MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70RM	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI), MS #23637 and MS #23664, at the facility on 12/19/23 related to an elopement. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The facility failed to provide supervision to prevent Resident #1, a cognitively impaired, vulnerable resident from leaving the facility (Facility #1) without supervision. Facility #1 failed to provide supervision to prevent the elopement of Resident #1, who was a wandering risk. Resident #1 left the facility unnoticed and unsupervised at an unknown time and was discovered by the staff at another nursing home (Facility #2) approximately 380 yards from the facility. This facility let the resident inside their nursing home and contacted Facility #1 at 9:04 PM to see if they had any resident missing and they discovered that it was Resident #1 and went to pick her up and return her to the facility. Resident #1 was last observed on 12/14/23 at 8:15 PM prior to the elopement. Resident #1 was transported back to the facility, where a head-to-toe assessment was completed and there were no noted injuries or complaints of pain or discomfort. During the investigation on 12/19/23 the SA identified an Immediate Jeopardy (IJ) that existed on 12/14/23 when Res #1 eloped from Facility #1 unsupervised. IJ existed at: Rule 45.21.8 Accidents (M640) Level IV	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/24

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M 000	Continued From page 1 The elopement placed Resident #1 and other residents at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ on 12/19/23 at 2:40 PM. Based on the facility's implementation of corrective actions on 12/14/23 through 12/15/23, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed on 12/16/23, prior to the SA's entrance on 12/19/23. At the time of the survey, the facility was licensed for 140 beds and had a census of 124.	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: Level IV Past Non Compliance Based on staff interviews, record review and facility policy review the facility failed to supervise and prevent the elopement of Resident #1, who was assessed as an elopement risk and left Facility #1 through an unarmed door on 12/14/23 unnoticed. Resident #1 was one (1) of three (3)	M 640	Past Non Compliance	12/19/23

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M 640	Continued From page 2	M 640		

residents reviewed.

The facility failed to provide supervision to prevent the elopement of Resident #1, who was a wandering risk. Res #1 walked 380 yards away from Facility #1 to Facility #2 and was discovered by staff at Facility #2 as Res #1 was attempting to get inside their building. Resident #1 left Facility #1 unnoticed and unsupervised at an unknown time. Facility #2 allowed the resident inside their nursing home and contacted Facility #1 at 9:04 PM to see if they had any resident missing and they discovered that it was Resident #1 and went to pick her up and return her to the facility. Resident #1 was last observed on 12/14/23 at 8:15 PM prior to the elopement. Resident #1 was transported back to Facility #1, where a head to toe assessment was completed and there were no noted injuries or complaints of pain or discomfort.

During the investigation on 12/19/23 the State Agency (SA) identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which existed on 12/14/23 when Res #1 eloped from Facility #1 unsupervised.

IJ and SQC existed at:

42 CFR (s): 483.25 (d) (1) (2) - Free of Accidents/Supervision/Devices (689) - Scope and Severity "J."

The elopement placed Resident #1 and other residents at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death.

The SA notified the facility's Administrator of the IJ and SQC on 12/19/23 at 2:40 PM and provided

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M 640	Continued From page 3	M 640		

the Administrator with the IJ templates.

Based on the facility's implementation of corrective actions on 12/14/23 through 12/15/23, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 12/16/23, prior to the SA's entrance on 12/19/23.

Findings include:

Review of the facility policy titled "Elopement" dated April 2017, revealed, "Purpose: To establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements..."

Record review of the facility investigation revealed that Resident #1 was allowed to exit Facility #1 on 12/14/23 unnoticed and unsupervised at an unknown time and was discovered by the staff at another nursing home, Facility #2, which was 380 yards away from Facility #1. The staff of Facility #2 heard someone trying to enter their facility by jerking on the door. Facility #2 let Resident #1 inside their building and contacted Facility #1 to see if they had a missing resident and they discovered it was Resident #1 and the staff from Facility #1 went to pick her up and returned her back to the facility. Resident #1 was last observed in Facility #1 at 8:15 PM and the call was received from Facility #2 at 9:04 PM informing them that this said resident was in their building.

