PM. The DON stated she could not find her documentation regarding the investigation of the elopement, but she knows she documented it. She stated the Corporate Nurse was present during the conversations of the incident, and she was documenting the information. The DON spoke with the Corporate Nurse concerning her notes and stated the Corporate Nurse documented, "Patient admitted, alcoholic with dementia, left AMA with a friend" and "Resident #1 left after about 4 hours. Called friend to pick her up." The DON stated Resident #1's son told her and the Interim Administrator that his mother was in (Insert Proper Name of Local Town) and that a friend picked her up and she is unsure how the resident got out of the facility. She stated "I was not here. Staff member had to let them in and out. Residents know the codes, also. They sit up front and learn the code. Sometimes staff hollers the code down the hall." The DON stated that no Against Medical Advice papers were signed and no staff members witnessed the resident leave the building.

Interview with LPN #2 on 7/19/2021 at 7:15 PM, revealed on 7/14/2021, she was working on D-Hall when Resident #1 left the building. LPN #2 stated she was passing medications around 7:20 PM when she received a text message from LPN #1 informing her that a resident could not be located. LPN #2 stated she notified RN #1 Nursing Supervisor, who notified the DON and the Interim Administrator. LPN #2 stated the building and outside was searched, and a head count was done and all other residents were

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located.

Interview with Licensed Practical Nurse (LPN) #1 on 7/20/2021 at 9:18 AM, revealed on 7/14/2021 at approximately 4:20 PM, she admitted Resident #1 to B-Hall from the hospital. LPN #1 stated the resident kept pacing back and forth in the hallway, saying she wanted to leave and go home and required redirecting several times. LPN #1 stated upon admission, Resident #1 was dressed in a hospital type gown, but the last time she saw her, a little before 7:00 PM, Resident #1 had changed into a t-shirt and pajama pants. LPN #1 stated at the end of her shift, around 7:15 PM - 7:20 PM, she counted medications with the oncoming nurse at the nurse's station and after counting the medications, she went to check on Resident #1 to see if she was calmer than she had been previously. LPN #1 stated Resident #1 was not in her room, so she looked around the hallway. She asked CNA #1 if she knew where Resident #1 was, and she also did not know. LPN #1 stated as she was searching the hall and rooms, she notified LPN #2 of the situation so other staff, the DON, Supervisor, and Interim Administrator could be contacted and a Code for elopement was called. LPN #1 stated each room inside the facility and outside the building was searched and Resident #1 could not be located. Concerning staffing on 7/14/2021, LPN #1 stated B-Hall had around 15 - 20 residents with two of those being new admissions, and it was only her and CNA #1 on that hall. LPN #1 stated, "when you have residents like (formal name of Resident #1), I would not say there was adequate staffing." LPN #1 stated she did not fill out an inventory list, but she looked through Resident #1's belongings to ensure there were no unsafe items and Resident #1 did not have a cell phone in her possessions. LPN #1 stated she did not make a

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phone call for the Resident #1, and she is unaware of anyone else making a phone call for the resident. LPN #1 revealed when she left the facility after work, it was not raining and had not rained that day.

Observation, interview, and tour with the Administrator on 7/20/2021 at 10:30 AM, of the doors on the end of B-Hall and front door revealed when the door latch was pressed, the alarm sounded and in 15 seconds the doors unlocked and were able to be opened. The alarm continued to sound until the keypad code was pressed. The Administrator stated, "In reality a resident could push the door and exit building."

Interview with the Maintenance Director #1 on 7/20/2021 at 10:35 AM, revealed he is changing the keypad codes on all the exterior doors. He stated the door alarms will sound if the lever is pushed or door is opened unless the code is entered.

