

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70RM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/22/2024
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF RIPLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Complaint Investigation (CI) MS# 23810 on 01/09/24 through 01/22/24 related to an elopement, when the facility failed to provide supervision to prevent the elopement of Resident #1 who was diagnosed with Alzheimer's Disease. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. Resident #1 was allowed to exit the facility on 01/07/24 unnoticed and unsupervised at an unknown time and was discovered to be missing from the facility at approximately 8:10 PM. On 01/07/24 at approximately 8:00 PM, the police department received a 911 call from an unknown bystander who had seen an elderly lady walking with no shoes on who appeared to belong to a nursing home. A local Police Officer was dispatched and found Resident #1 walking in the middle of the street approximately 1850 feet from the facility and she had no shoes and no coat on. The Police Officer assisted Resident #1 into the backseat of his car and took her to the facility where he discovered that the facility staff were looking for her. Resident #1 was last observed in the facility at 7:55 PM, a Code 10 (elopement) was called at 8:10 PM, and Resident #1 was returned to the facility at 8:25 PM. The facility failed to provide supervision and communicate the resident's attempts to exit the facility through the kitchen door for Resident #1, who was diagnosed with Alzheimer's and Dementia. Resident #1 was allowed to leave the facility unnoticed and unsupervised until she was picked up by a local Police Officer in the middle of the street about 1850 feet away from the facility. The elopement placed Resident #1 and other	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/09/24

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M 000	Continued From page 1 residents who were at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death. During the investigation on 01/09/24 the State Agency (SA) identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC). The IJ began on 01/01/24 when Res #1 was seen by facility staff attempting to exit through the kitchen. Resident #1 eloped from the facility on 1/07/24 through the kitchen. IJ and SQC existed at: Rule 45.17.2 Resient Rights M500 Level IV Rule 45.21.8 Accidents M640 Level IV The SA notified the facility's Administrator (ADM) of the IJ and SQC on 01/11/24 at 3:19 PM. The facility submitted an acceptable Removal Plan on 1/12/24, in which they alleged all corrective actions to remove the IJ were completed on 1/12/24, and the IJ removed on 1/13/24. The SA validated the Removal Plan on 1/22/24 and determined the IJ was removed on 1/13/24, prior to exit. Therefore, the scope and severity for Rule 45.17.2 Resient Rights M500 and Rule 45.21.8 Accidents M640 were lowered from a Level IV 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. At the time of the investigation on 01/09/24 the facility had a census of 122 with a license for 140 beds.	M 000		

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M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and	M 500		2/2/24

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M 500	Continued From page 3 understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline	M 500		

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M 500	Continued From page 4 or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M 500		

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M 500	Continued From page 5 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on interviews, record review and facility policy review the facility failed to protect the resident's right to be free from neglect as evidenced by failure of the staff to communicate and put measures in place to prevent the second elopement of Resident #1 who left the facility on 01/07/24 unnoticed and unsupervised. Resident #1 was one (1) of three (3) residents reviewed. Resident #1 was allowed to exit the facility on 01/07/24 unnoticed and unsupervised at an unknown time and was discovered to be missing from the facility at approximately 8:10 PM. On 01/07/24 at approximately 8:00 PM, the police department received a 911 call from an unknown bystander who had seen an elderly lady walking	M 500	M500 – Resident Rights The center addressed the corrective action for the resident #1. Upon return to center Resident #1 was assessed by staff nurse with no negative findings. One to one staff supervision was implemented. On 01/07/2024 at 8:30 pm 100% head count was completed of all other residents to ensure they were accounted for. Responsible party of Resident #1 was notified on 01/07/24 at 10:00pm and returned call the following day at 8:08am and notified of incident. Medical Director, Physician's Assistant and Nurse practitioner were notified of incident on 01/07/2024 at 8:55 pm. Maintenance staff arrived at center on 01/07/2024 at 9:30pm to ensure proper functionality of exit doors	

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M 500	Continued From page 6 with no shoes on who appeared to belong to a nursing home. A local Police Officer was dispatched and found Resident #1 walking in the middle of the street approximately 1850 feet from the facility and she had no shoes and no coat on. The Police Officer assisted Resident #1 into the backseat of his car and took her to the facility where he discovered that the facility staff were looking for her. Resident #1 was last observed in the facility at 7:55 PM, a Code 10 (elopement) was called at 8:10 PM, and Resident #1 was returned to the facility at 8:25 PM. A head-to-toe assessment was completed immediately upon her return to the facility. Resident #1 was a wandering risk and had previously exited the facility on 12/14/23 and once again eloped from the facility without staff knowledge on 1/7/24. The facility's failure to provide supervision to prevent an elopement for Resident #1 who was actively exit seeking and diagnosed with Alzheimer's and Dementia allowed her to leave the facility unnoticed and unsupervised until she was picked up by a local Police Officer in the middle of the street about 1850 feet away from the facility. The elopement placed Resident #1 and other residents who were at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which began on 01/07/24 when Res #1 eloped from the facility unsupervised. The SA notified the facility's Administrator (ADM) of the IJ and SQC on 01/11/24 at 3:19 PM, and provided IJ templates to the ADM.	M 500	and alarm systems. Director of Nursing Services checked all residents currently at risk for elopement for wanderguard bracelet placement and functionality. 100% of residents were reassessed for elopement risk to ensure care plans and interventions reflect appropriate risk for elopement, completed by Director of Nursing Services on 01/07/2024 with no negative findings. Minimum Data Set Nurse reviewed medical records of all residents to determine those residents that can be interviewed versus those who could not be interviewed. Those residents with a Brief Mental Status score of 11 or above were interviewed by the Assistant Director of Nursing, Unit Managers and Minimum Data Set nurses. Physical assessments of those residents with a Brief Mental Status score below 11 were conducted by the Assistant Director of Nursing, Unit Managers and Minimum Data Set nurses. No negative findings were noted in either assessments or interviews. This action was completed on 01/11/2024. • All residents have the potential to be affected by this deficient practice. • To avoid recurrence of this event Director of Clinical Education provided education of all staff across all shifts regarding resident's rights. This action started on 01/12/2024 and no staff was allowed to work until receiving education. • The center plans to monitor the effect of systemic changes to ensure solutions are sustained. Administrator and Director of Nursing Services. All exit doors will be monitored weekly by Maintenance Director for 12 weeks for safety and functionality	

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M 500	Continued From page 7 The facility submitted an acceptable Removal Plan on 1/12/24, in which they alleged all corrective actions to remove the IJ were completed on 1/12/24, and the IJ removed on 1/13/24. The SA validated the Removal Plan on 1/22/24 and determined the IJ was removed on 1/13/24, prior to exit. Therefore, the scope and severity for Rule 45.17.2 Resident Rights M500, was lowered from a Level IV 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. Findings Include: Record review of the facility policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy" with effective date of January 2019 revealed "Purpose: To prohibit and prevent ... neglect ...Definitions: ...Neglect: Failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress..." Record review of Facility "Investigation Template" completed by Administrator documented the following: "On 1/7/2024 at 8:10 pm a code 10 was called as resident was unable to be located. Staff completed a room to room audit to ensure all residents were safe and accounted for. At 8:25 pm resident was escorted back into center by Police Department officer. Investigation Summary: "Review of the center's maintenance camera revealed the resident exited the center out an unlocked door in the rear of the center..."	M 500	beginning on 01/15/2024. Director of Nursing Services and Assistant Director of Nursing will conduct 100% audit of residents at risk for elopement for appropriate care plans and interventions beginning week of 01/11/2024. Wanderguard bracelets and functionality will be checked weekly by maintenance staff weekly for 12 weeks beginning week 01/11/2024. Director of Nursing, and Assistant Director of Nursing are to monitor 100% of all residents at risk for elopement to ensure proper interventions and care plans are in place weekly for 4 weeks and monthly thereafter. This action was implemented on 01/11/2024. Social Services will conduct interviews of 5 residents with Brief Interview of Mental Status score of 11 or higher weekly for 8 weeks and monthly for one month, beginning on 01/11/2024. Director of Nursing or Nurse Managers will conduct physical assessments of 5 residents per week to determine abuse/neglect or injury of unknown origin for those residents with Brief Interview of Mental Status who score below 11: weekly for 8 weeks then monthly for one month. This action was started on 01/11/2024. All findings of these interviews and physical assessments will be presented weekly for 8 weeks then monthly thereafter in Quality Assurance meetings beginning on 01/11/2024 as a performance improvement plan until such time compliance is reached. Date of completion: 2/2/24	

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M 500	Continued From page 8 Record review of "Progress Notes" Type: Behavior Charting, completed by Licensed Practical Nurse (LPN) #2, dated 01/01/2024 at 18:48 (6:48 PM) revealed "Resident constantly trying to get out of building, she got into the kitchen and was headed out the back door before a staff member caught her. We are ensuring that she stays on this side of building however its hard to watch her 24/7." An additional entry by LPN #2 at 18:58 (6:58 PM) revealed "DON (Director of Nursing) notified, ensured that kitchen doors were locked." Record review of "Progress Note" dated 01/04/2024 and signed by the Family Nurse Practitioner (FNP) on 01/05/2024 revealed " ...Chief Complaint/Reason for this Visit - Facility requested visit for not sleeping at night and wandering throughout the night ...HPI (History of Present Illness) relating to this visit DNS (Director of Nursing Services Proper Name) reported that resident has insomnia during the night and wanders aimlessly throughout facility at night with exit seeking behaviors. Staff report resident wanders during day time hours but wandering increases late in the afternoon and continues through night time hours with exit seeking behavior increasing during night time hours as well ...Cognitive Status: Forgetful, Dementia, Confused ..." On 01/09/24 at 8:45 PM, during an interview with LPN #1, revealed that she was working the night of 01/07/24 when Resident #1 left the facility without staff knowledge. LPN #1 stated that she had last seen Resident #1 that night around 7:50 PM walking down B-Hall. She revealed that Resident #1's cognitive status is not good due to dementia. She stated they could hold her hand and easily redirect her back to her room. LPN #1	M 500		