An interview with the Administrator (ADM) on 12/19/23 at 9:00 AM, revealed that on 12/14/23, Resident #1 left Facility #1 unsupervised and unnoticed and she walked over to Facility #2. The ADM revealed that there were statements

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M 640	Continued From page 4	M 640		

from staff members taken saying no door alarms went off. He revealed that it was reported to him that Resident #1 was last seen standing at the C/D Nursing Station around 8:15 PM on 12/14/23. He revealed that it was also reported to him that at 9:04 PM on 12/14/23, Licensed Practical Nurse (LPN) #1 received a call from Facility #2 reporting that Resident #1 was at their facility and that her Wander Guard had set the alarm system off and they had her safe inside the building. ADM revealed that LPN #1 and Certified Nursing Assistant (CNA) #1, both from Facility #1 went to Facility #2 and picked the resident up and brought her back. He revealed that on 12/14/23, there was about forty-five minutes that resident was unaccounted for. ADM revealed that he hated it and that they couldn't prevent everything from happening; but tried really hard. The ADM stated, "It's our mess up and we are trying to minimize the damage and not let it happen again." He revealed that the breakdown was the system at the door, maintenance had discovered that the antenna on the left side of the door was not working properly and was not picking up on the wander guards; therefore, not triggering the alarm to go off. He revealed that they did not have a camera system and they could only speculate that the resident had exited out the front door. He revealed that the alarm should have triggered it, but the staff members revealed that the alarm never went off to indicate a problem. He revealed that the staff members changed out the resident's wander guard bracelet when she returned to the facility just to be safe.

On 12/19/23 at 10:00 AM, a phone interview with CNA #1 revealed that she was working the night of 12/14/23 and had last observed Resident #1 around 8:00 PM trying to enter the dining room beside the C/D nurse's station. CNA #1 revealed

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M 640	Continued From page 5	M 640		

that at 9:04 PM, a call was received from Facility #2 that they had a resident come into their facility and her name was (proper name) as stated by Resident #1 and she, CNA #1 went with LPN #1 to pick Resident #1 up. CNA #1 revealed that they arrived at Facility #2 to get Resident #1 at 9:13 PM and arrived back at Facility #1 with her at 9:23 PM. CNA #1 revealed that Facility #1's door alarms never went off as they were supposed to when a resident with a wander guard went through the door. CNA #1 recalled what Resident #1 was wearing that night and revealed that she had on a pair of gray sweatpants, a long-sleeved top, she was wearing socks, and no shoes. She revealed it was pretty chilly outside that night.

On 12/19/23 at 10:30 AM, an interview with the Maintenance Supervisor revealed that the expiration dates on all wander guards were checked monthly. He revealed that he made rounds and checked to make sure all doors were secure every morning and on a weekly basis, he checked the doors with a wander guard to make sure they were working properly. The Maintenance Supervisor revealed that when a resident with a wander guard bracelet was within 5 feet of the door, the keypad, which required a special code, would not work. The Maintenance Supervisor revealed that it would lock down the system so as not to allow anyone to get out. He stated, "We take this serious and realize that anything could have happened." The Maintenance Supervisor also revealed that if the door was opened and a resident with a wander guard walked up, the alarm would go off to alert staff members. The Maintenance Supervisor revealed that the alarm system on the doors were checked first thing on the morning of 12/15/23 and it was determined that there was an internal

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M 640	Continued From page 6	M 640		

malfunction with the antenna located on the left door which would not activate the alarm system. The Maintenance Supervisor revealed that normally the antenna would pick up the signal from the wander bracelet if a resident tried to exit the doors and the door alarm would go off. He revealed that they put a new antenna on the door, and everything was working fine now. The Maintenance Supervisor measured the distance from Facility #1 to Facility #2 which was 1,140 feet which equaled 380 yards resident walked on the night of 12/14/23.

On 12/19/23 at 11:00 AM, a phone interview with LPN #1 revealed that she was working on the night of 12/14/23 and had last observed Resident #1 standing at the C/D Nursing Desk at 8:15 PM. LPN #1 revealed that this resident walked up and down the halls all the time; but would usually walk up to the windows, look outside, turn around and walk the other way. She revealed that Resident #1 had never been noticed to try and get out of the doors. She revealed that at 9:04 PM, Facility #2 called and asked if they had a resident missing by the name of "Proper Name". She revealed that she and CNA #1 got into her car and went to Facility #2 and brought Resident #1 back to Facility #1. LPN #1 revealed that Resident #1 was in no distress and her vital signs were all normal. LPN #1 revealed that when they returned to Facility #1, she called and reported the incident to the Administrator and to the Director of Nursing. LPN #1 revealed that Resident #1 had Dementia and mumbled speech frequently. She also revealed that she had never witnessed Resident #1 pushing on the doors or trying to leave the facility. LPN #1 revealed that the door alarms never went off at Facility #1 to alert them that she had gotten out.