Phone interview with the Interim Administrator on 7/20/2021 at 11:27 AM, revealed on 7/14/2021 at approximately 7:45 PM, she and the DON received a call from the facility informing them that Resident #1 could not be located. She stated they immediately went to the facility and RN #1 had attempted to contact Resident #1's son, but calls had not been returned. The Interim Administrator stated she and the DON spoke with Resident #1's son and he informed them that a family member had picked Resident #1 up and brought her home and he was going to pick her up. She stated the son asked about bringing Resident #1 back to the facility but stated she told him not to bring her back and they would try to get another placement the next day. The Interim Administrator said she spoke with the Corporate

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Nurse and told her what Resident #1's son had said and asked if she thought it was an elopement or AMA, and the Corporate Nurse said it sounds like AMA since a family member picked her up. As for how the resident left the facility, the Interim Administrator stated the resident could have leaned on the doors for 15-20 seconds and they would have unlock due to the fire code and an alarm would sound or she could have followed someone out. The Interim Administrator stated Resident #1 did leave the building and staff were unaware of her location.

Interview with Resident #1 on 7/20/2021 at 2:30 PM, revealed the resident stated she walked out of the facility. She walked halfway home and somebody stopped and picked her up. She stated she does not know who it was, but it was a man. Resident #1 stated, "everybody in (Proper Name of Local Town) knows me." Resident #1 stated the weather was fine when she left the building and it was not raining.

Interview with Certified Nurse Assistant (CNA) #1 on 7/20/2021 at 3:12 PM, revealed she was working on B-Hall when Resident #1 was admitted to the facility and stated that Resident #1 came into the facility saying, "it's time to go home." CNA #1 stated she was able to calm Resident #1, and the resident was able to eat dinner, and when the dinner tray was picked up around 7:00 PM, the resident was in her room. CNA #1 stated she was outside B-Hall's exterior door around 7:00 PM with a resident that smokes for the smoke break, so she would have seen Resident #1 if she exited the building or attempted to exit the building through that door and the alarm would have sounded. CNA #1 stated when she was coming back into the building, LPN #1 told her Resident #1 was

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missing and a Code was called. CNA #1 stated there were about 15 residents in the isolation area of B-Hall on 7/14/2021. CNA #1 stated she checked Resident #1's inventory and she did not have a phone and she did not assist the resident to make a phone call.

Interview with RN #2 on 7/20/2021 at 4:19 PM, revealed she is the Infection Control Nurse and the Director of Clinical Education. RN #2 stated if a resident is determined to be at high risk for elopement, the assessment should be done immediately and interventions should include wander guard use, one on one with the resident, monitor and frequent visual checks, and baseline care plan.

Interview with Registered Nurse (RN) #1 on 7/20/2021 at 4:59 PM, revealed RN #1 stated she worked as A/B Hall Manager on 7/14/2021 when Resident #1 left the facility. RN #1 stated she was informed that Resident #1 could not be found so a Code 10 was called and this included searching inside the building, outside the building, driving on the road to search, and check of local stores. RN #1 stated she notified the Director of Nursing (DON) and the Interim Administrator at 7:59 PM of the elopement and that a Code 10 had been called. RN #1 stated the DON and the Interim Administrator came to the facility and the staff continued to search for Resident #1. RN #1 stated the DON was able to speak to Resident #1's son and he said Resident #1 was at home. RN #1 stated she did not know Resident #1 was wandering until the last minute when she left facility. Since Resident #1 was wandering, an elopement assessment should have been done, a wander guard bracelet should have been placed on the resident, the family and doctor should have been notified, and the resident's

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information should have been placed in the elopement book.

Interview with the DON on 7/20/2021 at 5:23 PM, revealed LPN #1 did the assessment on Resident #1 and she signed off on LPN #1's assessment. Stated due to Resident #1 making repetitive statements about going home and her ability to leave the building on her own, a care plan and interventions to prevent elopement should have been done immediately. Interventions should have included a wander guard, frequent monitoring, and staff to maintain close visual contact with the resident. She thought a care plan was automatically generated when the assessment was completed. The DON stated elopement is when a resident gets out of the facility and staff does not know where they are, and Resident #1 was out of the facility and the staff did not know where she was so this would be elopement. The Interim Administrator informed Resident #1's son not to bring her back to the facility. The DON confirmed the facility failed to accurately assess and investigate this incident and that it was elopement and not AMA.

Interview with the Interim Administrator on 7/21/2021 at 4:50 PM revealed the decision to call this incident an AMA rather than an elopement was made by the Corporate Nurse based on inaccurate information that a family member picked up Resident #1.