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M 500	Continued From page 9 revealed that Resident #1 had been seen exit seeking a lot lately and stated, "They think she may have exited the kitchen." On 01/09/24 at 9:05 PM, an interview with the Administrator (ADM) revealed that Resident #1 had gotten out of the building again on 01/07/24 on the night shift. He revealed that according to interviews and statements taken by staff, Resident #1 was last seen around 7:55 PM and that there was about 20 to 25 minutes that Resident #1 was unaccounted for that night. The ADM revealed that he thought she left through the kitchen door this time. He revealed that the staff had been doing hourly checks since the last elopement incident on 12/14/23 and that this happened between the scheduled hourly visual checks. The ADM revealed that a Code 10 (elopement of a resident) was called around 8:10 PM. Resident #1 was last seen around 7:55 PM and was returned to the facility by a police officer around 8:25 PM or 8:30 PM. The ADM revealed that Maintenance came in that night and checked all of the windows and doors, checked all of the door alarms and wander guard bracelets and everything worked properly. The ADM revealed that the only way possible for her to get out was through the kitchen door. He revealed that the two doors that led from the dining room into the kitchen had locks on them from the inside of the kitchen and staff had to push the lock in and turn it for them to lock properly. He stated he wasn't aware that Resident #1 had gone back into the kitchen earlier that evening until he read the statements provided by the staff during the investigation of the elopement. The ADM indicated that this resident wanders a lot and according to what he was told, Resident #1 was last seen in the dining room around 7:25 PM on 01/07/2024. The ADM revealed that Resident #1	M 500		

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M 500	Continued From page 10 was placed on one on one (1:1) supervision after the incident until the new kitchen door locks were installed on 01/08/24 at 1:00 PM. He stated, "The only thing we really changed were the kitchen doorknobs and put a pin lock on the doors so that everyone who entered had to have the code." On 01/09/24 at 10:05 PM, an interview with Certified Nursing Assistant (CNA) #1, revealed that she was working on the night of 01/07/24 when Resident #1 got out of the facility. She revealed that Resident #1 liked to wander at night and sometimes she would walk to the end of the hall, jiggle the door to see if it would open. CNA #1 revealed that it was hard to keep up with Resident #1 most of the time because she was constantly on the move. CNA #1 revealed that on 01/07/24 at around 7:35 PM, a kitchen staff member brought Resident #1 to her on the C/D hall and told her that Resident #1 had gotten into the kitchen again. CNA #1 revealed that she brought Resident #1 to the CNA she was assigned to for the night, and he took care of her. CNA #1 revealed that a little after 8 PM, Resident #1's CNA asked her if she had seen Resident #1. CNA #1 revealed that they looked down halls, resident rooms, and outside. CNA #1 revealed that a few minutes later, the police brought Resident #1 back to the facility. CNA #1 stated, "I have no idea how she got out." On 01/10/24 at 10:10 AM, an interview with the Administrator (ADM) revealed that all windows and doors were checked by Maintenance, and everything worked properly. He stated there was still 20 minutes that Resident #1 was unaccounted for the night of 01/07/24. The ADM agreed that a lot could have happened to her in 20 minutes and stated, "I'm just glad she was safe, it could have been really bad."	M 500		

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M 500	Continued From page 11 On 01/10/24 at 10:20 AM, a phone interview with the Director of Nursing (DON), revealed that on Sunday night 01/07/24, the Administrator called and told her about Resident #1 getting out of the building again. She revealed that she was off, but came on to the facility. The DON revealed that Maintenance came in and checked all the doors, and she was confident that the kitchen door was the only door Resident #1 could have gotten out of. The DON revealed that Resident #1 had walked into the kitchen a couple of times that she knew of prior to this night because staff had mentioned it to her. The DON stated, "This had happened during the day while we were there." The DON stated that she wasn't aware that Resident #1 had been brought out of the kitchen earlier the night of 01/07/24 until she arrived on that Sunday night around 9:00 PM. On 01/10/24 at 10:45 AM, an interview with Dietary Aide #1, revealed that she was working on the evening of 01/07/24 during the time that Resident #1 got out of the building. She revealed that at approximately 7:30 PM or a little after, she was bent down washing dishes in the washroom next to the kitchen door when she heard something. Dietary Aide #1 revealed that she saw that Resident #1 had come into the kitchen, had walked past her and was standing over by the stove and was walking towards the exit door which led to the outside of the building. Dietary Aide #1 revealed that she was in the kitchen by herself when this happened because Dietary Aide #2 had taken the trash out. Dietary Aide #1 revealed that she took Resident #1 by the hand and led her out of the kitchen and took her to CNA #1 who was working on the hall. Dietary Aide #1 revealed that about 30 minutes later, she came out of the kitchen to see that a CODE 10	M 500		

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M 500	Continued From page 12 was called and found out that Resident #1 was missing. This Dietary Aide #1 revealed that she was familiar with Resident #1 and that the resident walked constantly and was seen frequently at doors looking out. On 01/10/24 at 11:00 AM, an interview LPN #2 revealed that Resident #1 usually slept during the day until late afternoon or supper time and then walked the floors. LPN #2 stated, "She stays busy, just does her thing." She also stated, "We try to work together with the CNAs and do the best we can to keep our eyes on her but it's hard with her constantly on the move." She revealed that when Resident #1 walked the halls, she would push on the doors, then turn around and walk off if the doors wouldn't open. She revealed that Resident #1 was not combative and was easily redirected; but would often return to what she was doing. LPN #2 stated, "Everyone knows that as soon as you redirect her, she goes right back." LPN #2 revealed that Resident #1 had dementia but said she was "Smarter than you think, it's like she's watching and waiting." On 01/10/24 at 11:20 AM, an interview with the Administrator revealed that there were two older video cameras on the Maintenance Shop out behind the facility. He revealed that the cameras were 50 feet from the facility pointing back towards the back of the Nursing Home where the kitchen exit door was. The Administrator revealed that they played back the video camera footage, and it revealed Resident #1 exiting the kitchen door to the outside. The ADM stated, "We do have evidence of her exiting the building and I know for sure that she went out the side kitchen door, not out the Emergency Exit door in the dining room." The ADM revealed that it was dietary not keeping the doors from the dining	M 500		

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M 500	Continued From page 13 room into the kitchen locked properly that caused Resident #1 to get out. The ADM revealed that Maintenance had come in and changed the door locks on the doors which led from the dining room into the kitchen and had put in keypads that required a code to enter. The ADM stated, "Now they don't have a choice but to keep the doors locked." The ADM revealed that he did not realize Resident #1 had gotten into the kitchen earlier the day of 01/07/24 until he was reading statements. The ADM revealed that the kitchen doors would lock but staff were not keeping them locked and stated, "I do know that I've been on them about keeping the kitchen doors locked." On 01/10/24 at 11:55 AM, an interview with Dietary Aide #2, revealed that she was working on 01/07/24 in the kitchen. She revealed that she was outside taking the trash out and when she returned, was told by Dietary Aide #1, that Resident #1 had walked into the kitchen and was headed towards the exit door over by the stove. Dietary Aide #2 revealed that she got snacks together and when she passed out the snacks around 7:30 PM to A/B hall, she saw Resident #1 exiting a resident's room on that hall. She revealed that after 8:00 PM, a CODE 10 was called, and everyone went to look for her. Dietary Aide #2 revealed that Resident #1 came into the kitchen pretty often, but most of the time she just opened the door and closed it back without coming in. Dietary Aide #2 revealed that if Resident #1 opened the door to the kitchen, the staff would find a nurse or CNA to get her out of the kitchen. Dietary Aide #2 stated, "If we didn't, she would just come right back." She revealed that Resident #1 had come into the kitchen a couple times while she had been at work but couldn't recall the dates. Dietary Aide #2 revealed that they always made sure the kitchen doors	M 500		

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M 500	Continued From page 14 were locked before they left at night-time. She revealed that one door they had to manually lock when they were in the kitchen. Dietary Aide #2 revealed that Resident #1 must have gone into the kitchen while she (Dietary Aide #2) was passing out snacks and while Dietary Aide #1 was washing dishes for them not to have seen her. On 01/10/24 at 12:10 PM, a phone interview with the Police Officer who found the resident, revealed that on 01/07/24 around 8:00 PM, the Police Department had received a 911 call from a bystander who had seen an elderly lady walking with no shoes on who appeared to belong to a nursing home. The Officer revealed that he drove to the area and found that Resident #1 was walking in the middle of the street behind the Emergency Department at the local County Hospital which was a pretty good way from the nursing home. The Officer revealed that the resident had a shirt, jogging pants, and socks on. The Officer stated that Resident #1 "was not wearing a coat or shoes." He stated that he stopped her, and the resident seemed to be confused. He asked her where she was going, and she told him to the nursing home. He revealed that she was hard to understand but Resident #1 told him she was going back to "Proper Name of Facility". The officer revealed that he helped her into his car and drove her back to the facility. The Officer revealed that he released her to to LPN #3. Record review of the "City of (Proper name of City) Police Department Incident Report" revealed " ...Narrative ...I was informed by (Proper Name) LPN #3 that this was not the first time that this has happened, that one of the doors in the building was not locked and does not have an alarm on it" This incident report was	M 500		