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M 640	Continued From page 7 On 12/19/23 at 11:30 AM, an interview with Director of Nursing, revealed that LPN #1 had called and reported the elopement around 9:30 PM to her. The DON revealed they did a full body audit on Resident #1, watched all doors and initiated one on one care for Resident #1. Resident #1's son was notified as well. DON stated that Resident #1 always walked and mumbled. She stated, "Everyone just knows to watch her, she's constantly on the move." DON revealed that Resident #1 was on hourly checks already as a latest intervention updated on her Care Plan. DON revealed that it was reported to her that Resident #1 went to the old part of Facility #2 that wasn't used anymore which was "A straight shot from here." She revealed that Resident #1's wander guard bracelet had set off Facility #2's alarm system when she tried to get their door open; but had not set off the alarm at Facility #1 where she left from. DON revealed that the next morning, maintenance came in, investigated the door situation, and found that the antenna on the left side of the entrance door wasn't working properly, replaced it, and turned up the sensitivity. She revealed that on the night of 12/14/23, that Resident #1 had been on hourly checks and the nurse had not missed any of them. She revealed that the incident happened between her scheduled checks and that the staff members never knew she was out of the building until Facility #2 called them. She revealed that they also called for an on-site inspection of the door alarm system by the company and they expected them to be there December 27, 2023. She revealed that she reported the incident to the State Agency and to the Attorney General's Office, initiated an immediate investigation, In-services on abuse, neglect, elopement. She revealed that they had been conducting monthly elopement drills; but, after this incident, more	M 640		

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M 640	Continued From page 8	M 640		

frequently. She revealed that Maintenance Department was checking doors weekly. DON revealed that Nurses checked all wander guard bracelet function and location every shift and document on the Medication Administration Record (MAR).

Record review of "Progress Notes" dated 12/10/23 at 7:35 AM was documented that resident was alert with some confusion, had slurred speech at times but can be understood sometimes. Resident #1 ambulates throughout the facility with redirection and supervision.

Record review of the weather in (proper name of city) on 12/14/23 documented that the temperature at the time of the elopement was 52 degrees Fahrenheit, clear skies and no rain.

Record review of the Admission Record revealed the facility admitted Resident #1 on 04/14/2017 with diagnoses of Alzheimer's Disease, Need for Assistance with Personal Care, Dementia, and Unspecified psychosis.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/2023 revealed Section C0100 that the Brief Interview for Mental Status (BIMS) should not be conducted due to resident is rarely/never understood. Under C1000 Cognitive Skills for Daily Decision Making was documented that resident was severely impaired. Section P0200 revealed that a Wander/Elopement Alarm was used daily.

The facility implemented the following Corrective Action Plan prior to the State Agency's (SA) entrance on 12/19/23:

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M 640	Continued From page 9 On 12/14/23 at 9:23 PM, Resident #1 was assisted back into Facility #1 with easy redirection, one on one monitoring was initiated, Physician and Resident Responsible Party were notified. Resident #1 was assessed by nursing staff, elopement risk assessment performed, care plans, and elopement book were updated to reflect elopement risk and monitoring. Staff completed a room-to-room audit of all residents to assure them all were safe and accounted for. All residents with Code Alert Bracelets were checked for functionality and positioning. All doors and windows were checked for proper function and operation. ADM began an investigation to determine how this resident went outside and assessed each resident for potential risk for elopement. In-Services on Elopement guidelines, Abuse, Neglect, prevention of accidents and supervision of residents. Elopement drills were conducted on all three shifts beginning 12/15/23, then weekly was initiated. Care plans were updated for Wander Guard bracelets to be checked every shift rather than once a day. Initiated door checks daily. It was determined that Resident #1 was last seen by Facility #1 staff on 12/14/23 at 8:15 PM and was notified of resident being inside Facility #2 at 9:04 PM. The facility was notified that IJ's were identified for Federal Tag 656 Care Plans and Federal Tag 689 Failure to Prevent Accidents and Hazards on 12/19/23 at 2:20 PM. On 12/14/23 the facility was notified by Long Term Care Facility #2 at 9:04 pm that Resident #1 was trying to enter their facility. The nursing staff last saw the resident at 8:15 pm at C/D wing nurses' station. It was determined that Resident # 1 was last seen by facility staff at 8:15 pm and returned to facility at 9:23 pm on 12/14/23. On December	M 640		

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M 640	Continued From page 10 19 at 2:40 PM the facility was verbally notified that Immediate Jeopardy (IJ) was identified for Federal tag 656- Care Plans and Federal tag 689- Failure to Prevent Accidents and Hazards. The facility received IJ templates on December 19, 2023, at 2:40 PM. Immediate Actions: At 9:30 pm on 12/14/23 Executive Director notified Resident # 1 Responsible Representative of the resident elopement from facility. At 9:45 pm on 12/14/23 the facility completed a 100% head count of all other residents to ensure they were accounted for. All residents were found to be in the facility. Upon return to facility Resident # 1 was assessed by Licensed Practical Nurse (LPN) with no injuries noted. On 12/14/23 all doors were monitored throughout the night until maintenance staff arrived on 12/15/2023 at 8:00 am to assess all facility exit doors, doors were checked for proper functioning by Maintenance Assistant and PRN Maintenance personnel. It was discovered that a bad antenna could have caused the door not to alarm when resident exited the facility. A new antenna was immediately put in place and troubleshooting was completed with the vendor via phone to ensure proper functioning. On 12/15/23 at 8:30 am residents with risk of elopements were reevaluated and updated to ensure all residents for risk for elopement had appropriate interventions in place. No negative findings.	M 640		