Interview with Dietary #1 on 7/21/2021 at 5:30 PM revealed she has known the resident all of her life. Dietary #1 stated she went to see Resident #1 when she arrived at the facility to encourage her to eat her dinner. Stated while she was cleaning kitchen before leaving for the evening, Resident #1 came into the dining room area and

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asked for Dietary #1 to take her home. Dietary #1 stated she informed Resident #1 she could not take her home and the resident left the dietary area and headed back to her room. Stated she left work around 7:00 PM - 7:15 PM and soon after arriving home, she received a call from facility staff asking if she knew anything about Resident #1's location and she informed them she did not know.

Review of information from MapQuest revealed the distance from the Facility to the Resident's home is 15.2 miles.

Review of weather conditions on 7/14/2021 at 7:00 PM revealed: Temperature 79 degrees, Humidity 79%, Wind 13 MPH, No precipitation. Information obtained on TimeAndDate.com.

Observation on 7/21/2021 at 7:00 PM revealed the facility is located on a two-lane road. East of the facility on the next lot is an auto repair business that is completely fenced in. West of the facility is a small business. Across the street from the facility is a small community college. The Resident and the Resident ' s son stated the resident walked to a local highway (Insert Highway name), which is a two-lane highway located 0.5 miles from the facility. For the resident to walk to this highway, she left the facility and turned to the right and was walking east. The facility is on a two-lane road that runs east and west. Traffic at 7:00 PM on a weekday consists of traffic going west to east were 46 vehicles in a 10 minute period. Traffic traveling east to west consisted of 32 vehicles in a 10-minute time frame. None of these were 18 wheelers, only personal vehicles and two (2) small trucks. Once the resident walked east for 0.5 miles, there is an intersection with a traffic light which crosses the

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facility road and a local 2-lane highway. At that intersection there are four businesses, one on each corner. There are two convenience stores, one on the northwest corner and one on the northeast corner. On the southeast corner there is a veterinarian clinic. On the southwest corner, there is an outpatient physical therapy clinic. To head to the Resident ' s home, she would have turned right at this intersection. No one is certain on how far the resident walked prior to being picked up and taken home.
Traffic flow on this highway at 7:10 PM on a weekday consisted of traffic flow traveling north and south. In a ten-minute time frame, the traffic traveling from north to south consisted of 58 vehicles, and traffic traveling from south to north consisted of 53 vehicles. None of these vehicles during this time were 18 wheelers, only personal vehicles and 3 small trucks.

The terrain on the road the facility is on is flat with no curves or hills from the facility to the intersection. The shoulder of the road heading east has a 10 - 12-foot-wide paved shoulder that runs approximately 0.4 miles of the distance between the facility and the intersection. After that section, there is a shoulder that is approximately 5-6 feet wide with a gradual decline to a small drainage ditch approximately 2-3 feet at the lowest point. The terrain of the highway south of the intersection is flat with no immediate curves and good visibility for approximately 4 miles. Approximately 200 yards past the intersection going south on highway is a small residential neighborhood road and approximately 0.5 miles past that is a small church on the west side of the highway. There are scattered and wide spaced houses on east and west side of road as well as open fields. The shoulder of the road for the first 4 miles of the road from intersection heading

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towards resident ' s home, consist of a grassy shoulder approximately 7 feet wide. Past the shoulder is a steady decline into a drainage ditch that is approximately 7-8 feet below road height.

Interview with the Administrator on 7/22/2021 at 9:45 AM, revealed an assessment should have been done as well as implementing interventions such as wander guard use and frequent monitoring of resident by staff. Confirmed Resident #1 leaving the facility was an elopement and a reportable event, and the facility failed to report this to the proper agencies. Confirmed the facility failed to initiate a baseline care immediately when a problem/concern was identified for the risk of elopement and interventions to prevent an elopement were not initiated.

Interview with DON on 7/22/2021 at 10:20 AM, confirmed the resident leaving the facility and away from the staff's supervision should have been considered elopement and should have been reported to the proper entities, including the SA. DON confirmed that due to the needs of the residents and a resident at risk for elopement had been identified, the staffing was insufficient on the hall Resident #1 was on. DON confirmed the discharge was inappropriate and the resident should have been allowed to return to the facility. DON confirmed an elopement care plan and interventions should have been initiated as soon as the elopement risk was identified.