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M 500	Continued From page 15 completed by the Police Officer on 01/07/24. On 01/10/24 at 4:25 PM, a phone interview with LPN #3 revealed that she was working on 01/07/24, the night that Resident #1 got out of the facility. LPN #3 revealed that she had seen Resident #1 several times walking all around on A/B hall and E/F hall and staff members kept bringing her back to her room. LPN #3 revealed that Resident #1 was last seen just outside her room a little before 8:00 PM. She revealed that about 8:10 PM, she asked the CNA who was assigned to Resident #1 to go see if she was in her room and he found that she was not. LPN #3 revealed that she called a Code 10 and immediately started looking for her. She revealed that they looked on all halls, in all rooms and outside the building. LPN #3 revealed that she went to the front door about 8:25 PM and saw a police car drive up and then saw that he had Resident #1 in the back seat. She revealed that the police officer brought her to the door and stated, "I believe I have someone who belongs to y'all" and the officer released Resident #1 to them. LPN #3 revealed that Resident #1 had a pair of sweatpants on with a cuff at the bottom, had a long-sleeved shirt on, some gripper socks and had no coat or shoes on. She revealed that they immediately got her inside, checked her vital signs and did a head-to-toe assessment and there were no injuries noted. On 01/11/24 at 11:05 AM, an interview with LPN #2 revealed that on 01/01/24, Resident #1 had walked into the kitchen and was found to be on the left side of the stove walking towards the exit door when she was approached by a dietary aide and redirected back to the C/D hall. LPN #2 revealed that the kitchen doors should have been locked so that residents couldn't enter, and this	M 500		

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M 500	Continued From page 16 situation should have been reinforced and monitored better so as to help prevent the elopement. She revealed that the door that goes to the outside of the building from the kitchen was unlocked. LPN #2 revealed that on 01/01/24 after supper, the staff members were in the kitchen pulling trays getting ready to wash dishes when one of the staff members in the kitchen saw Resident #1 heading straight for the exit door. LPN #2 revealed that she reported this to the DON who told her to make sure the kitchen doors were locked and to put a progress note (behavior) in about the incident and to make sure to cover herself in case the resident was to get out of the building again. LPN#2 revealed that this was the first and only time that this had happened on her shift that she was aware of. She revealed that Resident #1 seemed to have her days and nights mixed up and that her wandering seemed to be worse later in the evening. LPN #2 agreed that had this incident been addressed and taken care of back the first of the month when it happened and was reported to the DON it might have prevented Resident #1 from getting out of the facility on 01/07/2024. On 01/11/24 at 11:30 AM, an interview with Minimum Data Set (MDS) Coordinator, revealed that they had been having Quality Assurance and Performance Improvement (QAPI) Meetings every month with the Medical Director present. The MDS Coordinator revealed that Quality Assurance Performance Improvement (QAPI) was a functional tool that forced everyone to look at flaws if something had happened and a good way to follow up. She stated, "It's a continual thing." The MDS Coordinator revealed that she was not aware of the wandering incident where Resident #1 was found inside the kitchen heading out the exit door on 01/01/2024. She revealed	M 500		

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M 500	Continued From page 17 that this was not brought up in stand up or in QAPI meeting but then she had missed some. The MDS Coordinator stated, "I didn't know about this incident and I should have. I must have missed some of this." The MDS Coordinator agreed that the facility neglected to handle this incident and it should have been reported, discussed, and taken care of. She revealed that it should have been care planned, interviews should have been completed, and they should have made sure that the incident was noted, and things were in place. The MDS Coordinator agreed that if the incident with Resident #1 had been taken care of on 01/01/24, it could have prevented the elopement incident on 01/07/24 which put the resident at risk of harm. The MDS Coordinator stated, "Apparently we dropped the ball on this one." On 01/11/24 at 12:20 PM, an interview with the ADM revealed that he was not aware of the incident with Resident #1 walking into the kitchen and heading out the exit door which occurred on 01/01/24. He stated, "I had no idea, no one told me that." The ADM revealed, "I was told that the kitchen staff was not keeping the doors to the kitchen locked and we educated them on how to properly lock the doors." The ADM revealed that when this was brought to his attention, he was thinking more about safety with knives, hot steam tables, and infection control issues, not elopement concerns. He revealed that he wasn't sure why this wasn't brought up in their morning meetings and that if it had happened, they should have addressed it, corrected the situation then, and had measures in place. He stated, "I was not aware and should have been notified." On 01/11/24 at 12:35 PM, a phone interview with the Director of Nursing Services (DON), revealed	M 500		

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M 500	Continued From page 18 that she was made aware after she arrived at the facility on the night of 01/07/24, that Resident #1 had gone into the kitchen earlier in the evening prior to the elopement. The DON revealed that they always tried to keep an eye on Resident #1 and the staff had to bring her back to her room constantly. She revealed that the kitchen staff had been in-serviced on keeping the kitchen doors locked 24/7 with no exceptions. The DON revealed that she checked the kitchen doors when she was there, always making sure the doors to the kitchen were locked. The DON revealed that Resident #1 wandered all the time, and worse in the evenings. She revealed that the staff were constantly having to redirect her. She also revealed that when she walked the floors, someone was usually with Resident #1. The DON was asked what she knew about Resident #1 getting into the kitchen on 01/01/24 prior to the elopement on 01/07/24, she stated, "LPN #2 didn't tell me until after the fact," but confirmed it was prior to the elopement on 01/07/24. The DON revealed that LPN #2 had called her and reported to her by phone because she was off work. She had told LPN #2 to chart a behavior note on Resident #1 in the computer. The DON revealed that she was off on 01/01/24, 01/02/24, and 01/03/24, and was not at work to bring it up and had not thought about it. The DON agreed that she should have reported this to other staff members even though she was off. She agreed the elopement on 01/07/24 might have been prevented had this been taken care of on 01/01/24. The DON confirmed that each morning at stand up meeting that a 24 hour report should be run to discuss any concerns from the last 24 hours in the facility and this was not done. On 01/11/24 at 1:00 PM, an interview with the ADM revealed that his goal was that Resident #1	M 500		

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M 500	Continued From page 19 and all one hundred twenty-one residents be kept safe. He revealed that he was ultimately responsible for everyone in the facility and his goal was to fix the problem and move on. The ADM revealed that after looking at video coverage, he knew how Resident #1 got out, he fixed the problem, and everything was secured. He revealed that he did not know about what happened on 01/01/24 and could not fix what he did not know because he was never made aware of it. Record review of the (Name of Local City) weather revealed on 01/07/24 at the time of the elopement that the temperature was 39 degrees Fahrenheit with clear skies. Record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 04/14/2017. Her current diagnoses include Alzheimer's Disease, Need for Assistance with Personal Care, Dementia with unspecified severity with other behavioral disturbance, and Unspecified Psychosis not due to a substance or known physiological condition. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/2023 revealed under Section C0100 that a Brief Interview for Mental Status (BIMS) should not be conducted because the resident is rarely/never understood. C1000, Cognitive Skills for Daily Decision Making, revealed Resident #1's cognitive status was severely impaired. Section P0200 revealed a Wander/elopement alarm was used daily. Record review of Resident #1's Elopement Risk Assessment completed on 01/07/24 revealed that resident had a history of wandering or elopement.	M 500		

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M 500	Continued From page 20 The facility implemented the following Removal Plan: On 1/7/2024 at approximately 8:10 pm the facility called a code 10 that Resident #1 was not found in her room, staff searched the entire building and upon going to look for resident outside an Officer with the local police department was pulling into facility parking lot with resident, resident was assisted back into the facility by nurse and Certified Nursing Assistant (CNA). The nursing staff last saw the resident at approximately 8:00 pm in the dining room and returned to facility at 8:25 pm on 1/7/2024. On January 11 at 3:19 PM the facility was verbally notified that Immediate Jeopardy (IJ) was identified for Federal tag 600 -Abuse, Federal tag 656- Care Plans, Federal tag 689- Failure to Prevent Accidents and Hazards, Federal tag 867 - QAPI (Quality Assurance Performance Improvement). The facility received IJ templates on January 11, 2024, at 3:19 PM. Immediate Corrective Actions for Resident #1: At 8:30 pm on 1/7/2024 the Executive Director and Director of Nursing (DON) begin official investigation of Resident #1 Elopement and determined the resident exited out of the door going through the kitchen. At 8:30 pm on 1/7/2024 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 ambulating independently, awake, alert with usual state of cognition. Resident was examined by	M 500		

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M 500	Continued From page 21 Licensed Practical Nurse (LPN) with no injuries noted. Resident was immediately taken to room and vitals and head to toe assessment obtained. Resident was smiling and had no complaints of pain noted. No signs of injury noted, no bruising, scratches, cuts, or bleeding noted blood pressure 135/72, pulse 75, respirations 18, temperature 96.8, blood oxygen saturation 92%. Resident changed b/p. 135/72, p. 75, r. 18, t. 96.8, saO2 92%. Resident changed for bed and CNA in room doing one on one care. Director of Nursing (DON) was notified at 8:27 pm. Upon her return to the center on 1/7/2024, the resident was examined by the staff nurse and noted to have no negative findings. She was placed on 1:1 supervision until 1 PM on 1/8/2024 after the door locks were replaced in the kitchen. After that she was placed on every 15-minute checks to assure her safety. The kitchen doors were monitored until locks were replaced at 1:00pm 1/8/2024. This close supervision continues as of 1/11/2024. Resident #1 will be placed on 15-minute checks until exit-seeking behavior ceases. On 1/7/2024 at 8:55 pm Medical Director (MD), Physician's Assistant (PA) and Nurse Practitioner (NP) was notified of Resident Elopement from facility. On 1/7/2024 maintenance staff arrived at 9:30 pm to assess all facility exit doors, doors were checked for proper functioning by maintenance staff. All doors and wander guard systems were functioning properly. On 1/7/2024 at 9:00 pm all residents with risk of elopements were reevaluated and updated to ensure all residents for risk for elopement had	M 500		