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M 640	Continued From page 11 At 9:23 pm on 12/14/2023 the Executive Director and Director of Nursing begin official investigation of Resident #1 Elopement. On 12/14/23 at 11:00pm in-services was initiated by Director of Nursing to include all staff on Elopement Policy and Procedures and Abuse-Neglect, in-services to be completed by 12/15/2023 with no staff allowed to work until in-service completed. On 12/15/23 at 9:00 am, Infection Preventionist Registered Nurse (RN) checked all residents at risk for elopement wander-guard bracelet for placement and function with no negative findings. On 12/15/23 at 9:30 am, a Quality Assurance (QA) meeting was held with the Medical Director via phone, Director of Nursing, Administrator, Nurse Practitioner (NP), Social Services, Director of Care Coordinator, Assistant Director of Nursing, Director of Clinical Education and Minimum Data Set Nurse (MDS). At 2:57 pm on 12/15/23, the Mississippi State Department of Health (MSDH) was notified of the elopement with the resident by Executive Director. On 12/15/23 at 3:20 pm Maintenance Assistance initiated an Elopement Alarm Drill with employees across all shifts, to include 7a-3p, 3p-11p, 11p-7a shift employees. All corrective actions were completed on 12/15/23 and the facility alleges removal of the Immediate Jeopardy (IJ) on 12/16/2023. The State Agency (SA) validated the facility's Past Non-Compliance (PNC) Removal Plan/Corrective	M 640		

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M 640	Continued From page 12 Action on 12/19/23: The SA validated through interviews and record review that on 12/14/23 at 9:30 PM Executive Director notified Resident #1 Responsible Representative of the resident elopement from facility. The SA validated through interview and record review that on 12/14/23 at 9:45 PM the facility completed a 100% head count of all other residents to ensure they were accounted for. The SA validated through interview and record review that on 12/14/23 upon return to facility Resident #1 was assessed by Licensed Practical Nurse (LPN) with no injuries noted. The SA validated through interviews and record review that on 12/14/23 all doors were monitored throughout the night until maintenance staff arrived on 12/15/23 at 8:00 AM to assess all facility exit doors, doors were checked for proper functioning by Maintenance Department. It was discovered that a bad antenna could have caused the door not to alarm when resident exited the facility. A new antenna was immediately put in place and troubleshooting was completed with the vendor via phone to ensure proper functioning. The SA validated through interviews and record reviews that on 12/15/23 residents with risk of elopements were reevaluated and updated to ensure all residents at risk had appropriate interventions in place. The SA validated through interviews and record review that on 12/14/23 at 9:23 PM, the Executive Director and Director of Nursing began official	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70RM	A. BUILDING: _____ B. WING _____	C 12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

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M 640	Continued From page 13 investigation of Resident #1 elopement. The SA validated through interview and record review that on 12/14/23 at 11:00 PM that In-Services were initiated by Director of Nursing to include all staff on Elopement Policy and Procedures, Abuse-Neglect, In-Services were completed by 12/15/23. The SA validated through interview and record review that on 12/15/23 Infection Preventionist Registered Nurse checked all residents at risk for elopement wander-guard bracelet for placement and function with no negative findings. The SA validated through interview and record review that on 12/15/23 at 9:30 AM, a Quality Assurance (QA) meeting was held with the Medical Director via phone, Director of Nursing, Administrator, Nurse Practitioner (NP), Social Services, Director of Care Coordinator, Assistant Director of Nursing, Director of Clinical Education and Minimum Data Set Nurse (MDS). The SA validated through interview and record review that on 12/15/23 at 2:57 PM, the Mississippi State Department of Health (MSDH) was notified of the elopement with the resident by Director of Nursing. The SA validated that on 12/15/23 at 3:20 PM Maintenance Assistant initiated an Elopement Alarm Drill with employees across all shifts, to include 7a-3p, 3p-11p, 11p-7a shift employees. The SA validated through observations, record reviews, and facility policy reviews that all corrective actions were completed on 12/15/23 and the facility alleges removal of the Immediate Jeopardy (IJ) on 12/16/2023.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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