Telephone interview on 7/22/21 at 10:57 AM with Resident #1's son revealed the facility did call him when his mom was missing. When asked on the first phone call with the facility if he told the staff he knew where his mother was and that a family member picked her up, he responded, "No

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ma'am, I did not tell them that. I did not know where she was or who picked her up. I had to leave work to look for her." The Son stated when he found his mother, he called back to the facility to tell them he had located her.

Interview with Corporate Nurse on 7/22/2021 at 2:00 PM revealed the information she received initially led her to consider this incident an AMA. She stated once the situation was looked into more, it was apparent the situation was an elopement rather than AMA and confirmed the facility failed to report the elopement of Resident #1 and failure to use appropriate measures to prevent elopement put Resident #1 and other residents with wandering behaviors at risk.

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 7/14/21.

Record review of the Minimum Data Set (MDS), Section C had not been done due to the short period of time the resident was in the facility. Resident was admitted to facility at 4:20 PM on 7/14/2021 and left the facility around 7 PM on 7/14/2021.

The facility provided an acceptable Removal Plan on 7/22/2021. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan

On 7/20/21, at 7 PM the State Agency (SA) surveyors notified the facility's Administrator of an Immediate Jeopardy (IJ) which began on 7/14/21 related to the facility's failure to supervise, provide adequate staffing, failed to report, and failed to

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leaving. The resident did not return to the center for further assessment after elopement. The family was given a verbal discharge over the phone. The facility failed to do proper discharge planning. The facility failed to report the elopement to the appropriate entities.

Measures immediately taken to achieve compliance with prevention of elopement, adequate discharge, and staffing expectation, and to aide in preventing future elopements and possible harm were:

* Quality Assurance meeting was completed on 7/20/21 @ 9 PM. Discussion and an immediate plan including initiation of 100% head count. There were 89 residents on census that day. After a head count was completed there was only 88 residents accounted. All doors were checked. The egress doors did not open. The Quality Assurance meeting was held via telephone conference and included: Medical Director; Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and Regional Director of Clinical Operations.

* An initial investigation was started the evening of 7/14/21 by the Interim - Administrator and Director of Nursing, including interviews of team member's that were in the center at that time.

* Doors were checked by the Interim-Administrator on 7/14/21. Doors were checked on 7/19/21 by the Administrator. Doors and windows were checked on 7/20/21 by the Maintenance Assistant. Door codes were change on 7/20/21 by the Maintenance Director.

* Facility had census of 90 residents, elopement evaluations were completed on 7/20/21 & 7/21/21

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	41TM	A. BUILDING: _____ B. WING _____	C 07/23/2021

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M 640	Continued From page 37 for all 90 residents by the Director of Nursing and MDS nurse. Five residents were identified at risk for elopement and reviewed. Three residents were previously at risk for elopement and already had wander guards in place. Two additional residents were identified that voiced desire to leave the center that had not previously made those comments. Wander guards were placed on them at that time. * Care plans for those five residents identified at risk for elopement were reviewed and updated as appropriate by the Minimum Data Set Nurse #1 (MDS1) and Director of Clinical Operations #1 (DCO1). All 5 were identified to have appropriate interventions in place to prevent elopement. * On 7/20/21, one resident was admitted Res # 98150 and he was assessed and was not at risk for elopement. * Beginning on 7/20/21, Director of Nursing/Assistant Director of Nursing/Unit managers to review the Baseline Care plan for 100% of new admissions on the day of admission to ensure that all high risk areas have an appropriate care plan in place. * The Director of Care Coordination reviewed discharge planning with Resident #98150 on admission on 7/20/21, and will update as needed throughout residents stay in the facility. Discharge planning will include the resident, their representative and the administrative team. Education has been provided to the Social Services Director and Director of Care Coordination by the Director of Clinical Operations regarding daily monitoring expectations regarding Discharge notification education provided on 7/21/21 @ 9:00 am.	M 640		