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M 500	Continued From page 22 appropriate interventions in place. No negative findings. On 1/7/2024 at 9:00 pm, Director of Nursing (DON) checked all residents at risk for elopement wander-guard bracelet for placement and function with no negative findings. On 1/7/2024 at 10:00 pm in-services was initiated by Director of Nursing (DON) to include all staff on Elopement Policy and Procedures and Abuse-Neglect, in-services to be completed by 1/8/2024 with no staff allowed to work until in-service completed. At 10:00 pm on 1/7/2024 Director of Nursing (DON) attempted to notify Resident # 1 Responsible Representative (RR) of the resident elopement from facility with no answer message left for RR to return call. RR returned call at 8:08 AM on 1/8/2024 and was notified of incident. On 1/8/2024, the Administrator and the Director of Nursing (DON) immediately took the following actions to address the citation to prevent any additional residents from experiencing an adverse outcome. On 1/8/2024 at 9:30 am, a Quality Assurance (QA) meeting was held with the Medical Director via phone, Director of Nursing via phone, Administrator, Nurse Practitioner (NP), Social Services, Director of Care Coordinator, Assistant Director of Nursing (ADON), Infection Preventionist and Minimum Data Set Nurse (MDS) to discuss Resident #1's exit seeking behavior and all safeguards put in place to ensure safety of all residents. QA identified modification to resident #1's plan of care to include the addition of melatonin and snack at	M 500			

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M 500	Continued From page 23 bedtime and involvement in daytime activities. At 2:46 pm on 1/8/2024, the Mississippi State Department of Health (MSDH) was notified of the elopement with the resident by Executive Director. On 1/8/2024 at 11:30 pm maintenance staff initiated an Elopement Alarm Drill with all employees across all shifts, to include 7a-3p, 3p-11p, 11p-7a shift employees. On 1/8/2024, the maintenance assistant replaced the lock on the exterior door leaving the kitchen to avoid unsupervised residents leaving the center. On 1/8/2024, the Maintenance supervisor replaced the locks going into the kitchen with automatic door locks to assure that the kitchen doors will lock when they shut and to assure that unsupervised residents are not allowed into the kitchen. On 1/11/24, the psych nurse practitioner conducted a Telehealth visit to determine if medications needed to be adjusted. The nurse practitioner indicated she was pleasant and did not pose a risk to herself and others. On 1/11/2024, the Director of Clinical Education initiated education related to the importance of providing adequate supervision to resident to avoid accidents to including securing unsafe areas in the center. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training. On 1/11/2024, the MDS Nurse conducted medical record reviews of all residents to identify which residents were interviewable verses those that	M 500		

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M 500	Continued From page 24 could not be interviewed. BIMS scores were collected to determine those residents that could be interviewed verses those that were considered non interviewable. On 1/11/2024, The Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager completed physical assessments of all residents with a BIMS score of less than 11 to determine if there was evidence of abuse or neglect. Assessments of these resident revealed no such evidence of abuse or neglect. Documentation of these assessments was captured on an assessment tool and placed in the survey binder. This action was completed on 1/11/24. On 1/11/2024, the Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager interviewed each resident with a BIMS of 11 or higher to assure they had not been abused or experienced abuse or neglect. Interview of these residents was captured on an interview tool and placed in the survey binder. Neither evidence of abuse nor injury of unknown origin was identified through interviews or body audits. This action was completed on 1/11/2024. On 1/11/2024, the Senior Director of Clinical Operations provided training for the Administrator, Director of Nursing (DON), the Assistant Director of Nursing (ADON) regarding abuse and neglect identification, protection, investigation. This action was completed on 1/11/2024. On 1/8/2024, the Director of Clinical Education initiated training on abuse and neglect to include identification of abuse and neglect, protections of residents, investigation, and reporting requirements. This training will continue until all	M 500			

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M 500	Continued From page 25 staff are trained. Employees will not be allowed to work until they have received this training. On 1/12/24, the Senior Vice President of Operations provided education to the Administrator regarding the expectation of following the facility Quality Assurance Policy and Procedure in having ADHOC meetings as needed when new concerns are identified to immediately discuss, and determine immediate action needed to correct/address the identified area of concern to prevent safety issues related to elopement and then to continue monthly meetings to review effectiveness of plans and adjust plans as needed to ensure sustained compliance. The Administrator educated the Quality Assurance Committee Members on 1/12/24. The Director of Nursing (DON) will be educated prior to next scheduled shift by the Administrator. Education initiated on 1/12/24 by the Director Clinical Education with all staff regarding the expectations to immediately report any identified deficient practice to the Administrator or Director of Nursing (DON) so that the deficient practice or new concern can be addressed through the facility Quality Assurance Performance Improvement Committee by initiation of a plan of correction to include education, systemic changes, and auditing to ensure correction and sustained compliance. Education included review of the Quality Assurance and Performance Improvement Policy. Staff that did not receive education on 1/12/24 will be educated prior to working next scheduled shift. An adhoc QAPI meeting addressing the finding was initiated and completed 1/12/24 with the attendance of the Administrator, Nurse Practitioner (NP), Human Resources Coordinator,	M 500			

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M 500	Continued From page 26 Director of Rehab, Registered MDS Coordinator, Director of Clinical Education (Infection Preventionist), Director of Nursing via phone, Maintenance Director, Dietary Manager, Activity Director, and Health Information Manager and Medical Director via phone. All corrective actions were completed by 1/12/2024 and the facility alleges removal of the Immediate Jeopardy (IJ) 1/13/2024. The State Agency (SA) validated the facility's Removal Plan/Corrective Action on 01/22/24. The SA validated through interviews and record review that at 8:30 pm on 1/7/2024 the Executive Director and Director of Nursing (DON) begin official investigation of Resident #1 Elopement and determined the resident exited out of the door going through the kitchen. The SA validated through interviews and record review that at 8:30 pm on 1/7/2024 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. The SA validated through interviews and record review that upon return to facility Resident # 1 was ambulating independently, awake, alert with usual state of cognition. Resident was examined by Licensed Practical Nurse (LPN) with no injuries noted. Resident was immediately taken to room and vitals and head to toe assessment obtained. Resident was smiling and had no complaints of pain noted. No signs of injury noted, no bruising, scratches, cuts, or bleeding noted blood pressure 135/72, pulse 75, respirations 18, temperature 96.8, blood oxygen saturation 92%. Resident changed b/p. 135/72, p.	M 500		

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M 500	Continued From page 27 75, r. 18, t. 96.8, sa02 92%. Resident changed for bed and CNA in room doing one on one care. Director of Nursing (DON) was notified at 8:27pm. The SA validated through interviews and record review that upon her return to the center on 1/7/2024, the resident was examined by the staff nurse and noted to have no negative findings. She was placed on 1:1 supervision until 1 PM on 1/8/2024 after the door locks were replaced in the kitchen. After that she was placed on every 15-minute checks to assure her safety. The kitchen doors were monitored until locks were replaced at 1:00pm 1/8/2024. This close supervision continues as of 1/11/2024. Resident #1 will be placed on 15-minute checks until exit-seeking behavior ceases. The SA validated through interviews and record review that on 1/7/2024 at 8:55 pm Medical Director (MD), Physician's Assistant (PA) and Nurse Practitioner (NP) was notified of Resident Elopement from facility. The SA validated through interviews and record review that on 1/7/2024 maintenance staff arrived at 9:30 pm to assess all facility exit doors, doors were checked for proper functioning by maintenance staff. All doors and wander guard systems were functioning properly. The SA validated through interviews and record review that on 1/7/2024 at 9:00 pm all 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. The SA validated through interviews and record	M 500		

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M 500	Continued From page 28 review that on 1/7/2024 at 9:00 pm, Director of Nursing (DON) checked all residents at risk for elopement wander-guard bracelet for placement and function with no negative findings. The SA validated through interviews and record review that on 1/7/2024 at 10:00 pm in-services were initiated by Director of Nursing (DON) to include all staff on Elopement Policy and Procedures and Abuse-Neglect, in-services to be completed by 1/8/2024 with no staff allowed to work until in-service completed. The SA validated through interviews and record review that at 10:00 pm on 1/7/2024 Director of Nursing (DON) attempted to notify Resident # 1 Responsible Representative (RR) of the resident elopement from facility with no answer message left for RR to return call. RR returned call at 8:08 AM on 1/8/2024 and was notified of incident. The SA validated through interviews and record review that on 1/8/2024, the Administrator and the Director of Nursing (DON) immediately took the following actions to address the citation to prevent any additional residents from experiencing an adverse outcome. The SA validated through interviews and record review that on 1/8/2024 at 9:30 am, a Quality Assurance (QA) meeting was held with the Medical Director via phone, Director of Nursing via phone, Administrator, Nurse Practitioner (NP), Social Services, Director of Care Coordinator, Assistant Director of Nursing (ADON), Infection Preventionist and Minimum Data Set Nurse (MDS) to discuss Resident #1's exit seeking behavior and all safeguards put in place to ensure safety of all residents. QA identified modification to resident #1's plan of care to	M 500		

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M 500	Continued From page 29 include the addition of melatonin and snack at bedtime and involvement in daytime activities. The SA validated through interviews and record review that at 2:46 pm on 1/8/2024, the Mississippi State Department of Health (MSDH) was notified of the elopement with the resident by Executive Director. The SA validated through interviews and record review that on 1/8/2024 at 11:30 pm maintenance staff initiated an Elopement Alarm Drill with all employees across all shifts, to include 7a-3p, 3p-11p, 11p-7a shift employees. The SA validated through interviews and record review that on 1/8/2024, the maintenance assistant replaced the lock on the exterior door leaving the kitchen to avoid unsupervised residents leaving the center. The SA validated through observation, interviews and record review that on 1/8/2024, the Maintenance supervisor replaced the locks going into the kitchen with automatic door locks to assure that the kitchen doors will lock when they shut and to assure that unsupervised residents are not allowed into the kitchen. The SA validated through interviews and record review that on 1/11/24, the psych nurse practitioner conducted a Telehealth visit to determine if medications needed to be adjusted. The nurse practitioner indicated she was pleasant and did not pose a risk to herself and others. The SA validated through interviews and record review that on 1/11/2024, the Director of Clinical Education initiated education related to the importance of providing adequate supervision to	M 500		