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M 640	Continued From page 38 * Administrator was educated on expectations of Reporting of any violation of Centers for Medicare and Medicaid (CMS) regulations per CMS guidance on 7/21/21 by the Director of Clinical Operations. * An Elopement drill was completed on 7/21/21 @ 6:20PM by the Administrator. Staff were observed to appropriately respond to the elopement drill. * Elopement books on each unit were updated on 7/21/21 with photos of all identified at risk residents by the Social Service Director. * All staff education began on 7/20/21 @ 9:30 PM by the Director of Clinical Operations regarding the following areas: Elopement process and monitoring to prevent elopement, adequate staffing to prevent elopement, expectations of reporting to State and Federal regulations, discharge process with timely notification of discharge guidelines, and process and implementation of baseline care plan for all high risk areas identified. Education to be completed by 7/21/21. Any staff who have not received the education will be removed from the schedule after 7/21/21 and will not be allowed to work until education is completed. * Beginning on 7/21/21, all new admissions/readmissions will be reviewed in Daily Clinical Start up by the DNS/ADNS to assess elopement risk and to ensure appropriate interventions in place. * On 7/21/21 @ 5:22 PM, the Administrator called the elopement in to the Mississippi State Department of Health.	M 640		

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M 640	Continued From page 39 * Facility will ensure adequate staffing to ensure proper monitoring of residents through scheduling of additional staff and use of extra shift bonus program as needed for any additional shift worked. Daily work force management meeting was held on 7/20/21 and staffing was reviewed. Staffing will be held daily Monday through Friday by Administrator, Director of Nursing, and Human Resources Coordinator to review and ensure staffing is adequate and address as needed. DNS receives all call outs and will adjust staffing as needed with use of shift bonus offerings and utilization of PRN staff when needed. * The facility's corrective actions were initiated on 07/20/2021. All actions to remove the Immediate Jeopardy were completed on 7/21/21. The facility alleged immediate jeopardy removal as of 7/21/21. (Proper Name)Administrator On 7/23/21, the SA validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign in sheets. The SA verified the facility had implemented the following measures to remove the IJ: * The SA validated through interview with the Administrator and DON and record review of the sign-in sheet and agenda that a Quality Assurance meeting was completed on 7/20/21 @ 9PM. Discussion and an immediate plan including initiation of 100% head count. There were 89 residents on census that day. After a head count was completed there was only 88 residents accounted. All doors were checked. The egress doors did not open. The Quality Assurance meeting was held via telephone conference and included: Medical Director;	M 640		

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M 640	Continued From page 40 Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and Regional Director of Clinical Operations. * The SA validated through a record review that the initial investigation was started the evening of 7/14/21 by the Interim - Administrator and Director of Nursing, including interviews of team member's that were in the center at that time. * The SA validated through interview with the Administrator and Maintenance Director that doors were checked by the Interim-Administrator on 7/14/21. Doors were checked on 7/19/21 by the Administrator. Doors and windows were checked on 7/20/21 by the Maintenance Assistant. Door codes were change on 7/20/21 by the Maintenance Director. * The SA validated through interview with the DON and record review that elopement evaluations were completed on 7/20/21 & 7/21/21 for all 90 residents by the Director of Nursing and MDS nurse. Five residents were identified at risk for elopement and reviewed. Three residents were previously at risk for elopement and already had wander guards in place. Two additional residents were identified that voiced desire to leave the center that had not previously made those comments. Wander guards were placed on them at that time. * The SA validated through interview with the Minimum Data Set Nurse (MDS) and record review that care plans for those five residents identified at risk for elopement were reviewed and updated as appropriate by the Minimum Data Set Nurse #1 (MDS1) and Director of Clinical Operations #1 (DCO1). All 5 were identified to have appropriate interventions in place to prevent	M 640		

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M 640	Continued From page 41 elopement. * The SA validated through record review that on 7/20/21, one resident was admitted Res # 98150 and he was assessed and was not at risk for elopement. * The SA validated through record review and interview with the MDS nurse that beginning on 7/20/21, Director ofNursing/Assistant Director of Nursing/Unit managers to review the Baseline Care plan for 100% of new admissions on the day of admission to ensure that all high risk areas have an appropriate care plan in place. * The SA validated through record review and interview with th	M 640		