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M 500	Continued From page 30 resident to avoid accidents to including securing unsafe areas in the center. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training. The SA validated through interviews and record review that on 1/11/2024, the MDS Nurse conducted medical record reviews of all residents to identify which residents were interviewable versus those that could not be interviewed. BIMS scores were collected to determine those residents that could be interviewed versus those that were considered non interviewable. The SA validated through interviews and record review that on 1/11/2024, The Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager completed physical assessments of all residents with a BIMS score of less than 11 to determine if there was evidence or abuse or neglect. Assessments of these resident revealed no such evidence of abuse or neglect. Documentation of these assessments was captured on an assessment tool and placed in the survey binder. This action was completed on 1/11/24. The SA validated through interviews and record review that on 1/11/2024, the Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager and interviewed each resident with a BIMS of 11 or higher to assure they had not been abused or experienced abuse or neglect. Interview of these residents was captured on an interview tool and placed in the survey binder. Neither evidence of abuse nor injury of unknown origin was identified through interviews or body audits. This action was completed on 1/11/2024.	M 500		

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M 500	Continued From page 31 The SA validated through interviews and record review that on 1/11/2024, the Senior Director of Clinical Operations provided training for the Administrator, Director of Nursing (DON) the Assistant Director of Nursing (ADON) regarding abuse and neglect identification, protection, investigation. This action was completed on 1/11/2024. The SA validated through interviews and record review that on 1/8/2024, the Director of Clinical Education initiated training on abuse and neglect to include identification of abuse and neglect, protections of residents, investigation, and reporting requirements. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training. The SA validated through interviews and record review that on 1/12/24, the Senior Vice President of Operations provided education to the Administrator regarding the expectation of following the facility Quality Assurance Policy and Procedure in having ADHOC meetings as needed when new concerns are identified to immediately discuss, and determine immediate action needed to correct/address the identified area of concern to prevent safety issues related to elopement and then to continue monthly meetings to review effectiveness of plans and adjust plans as needed to ensure sustained compliance. The Administrator educated the Quality Assurance Committee Members on 1/12/24. The Director of Nursing (DON) will be educated prior to next scheduled shift by the Administrator. The SA validated through interview and record review that Director of Nursing had been educated prior to her return to work.	M 500		

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M 500	Continued From page 32 The SA validated through interviews and record review that education was initiated on 1/12/24 by the Director Clinical Education with all staff regarding the expectations to immediately report any identified deficient practice to the Administrator or Director of Nursing (DON) so that the deficient practice or new concern can be addressed through the facility Quality Assurance Performance Improvement Committee by initiation of a plan of correction to include education, systemic changes, and auditing to ensure correction and sustained compliance. Education included review of the Quality Assurance and Performance Improvement Policy. Staff that did not receive education on 1/12/24 will be educated prior to working next scheduled shift. The SA validated through interviews and record review that an adhoc QAPI meeting addressing the finding was initiated and completed 1/12/24 with the attendance of the Administrator, Nurse Practitioner (NP), Human Resources Coordinator, Director of Rehab, Registered MDS Coordinator, Director of Clinical Education (Infection Preventionist), Director of Nursing via phone, Maintenance Director, Dietary Manager, Activity Director, and Health Information Manager and Medical Director via phone. The SA validated through observation, interview, and record review that the facility removed the Immediate Jeopardy (IJ) on 01/12/24 and alleged compliance on 01/13/24.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of	M 640		2/2/24

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M 640	Continued From page 33 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 Based on interviews, record review and facility policy review the facility failed to supervise and prevent the elopement of Resident #1 who left the facility on 01/07/24 for the second time unnoticed and unsupervised. Resident #1 was one (1) of three (3) residents reviewed. Resident #1 was allowed to exit the facility on 01/07/24 unnoticed and unsupervised at an unknown time and was discovered to be missing from the facility at approximately 8:10 PM. On 01/07/24 at approximately 8:00 PM, the police department received a 911 call from an unknown bystander who had seen an elderly lady walking with no shoes on who appeared to belong to a nursing home. A local Police Officer was dispatched and found Resident #1 walking in the middle of the street approximately 1850 feet from the facility and she had no shoes and no coat on. The Police Officer assisted Resident #1 into the backseat of his car and took her to the facility where he discovered that the facility staff were looking for her. Resident #1 was last observed in the facility at 7:55 PM, a Code 10 (elopement) was called at 8:10 PM, and Resident #1 was returned to the facility at 8:25 PM. A head-to-toe assessment was completed immediately upon her return to the facility. Resident #1 was a wandering risk and had previously exited the facility on 12/14/23 and once again eloped from the facility without staff knowledge on 1/7/24.	M 640	M640 – Accidents - Center addressed the corrective action for Resident #1 by assessing for injury upon return to center. Resident #1 was placed on one-to-one staff supervision upon return. Center wide head count was completed by Director of Nursing Services to ensure all residents were accounted for. All center exit doors were checked by maintenance for proper functionality at 9:30 pm on 01/07/2024. Wanderguard system was checked and found to be functioning properly. All residents at risk for elopement were checked for wanderguard placement and functionality by Director of Nursing Services on 01/07/2024. Elopement risk assessment was completed by Director of Nursing Services on 100% of residents to ensure appropriate interventions and care plans were in place. Quality Assurance Meeting was held on 01/08/2024 to discuss investigation of incident. The psychiatric Nurse Practitioner preformed a tele-health visit with Resident #1 on 01/11/2024 to review medications with no adverse findings noted. - All residents have the potential to be affected by this deficient practice. - To avoid recurrence of the deficient practice, dietary door locks were changed on 01/08/2024. Staff education on abuse/neglect and elopement policy was initiated	

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M 640	Continued From page 34 The facility's failure to provide supervision to prevent the second elopement for Resident #1 who was diagnosed with Alzheimer's and Dementia placed Resident #1 and other residents who were at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which began on 01/01/24 when Res #1 eloped from the facility unsupervised. The SA notified the facility's Administrator (ADM) of the IJ and SQC on 01/11/24 at 3:19 PM, and provided IJ templates to the ADM. The facility submitted an acceptable Removal Plan on 1/12/24, in which they alleged all corrective actions to remove the IJ were completed on 1/12/24, and the IJ removed on 1/13/24. The SA validated the Removal Plan on 1/22/24 and determined the IJ was removed on 1/13/24, prior to exit. Therefore, the scope and severity for Rule 45.21.8 Accidents M640 was lowered from a Level IV 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. Findings Include: Record review of the facility policy "Elopement" dated April 2017, revealed "Purpose To establish a process that identifies risk and establishes interventions to mitigate the occurrence of	M 640	by Director of Clinical Education on 01/07/2024. No employees were allowed to work until trained. Elopement drills were initiated by Maintenance Department on 01/08/2024 with all employees across all shifts. On 01/08/2024, Director of Clinical Education initiated training on abuse and neglect to include identification, protection of residents and reporting requirements. On 01/11/2024, Assistant Director of Nursing, Unit Manager and Minimum Data Set Nurses conducted interviews and physical assessments of 100% of all residents to determine evidence of abuse/neglect. Neither evidence of abuse/neglect nor injury of unknown origin was determined by interviews or physical assessments. On 01/11/2024 Senior Director of Clinical Operations provided training to Administrator, Director of Nursing Services, Assistant Director of Nursing regarding abuse/neglect identification, protection investigation and reporting requirements. The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by the Director of Nursing, and Assistant Director of Nursing are to monitor 100% of all residents at risk for elopement to ensure proper interventions and care plans are in place weekly for 4 weeks and monthly thereafter. This action was implemented on 01/11/2024. Social Services will conduct interviews of 5 residents with Brief Interview of Mental Status score of 11 or higher weekly for 8 weeks and monthly for one month, beginning on 01/11/2024. Director of Nursing or Nurse Managers will conduct physical assessments of 5	

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M 640	Continued From page 35 elopements..." Record review of Facility "Investigation Template" completed by Administrator documented the following: "On 1/7/2024 at 8:10 pm a code 10 was called as resident was unable to be located. Staff completed a room to room audit to ensure all residents were safe and accounted for. At 8:25 pm resident was escorted back into center by Police Department officer... Investigation Summary: "Review of the center's maintenance camera revealed the resident exited the center out an unlocked door in the rear of the center..." Record review of the "City of (proper name) Police Department Incident Report" revealed that the Police Officer responded to a call which was received at 8:00 PM on 01/07/24 from a bystander. Police Officer responded to the area of Martindale Lane and observed a confused, white female with no coat, sock footed who was walking in the middle of the street on hospital street. Police Officer approached Resident #1 and she told him that she was going back to the nursing home. Police Officer assisted Resident #1 into the back seat of his patrol car and transported her back to the facility. Police Officer was informed by LPN #3 that "This was not the first time that this has happened, that one of the doors in the building was not locked and does not have an alarm on it" This Incident Report was completed by the Police Officer on 01/07/24. During an interview on 01/09/24 at 8:45 PM, with Licensed Practical Nurse (LPN) #1, revealed that she was working the night of 01/07/24 when Resident #1 got out of the building. She revealed that she had last seen Resident #1 that night around 7:50 PM walking down B-Hall. LPN #1 revealed that when the staff saw Resident #1 out	M 640	residents per week to determine abuse/neglect or injury of unknown origin for those residents with Brief Interview of Mental Status who score below 11: weekly for 8 weeks then monthly for one month. This action was started on 01/11/2024. Any variance will be addressed in the Quality Assurance Meeting weekly for 8 weeks then monthly thereafter beginning on 01/11/2024 as a performance improvement project or until such time compliance is reached. Date of completion: 2/2/2024	

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M 640	Continued From page 36 walking around in the building, they redirected her back to her room. She revealed that Resident #1's cognition was not good, that she had dementia, but they could hold her hand and easily redirect her back to her room. This LPN revealed that a CODE 10 for elopement was called around 8:00 PM, all staff stopped what they were doing and went to look for her. LPN #1 revealed that right before 8:30 PM, Resident #1 was returned to the facility by the police. LPN #1 revealed that someone had called the police, reported that they had seen an elderly woman walking and the police brought her back to the facility. She stated Resident #1 had been seen exit seeking a lot lately and the door alarms went off when she walked near them. After this incident, they had someone watch all the doors until maintenance could get to the facility and check them out that night. Since the incident on 01/07/24, maintenance had put pin pads on the kitchen doors so the residents couldn't get in there. LPN #1 stated, "They think she may have exited the kitchen." During an interview with Administrator on 01/09/24 at 9:05 PM, revealed that Resident #1 had gotten out of the building again on 01/07/24 on the night shift. He revealed that according to interviews and statements taken by staff, Resident #1 was last seen around 7:55 PM and that there was about 20 to 25 minutes that Resident #1 was unaccounted for that night. He thought she left through the kitchen door this time. The staff had been doing hourly checks since the last elopement incident on 12/14/23 and that this had happened between the scheduled visual checks. A Code 10 was called around 8:10 PM, Resident #1 was last seen around 7:55 PM and was returned to the facility by a police officer around 8:25 PM or 8:30 PM. He state he wasn't	M 640		

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M 640	Continued From page 37 sure of all the details, but someone must have called the police or either he was patrolling and found her. ADM revealed that he was not sure of the exact location where she was picked up from either. Maintenance came in that night and checked all of the windows and doors, checked all of the door alarms and wander guard bracelets and everything worked properly. The only way possible for her to get out was through the kitchen door. He revealed that the two doors that led from the dining room into the kitchen had locks on them from the inside of the kitchen and staff had to push the lock in and turn it for them to lock properly. ADM confirmed that he wasn't aware that Resident #1 had gone back into the kitchen earlier that evening until he read the statements provided by the staff. ADM stated that this resident wanders a lot and according to what he was told, Resident #1 was last seen in the dining room around 7:25 PM. Resident was placed on 1 on 1 supervision after the incident until the new kitchen door locks were installed on 01/08/24 at 1:00 PM. He revealed that the exit doors on the hall doors would not release to open unless the fire alarm was pulled so she couldn't have gotten out there. He stated, "The only thing we really changed were the kitchen doorknobs and put a pin lock on the doors so that everyone who entered had to have the code." During an interview on 01/09/24 at 9:55 PM, with Certified Nursing Assistant (CNA) #2, revealed that she was working on D-Hall on 01/07/24 on the night shift. She revealed that she saw Resident #1 that night between 7:30 PM and 8:00 PM coming out of the dining room walking towards the front door. CNA #2 revealed that the kitchen staff had brought her out of the kitchen to C-Wing, and the CNAs went and put her to bed. CNA #2 revealed that about 20 to 30 minutes	M 640		

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M 640	Continued From page 38 later, she was missing, and they were looking for her. They checked all the rooms and halls, and she wasn't there, then around 8:25 PM, she saw that a police officer had pulled up and had Resident #1 in the backseat. The nurse opened the front door and let her back into the facility. CNA revealed that Resident #1 was brought in, was assessed, and had seemed to be fine, no skin issues and no injuries. During an interview on 01/09/24 at 10:05 PM, CNA #1 revealed that she was working on the night of 01/07/24 when Resident #1 got out of the facility. She stated that the resident liked to wander at night and sometimes she would walk to the end of the hall, jiggle the door to see if it would open. They would go get her by the hand and redirect her back. It was hard to keep up with Resident #1 most of the time because she was constantly on the move and that the staff worked together and tried to keep her in their sight. On 01/07/24 at around 7:35 PM, a kitchen staff member brought Resident #1 to her CNA on C/D hall and told her that Resident #1 had gotten into the kitchen. CNA #1 revealed that she brought Resident #1 to the CNA she was assigned to for the night, and he took care of her. CNA #1 revealed that a little after 8 PM, Resident #1's CNA asked her if she had seen Resident #1. CNA #1 revealed that they looked down halls, resident rooms, and outside. CNA #1 revealed that a few minutes later, the police brought Resident #1 back to the facility and stated, "I have no idea how she got out." During an interview on 01/10/24 at 10:10 PM, the Administrator (ADM) revealed that he was glad that the codes on the doors checked out and worked properly and that everything else checked out, but there was still 20 minutes that Resident	M 640		

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M 640	Continued From page 39 #1 was unaccounted for, and he agreed that a lot could have happened to her in 20 minutes. The ADM stated, "I'm just glad she was safe, it could have been real bad." During an interview by phone on 01/10/24 at 10:20 AM, with Director of Nursing Services (DON), revealed that on Sunday night 01/07/24, the Administrator called and told her about Resident #1 getting out of the building again. She revealed that she was off; but came on to the facility. She walked around with maintenance, started interviews, took statements, and had all the wander guard bracelets checked and they were all working properly. She then completed elopement assessments on every resident in the building and updated care plans. She stated that maintenance came in and checked all the doors, and she was confident that the kitchen door was the only one she could have gotten out of. The DON revealed that Resident #1 had walked into the kitchen a couple of times that she knew of prior to this night because staff had told her about it. The DON stated, "This had happened during the day while we were there." The DON stated that she wasn't aware that Resident #1 had been brought out of the kitchen earlier the night of 01/07/24 until she arrived on that Sunday night around 9:00 PM, but that she did know the resident had been in the kitchen days prior and was attempting to go out the exit door. During an interview on 01/10/24 at 10:45 AM, with Dietary Aide #1 revealed that she was working on the evening of 01/07/24 during the time that Resident #1 got out of the building. She revealed that at approximately 7:30 PM or a little after, she was bent down washing dishes in the washroom next to the kitchen door when she heard something. Dietary Aide #1 revealed that she	M 640		

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M 640	Continued From page 40 saw that Resident #1 had come into the kitchen, had walked past her, and was over by the stove walking towards the exit door which led to the outside of the building. This dietary aide revealed that she walked constantly and was seen frequently at doors looking out. Dietary Aide #1 revealed that she was working in the kitchen by herself when this happened because Dietary Aide #2 had taken the trash out. She got Resident #1 by the hand and led her out of the kitchen and took her to CNA #1 who was working out on the hall. About 30 minutes later, she came out of the kitchen to see what a CODE 10 was that was called and found out that Resident #1 was missing. She revealed that Dietary Aide #2 worked in the kitchen with her that evening and had passed the snacks out on the night of 01/07/24. Dietary Aide #1 revealed that Resident #1 walked constantly and was seen frequently at doors looking out. During an interview on 01/10/24 at 11:00 AM, LPN #2 revealed that Resident #1 usually slept during the day until late afternoon or supper time and then walked the floors. LPN #2 stated, "She stays busy, just does her thing." She and the CNAs tag teamed to try and keep an eye on her. She stated, "We try to work together with the CNAs and do the best we can to keep our eyes on her but it's hard with her constantly on the move." She revealed that when Resident #1 walked the halls, she would push on the doors, then turn around and walk off if they wouldn't open. Resident #1 was not combative and was easily redirected; but would often return to what she was doing. LPN #2 stated, "Everyone knows that as soon as you redirect her, she goes right back." LPN #2 revealed that Resident #1 had dementia but said she was "smarter than you think, it's like she's watching and waiting." LPN	M 640		

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M 640	Continued From page 41 #2 revealed that they had to work together as best they could to keep their eyes on her. During an interview on 01/10/24 at 11:20 AM, the Administrator (ADM) revealed that there were two older video cameras on the Maintenance Shop out behind the facility. He revealed that he knew they were out there but didn't know if they worked or not. The cameras were 50 feet from the facility pointing back towards the back of the Nursing Home where the kitchen exit door was. They played back the video camera footage, and it showed Resident #1 exiting the kitchen door to the outside. ADM stated, "We do have evidence of her exiting the building and I know for sure that she went out the side kitchen door, not out the Emergency Exit in the dining room." ADM revealed that it was dietary not keeping the doors from the dining room into the kitchen locked properly that caused Resident #1 to get out. He revealed that the camera footage showed her getting out at 7:55 PM and that she was out of camera view when she turned left at about 8:05 PM. He revealed that it showed that she walked across the back parking lot back to the left, basically, followed the concrete road around. The Administrator revealed that they replaced the kitchen door locks, removed the flex locks, and replaced them with locks that required a code to enter. The ADM stated, "Now they don't have an option but to keep the doors locked." Administrator stated that he did not realize Resident #1 had gotten into the kitchen earlier the day of 01/07/24 or on 01/01/24 until he was reading statements. ADM revealed that the kitchen doors would lock but staff were not keeping them locked. ADM stated, "I do know that I've been on them about keeping the kitchen doors locked" and confirmed they had completed an in-service earlier this month to keep the	M 640		

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M 640	Continued From page 42 kitchen doors locked so residents could not enter the kitchen. During an interview on 01/10/24 at 11:55 AM, Dietary Aide #2, revealed she was working on 01/07/24 in the kitchen. She revealed she was outside taking the trash out and when she returned, was told by Dietary Aide #1, that Resident #1 had walked into the kitchen and was headed towards the exit door over by the stove. Dietary Aide #2 revealed that she got snacks together and when she passed out the snacks around 7:30 PM to A/B hall, she saw Resident #1 exiting a resident's room on that hall. She revealed that after 8:00 PM, a CODE 10 was called, and everyone went to look for her. Dietary Aide #2 revealed that Resident #1 had come back to the kitchen pretty often; but most of the time she just opened the door and closed it back without coming in. Dietary Aide #2 revealed that if Resident #1 opened the door, the kitchen staff would get her out of the kitchen and find a nurse or CNA to get her. Dietary Aide #2 stated, "If we don't, she would just come back." She revealed that Resident #1 had come into the kitchen a couple times while she had been at work but couldn't recall the dates. Dietary Aide #2 revealed that they always made sure the kitchen doors were locked before they left at night-time. She revealed that one door they had to manually lock when they were in the kitchen. Dietary Aide #2 revealed that Resident #1 had to have gone into the kitchen while she (Dietary Aide #2) was passing out snacks and while Dietary Aide #1 was washing dishes for them not to have seen her. During an interview on 01/10/24 at 12:10 PM, via telephone with the Police Officer revealed that on 01/07/24 around 8:00 PM, the local Police Department received a 911 call from a bystander	M 640		

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M 640	Continued From page 43 who had seen an elderly lady walking with no shoes on who appeared to belong to a nursing home. Police Officer revealed that he drove to the area and found that Resident #1 was walking in the middle of the street behind the Emergency Department at the County Hospital which was a pretty good way from the nursing home. The resident had a shirt, jogging pants, and socks on. Resident #1 was not wearing a coat or shoes. He revealed that he stopped her, and this resident seemed to be confused. He asked her where she was going, and she told him to the nursing home. He revealed that Resident #1 was hard to understand but told him she was going back to (Proper Name of Facility). He helped her into his car and drove her back to the facility. When he pulled into the parking lot, he did notice that some of staff were in personal vehicles headed out to look for her. The Police Officer revealed that he released her to LPN #3. During an interview on 01/10/24 at 4:25 PM, via phone with LPN #3 revealed that she was working on 01/07/24, the night that Resident #1 got out of the facility. LPN #3 revealed that she had seen Resident #1 several times walking all around on A/B hall and E/F hall and staff members kept bringing her back to her room. Resident #1 was last seen just outside her room a little before 8:00 PM. She revealed that about 8:10 PM, she asked the CNA who was assigned to Resident #1 to go see if the resident was in her room and he found that she was not. LPN #3 revealed that she called a Code 10 and immediately started looking for her. They looked on all halls, in all rooms and outside the building. She went to the front door about 8:25 PM and saw a police car drive up and then saw that he had Resident #1 in the back seat. She revealed that there were a couple staff who had gotten in	M 640		

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M 640	Continued From page 44 their cars to go look for her when they saw the police officer drive up with Resident #1. The police officer brought her to the door and stated, "I believe I have someone who belongs to y'all" and the officer released Resident #1 to them. LPN #3 revealed that Resident #1 had a pair of sweatpants on with a cuff at the bottom, had a long-sleeved shirt on, some gripper socks and had no coat or shoes on. They immediately got her inside, checked her vital signs and did a head-to-toe assessment and there were no injuries noted. LPN #3 revealed that they put her on one-on-one supervision and had someone in the room with her to always have eyes on her. She revealed that Resident #1 went to bed as soon as they got her checked out. LPN #3 revealed that she couldn't see how they could do any better with monitoring this resident. Record review of the "Name of local city" weather on 01/07/24 revealed that the temperature at the time of the elopement was 39 degrees Fahrenheit with clear skies. Record review of Resident #1's "Admission Record" revealed Admission date of 04/14/2017 and had the following diagnoses to include: Alzheimer's Disease, Need for Assistance with Personal Care, Dementia with unspecified severity with other behavioral disturbance, and Unspecified Psychosis. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/27/2023 under Section C revealed a Brief Interview for Mental Status (BIMS) should not be conducted because resident is rarely/never understood. Under C1000, Cognitive Skills for Daily Decision Making was documented that resident was severely impaired. Section	M 640		

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M 640	Continued From page 45 P0200 revealed a Wander/Elopement Alarm was used daily. Record review of Resident #1's Elopement Risk Assessment completed on 01/07/24 revealed that resident had history of wandering or elopement. The facility implemented the following Removal Plan: On 1/7/2024 at approximately 8:10 pm the facility called a code 10 that Resident #1 was not found in her room, staff searched the entire building and upon going to look for resident outside an Officer with the local police department was pulling into facility parking lot with resident, resident was assisted back into the facility by nurse and Certified Nursing Assistant (CNA). The nursing staff last saw the resident at approximately 8:00 pm in the dining room and returned to facility at 8:25 pm on 1/7/2024. On January 11 at 3:19 PM the facility was verbally notified that Immediate Jeopardy (IJ) was identified for Federal tag 600 -Abuse, Federal tag 656- Care Plans, Federal tag 689- Failure to Prevent Accidents and Hazards, Federal tag 867 - QAPI (Quality Assurance Performance Improvement). The facility received IJ templates on January 11, 2024, at 3:19 PM. Immediate Corrective Actions for Resident #1: At 8:30 pm on 1/7/2024 the Executive Director and Director of Nursing (DON) begin official investigation of Resident #1 Elopement and determined the resident exited out of the door going through the kitchen. At 8:30 pm on 1/7/2024 the facility completed a 100% head count of all other residents to ensure they were accounted for. All residents were found	M 640		

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M 640	Continued From page 46 to be in the facility. Upon return to facility Resident # 1 was ambulating independently, awake, alert with usual state of cognition. Resident was examined by Licensed Practical Nurse (LPN) with no injuries noted. Resident was immediately taken to room and vitals and head to toe assessment obtained. Resident was smiling and had no complaints of pain noted. No signs of injury noted, no bruising, scratches, cuts, or bleeding noted blood pressure 135/72, pulse 75, respirations 18, temperature 96.8, blood oxygen saturation 92%. Resident changed b/p. 135/72, p. 75, r. 18, t. 96.8, saO2 92%. Resident changed for bed and CNA in room doing one on one care. Director of Nursing (DON) was notified at 8:27 pm. Upon her return to the center on 1/7/2024, the resident was examined by the staff nurse and noted to have no negative findings. She was placed on 1:1 supervision until 1 PM on 1/8/2024 after the door locks were replaced in the kitchen. After that she was placed on every 15-minute checks to assure her safety. The kitchen doors were monitored until locks were replaced at 1:00pm 1/8/2024. This close supervision continues as of 1/11/2024. Resident #1 will be placed on 15-minute checks until exit-seeking behavior ceases. On 1/7/2024 at 8:55 pm Medical Director (MD), Physician's Assistant (PA) and Nurse Practitioner (NP) was notified of Resident Elopement from facility. On 1/7/2024 maintenance staff arrived at 9:30 pm to assess all facility exit doors, doors were checked for proper functioning by maintenance staff. All doors and wander guard systems were	M 640		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70RM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/22/2024
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF RIPLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 640	Continued From page 47 functioning properly. On 1/7/2024 at 9:00 pm all 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. On 1/7/2024 at 9:00 pm, Director of Nursing (DON) checked all residents at risk for elopement wander-guard bracelet for placement and function with no negative findings. On 1/7/2024 at 10:00 pm in-services was initiated by Director of Nursing (DON) to include all staff on Elopement Policy and Procedures and Abuse-Neglect, in-services to be completed by 1/8/2024 with no staff allowed to work until in-service completed. At 10:00 pm on 1/7/2024 Director of Nursing (DON) attempted to notify Resident # 1 Responsible Representative (RR) of the resident elopement from facility with no answer message left for RR to return call. RR returned call at 8:08 AM on 1/8/2024 and was notified of incident. On 1/8/2024, the Administrator and the Director of Nursing (DON) immediately took the following actions to address the citation to prevent any additional residents from experiencing an adverse outcome. On 1/8/2024 at 9:30 am, a Quality Assurance (QA) meeting was held with the Medical Director via phone, Director of Nursing via phone, Administrator, Nurse Practitioner (NP), Social Services, Director of Care Coordinator, Assistant Director of Nursing (ADON), Infection Preventionist and Minimum Data Set Nurse (MDS) to discuss Resident #1s exit seeking	M 640		

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M 640	Continued From page 48 behavior and all safeguards put in place to ensure safety of all residents. QA identified modification to resident #1's plan of care to include the addition of melatonin and snack at bedtime and involvement in daytime activities. At 2:46 pm on 1/8/2024, the Mississippi State Department of Health (MSDH) was notified of the elopement with the resident by Executive Director. On 1/8/2024 at 11:30 pm maintenance staff initiated an Elopement Alarm Drill with all employees across all shifts, to include 7a-3p, 3p-11p, 11p-7a shift employees. On 1/8/2024, the maintenance assistant replaced the lock on the exterior door leaving the kitchen to avoid unsupervised residents leaving the center. On 1/8/2024, the Maintenance supervisor replaced the locks going into the kitchen with automatic door locks to assure that the kitchen doors will lock when they shut and to assure that unsupervised residents are not allowed into the kitchen. On 1/11/24, the psych nurse practitioner conducted a Telehealth visit to determine if medications needed to be adjusted. The nurse practitioner indicated she was pleasant and did not pose a risk to herself and others. On 1/11/2024, the Director of Clinical Education initiated education related to the importance of providing adequate supervision to resident to avoid accidents to including securing unsafe areas in the center. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training.	M 640		

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M 640	Continued From page 49 On 1/11/2024, the MDS Nurse conducted medical record reviews of all residents to identify which residents were interviewable versus those that could not be interviewed. BIMS scores were collected to determine those residents that could be interviewed versus those that were considered non interviewable. On 1/11/2024, The Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager completed physical assessments of all residents with a BIMS score of less than 11 to determine if there was evidence of abuse or neglect. Assessments of these resident revealed no such evidence of abuse or neglect. Documentation of these assessments was captured on an assessment tool and placed in the survey binder. This action was completed on 1/11/24. On 1/11/2024, the Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager and interviewed each resident with a BIMS of 11 or higher to assure they had not been abused or experienced abuse or neglect. Interview of these residents was captured on an interview tool and placed in the survey binder. Neither evidence of abuse nor injury of unknown origin was identified through interviews or body audits. This action was completed on 1/11/2024. On 1/11/2024, the Senior Director of Clinical Operations provided training for the Administrator, Director of Nursing (DON) the Assistant Director of Nursing (ADON) regarding abuse and neglect identification, protection, investigation. This action was completed on 1/11/2024.	M 640		

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M 640	Continued From page 50 On 1/8/2024, the Director of Clinical Education initiated training on abuse and neglect to include identification of abuse and neglect, protections of residents, investigation, and reporting requirements. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training. On 1/12/24, the Senior Vice President of Operations provided education to the Administrator regarding the expectation of following the facility Quality Assurance Policy and Procedure in having ADHOC meetings as needed when new concerns are identified to immediately discuss, and determine immediate action needed to correct/address the identified area of concern to prevent safety issues related to elopement and then to continue monthly meetings to review effectiveness of plans and adjust plans as needed to ensure sustained compliance. The Administrator educated the Quality Assurance Committee Members on 1/12/24. The Director of Nursing (DON) will be educated prior to next scheduled shift by the Administrator. Education initiated on 1/12/24 by the Director Clinical Education with all staff regarding the expectations to immediately report any identified deficient practice to the Administrator or Director of Nursing (DON) so that the deficient practice or new concern can be addressed through the facility Quality Assurance Performance Improvement Committee by initiation of a plan of correction to include education, systemic changes, and auditing to ensure correction and sustained compliance. Education included review of the Quality Assurance and Performance Improvement Policy. Staff that did not receive education on 1/12/24 will be educated prior to working next scheduled shift.	M 640			

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M 640	Continued From page 51 An adhoc QAPI meeting addressing the finding was initiated and completed 1/12/24 with the attendance of the Administrator, Nurse Practitioner (NP), Human Resources Coordinator, Director of Rehab, Registered MDS Coordinator, Director of Clinical Education (Infection Preventionist), Director of Nursing via phone, Maintenance Director, Dietary Manager, Activity Director, and Health Information Manager and Medical Director via phone. All corrective actions were completed by 1/12/2024 and the facility alleges removal of the Immediate Jeopardy (IJ) 1/13/2024. The State Agency (SA) validated the facility's Removal Plan on 01/22/24. The SA validated through interviews and record review that at 8:30 pm on 1/7/2024 the Executive Director and Director of Nursing (DON) begin official investigation of Resident #1 Elopement and determined the resident exited out of the door going through the kitchen. The SA validated through interviews and record review that at 8:30 pm on 1/7/2024 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. The SA validated through interviews and record review that upon return to facility Resident # 1 was ambulating independently, awake, alert with usual state of cognition. Resident was examined by Licensed Practical Nurse (LPN) with no injuries noted. Resident was immediately taken to room and vitals and head to toe assessment obtained. Resident was smiling and had no	M 640		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70RM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/22/2024
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M 640	Continued From page 52 complaints of pain noted. No signs of injury noted, no bruising, scratches, cuts, or bleeding noted blood pressure 135/72, pulse 75, respirations 18, temperature 96.8, blood oxygen saturation 92%. Resident changed b/p. 135/72, p. 75, r. 18, t. 96.8, saO2 92%. Resident changed for bed and CNA in room doing one on one care. Director of Nursing (DON) was notified at 8:27 pm. The SA validated through interviews and record review that upon her return to the center on 1/7/2024, the resident was examined by the staff nurse and noted to have no negative findings. She was placed on 1:1 supervision until 1 PM on 1/8/2024 after the door locks were replaced in the kitchen. After that she was placed on every 15-minute checks to assure her safety. The kitchen doors were monitored until locks were replaced at 1:00pm 1/8/2024. This close supervision continues as of 1/11/2024. Resident #1 will be placed on 15-minute checks until exit-seeking behavior ceases. The SA validated through interviews and record review that on 1/7/2024 at 8:55 pm Medical Director (MD), Physician's Assistant (PA) and Nurse Practitioner (NP) was notified of Resident Elopement from facility. The SA validated through interviews and record review that on 1/7/2024 maintenance staff arrived at 9:30 pm to assess all facility exit doors, doors were checked for proper functioning by maintenance staff. All doors and wander guard systems were functioning properly. The SA validated through interviews and record review that on 1/7/2024 at 9:00 pm all residents with risk of elopements were reevaluated and	M 640		

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M 640	Continued From page 53 updated to ensure all residents for risk for elopement had appropriate interventions in place. No negative findings. The SA validated through interviews and record review that on 1/7/2024 at 9:00 pm, Director of Nursing (DON) checked all residents at risk for elopement wander-guard bracelet for placement and function with no negative findings. The SA validated through interviews and record review that on 1/7/2024 at 10:00 pm in-services was initiated by Director of Nursing (DON) to include all staff on Elopement Policy and Procedures and Abuse-Neglect, in-services to be completed by 1/8/2024 with no staff allowed to work until in-service completed. The SA validated through interviews and record review that at 10:00 pm on 1/7/2024 Director of Nursing (DON) attempted to notify Resident # 1 Responsible Representative (RR) of the resident elopement from facility with no answer message left for RR to return call. RR returned call at 8:08 AM on 1/8/2024 and was notified of incident. The SA validated through interviews and record review that on 1/8/2024, the Administrator and the Director of Nursing (DON) immediately took the following actions to address the citation to prevent any additional residents from experiencing an adverse outcome. The SA validated through interviews and record review that on 1/8/2024 at 9:30 am, a Quality Assurance (QA) meeting was held with the Medical Director via phone, Director of Nursing via phone, Administrator, Nurse Practitioner (NP), Social Services, Director of Care Coordinator, Assistant Director of Nursing (ADON), Infection	M 640		

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M 640	Continued From page 54 Preventionist and Minimum Data Set Nurse (MDS) to discuss Resident #1s exit seeking behavior and all safeguards put in place to ensure safety of all residents. QA identified modification to resident #1's plan of care to include the addition of melatonin and snack at bedtime and involvement in daytime activities. The SA validated through interviews and record review that at 2:46 pm on 1/8/2024, the Mississippi State Department of Health (MSDH) was notified of the elopement with the resident by Executive Director. The SA validated through interviews and record review that on 1/8/2024 at 11:30 pm maintenance staff initiated an Elopement Alarm Drill with all employees across all shifts, to include 7a-3p, 3p-11p, 11p-7a shift employees. The SA validated through interviews and record review that on 1/8/2024, the maintenance assistant replaced the lock on the exterior door leaving the kitchen to avoid unsupervised residents leaving the center. The SA validated through observation, interviews and record review that on 1/8/2024, the Maintenance supervisor replaced the locks going into the kitchen with automatic door locks to assure that the kitchen doors will lock when they shut and to assure that unsupervised residents are not allowed into the kitchen. The SA validated through interviews and record review that on 1/11/24, the psych nurse practitioner conducted a Telehealth visit to determine if medications needed to be adjusted. The nurse practitioner indicated she was pleasant and did not pose a risk to herself and others.	M 640		

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M 640	Continued From page 55 The SA validated through interviews and record review that on 1/11/2024, the Director of Clinical Education initiated education related to the importance of providing adequate supervision to resident to avoid accidents to including securing unsafe areas in the center. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training. The SA validated through interviews and record review that on 1/11/2024, the MDS Nurse conducted medical record reviews of all residents to identify which residents were interviewable versus those that could not be interviewed. BIMS scores were collected to determine those residents that could be interviewed versus those that were considered non interviewable. The SA validated through interviews and record review that on 1/11/2024, The Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager completed physical assessments of all residents with a BIMS score of less than 11 to determine if there was evidence or abuse or neglect. Assessments of these resident revealed no such evidence of abuse or neglect. Documentation of these assessments was captured on an assessment tool and placed in the survey binder. This action was completed on 1/11/24. The SA validated through interviews and record review that on 1/11/2024, the Assistant Director of Nursing (ADON), Minimum Data Set Nurses (MDS) and Unit Manager and interviewed each resident with a BIMS of 11 or higher to assure they had not been abused or experienced abuse or neglect. Interview of these residents was	M 640		

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M 640	Continued From page 56 captured on an interview tool and placed in the survey binder. Neither evidence of abuse nor injury of unknown origin was identified through interviews or body audits. This action was completed on 1/11/2024. The SA validated through interviews and record review that on 1/11/2024, the Senior Director of Clinical Operations provided training for the Administrator, Director of Nursing (DON) the Assistant Director of Nursing (ADON) regarding abuse and neglect identification, protection, investigation. This action was completed on 1/11/2024. The SA validated through interviews and record review that on 1/8/2024, the Director of Clinical Education initiated training on abuse and neglect to include identification of abuse and neglect, protections of residents, investigation, and reporting requirements. This training will continue until all staff are trained. Employees will not be allowed to work until they have received this training. The SA validated through interviews and record review that on 1/12/24, the Senior Vice President of Operations provided education to the Administrator regarding the expectation of following the facility Quality Assurance Policy and Procedure in having ADHOC meetings as needed when new concerns are identified to immediately discuss, and determine immediate action needed to correct/address the identified area of concern to prevent safety issues related to elopement and then to continue monthly meetings to review effectiveness of plans and adjust plans as needed to ensure sustained compliance. The Administrator educated the Quality Assurance Committee Members on 1/12/24. The Director of	M 640		

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M 640	Continued From page 57 Nursing (DON) will be educated prior to next scheduled shift by the Administrator. The SA validated through interview and record review that Director of Nursing had been educated prior to her return to work. The SA validated through interviews and record review that education was initiated on 1/12/24 by the Director Clinical Education with all staff regarding the expectations to immediately report any identified deficient practice to the Administrator or Director of Nursing (DON) so that the deficient practice or new concern can be addressed through the facility Quality Assurance Performance Improvement Committee by initiation of a plan of correction to include education, systemic changes, and auditing to ensure correction and sustained compliance. Education included review of the Quality Assurance and Performance Improvement Policy. Staff that did not receive education on 1/12/24 will be educated prior to working next scheduled shift. The SA validated through interviews and record review that an adhoc QAPI meeting addressing the finding was initiated and completed 1/12/24 with the attendance of the Administrator, Nurse Practitioner (NP), Human Resources Coordinator, Director of Rehab, Registered MDS Coordinator, Director of Clinical Education (Infection Preventionist), Director of Nursing via phone, Maintenance Director, Dietary Manager, Activity Director, and Health Information Manager and Medical Director via phone. The SA validated through observation, interview, and record review that the facility removed the Immediate Jeopardy (IJ) on 01/12/24 and alleged compliance on 01/13/24.	M 640		