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M 000	Initial Comments The State Agency (SA) conducted an onsite Complaint Investigation (CI) MS #24043 from 02/05/24 through 02/06/24 for a Facility Reported Incident (FRI) related to the elopement of Resident #1. On 01/30/24 Resident #1 obtained the remote control device and he unlocked the front door and left the facility without the knowledge of the facility staff. Upon entrance to the facility on 02/05/24 the SA determined that the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M640 at Past Non-compliance (PNC) for failure to supervise and prevent the potential for accidents/hazards related to an elopement. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 01/30/24 when Res #1 eloped from the facility unsupervised and undetected by facility staff. Resident #1 was missing from the facility for approximately two and a half (2 1/2) hours to three (3) and a half (1/2) hours prior to discovery. No facility staff saw resident leave the facility and no facility staff were aware that Resident #1 was missing until approximately 9:30 PM when they received a call that Resident #1 was at a convenience store. Resident #1 was found at a convenience store approximately eight-tenths of a mile from the facility on a busy four lane. Resident #1 was returned to the facility via personal vehicle by a facility staff at approximately 9:50 PM on 01/30/24 after the convenience store employee called the facility to report that Resident #1 was at the convenience store unsupervised and needed to be picked up and taken back to the facility.	M 000		

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M 000	Continued From page 1 The facility's failure to provide supervision placed Resident #1 and other residents at risk for wandering and elopement, at risk in a situation which was likely to cause serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC Past Non- Compliance (PNC) on 02/06/24 at 1:00 PM. IJ and SQC existed at: 45.21.8 Accidents (M640) Level IV Based on the facility's implementation of corrective actions on 01/30/24 through 02/02/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 02/02/24, prior to the SA's entrance on 02/05/24.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on staff interviews, family interview, observations, facility security camera video review, record reviews, and facility policy review the facility failed to ensure Resident #1 had adequate supervision to prevent an elopement	M 640	1) Past Non Compliance	2/13/24

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from the facility on 01/30/24 and failed to ensure the wander guard system was properly functioning for one (1) of five (5) residents who were elopement risk and wore wander guards. Resident #1.

Resident #1 was missing from the facility for approximately two and a half (2 1/2) hours to three (3) and a half (1/2) hours prior to discovery. No facility staff saw the resident leave the facility and no facility staff were aware that Resident #1 was missing until approximately 9:30 PM when they received a call that Resident #1 was at a convenience store. Resident #1 was found at a convenience store approximately eight-tenths of a mile from the facility on a busy four lane. Resident #1 was returned to the facility via personal vehicle by a facility staff at approximately 9:50 PM on 01/30/24 after the convenience store employee called the facility to report that Resident #1 was at the convenience store unsupervised and needed to be picked up and taken back to the facility.

The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 01/30/24 when Resident #1 eloped from the facility unsupervised and undetected by facility staff.

The facility's failure to provide supervision placed Resident #1 and other residents at risk for wandering and elopement, at risk in a situation which was likely to cause serious injury, harm, impairment, or death.

IJ and SQC existed at:

Rule 45.21.8 Accidents (M640)- Level IV

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M 640	Continued From page 3 Based on the facility's implementation of corrective actions on 01/30/24 through 02/02/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 02/02/24, prior to the SA's entrance on 02/05/24. Findings include: Record review of the facility policy "Elopement -General Policy... with a review date of 01/23, revealed "Elopement occurs when a resident who is incapable of adequately protecting themselves leaves the premises without necessary supervision to do so." Record review of the facility policy and procedure "Elopement/Wandering-Security System... with a review date of 01/23, revealed "Policy: To provide a safety system to ensure wandering residents/elopement risk residents leave the premises without necessary supervision. To implement protective measures to help guard against wandering/eloping from the facility ..." Interview with the Administrator (ADM) at 4:55 PM, on 02/05/24 revealed that she obtained a copy of the video from the facility surveillance camera and saw Resident #1 eloping from the facility. The ADM stated that Resident #1 had been identified as an elopement risk and had worn a "wander guard" ankle security bracelet since his admission in August 2023. The ADM stated that upon admission the family of Resident #1 had stated that he had attempted to elope from his home on several occasions and had suffered several falls and was at risk of falling. The ADM stated that the video revealed the wander guard had not sounded when Resident #1 eloped from the facility on 01/30/24. On 01/30/24	M 640		

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at approximately 7:00 PM, Resident #1 came to the front of the building at the front door and tried numerous times to get the front door to open to no avail. The ADM stated that Resident #1 attempted to open the front door for approximately 45 minutes from 7:00 PM until 7:45 PM. At 7:45 PM on 01/30/23 the resident discovered the remote-control device that opens the front door lying on top of a table near the front door. The ADM stated that someone left the remote control unattended and out on top of a table at the front door. Resident #1 used the remote-control device to open the door and let himself out of the facility. The ADM stated that no staff at the facility was aware that Resident #1 had left the building until approximately 9:20 PM when a clerk at a convenience store called the facility and told the nurse that Resident #1 was at the store asking for food and drinking coffee. The nurse asked a Certified Nursing Assistant (CNA) to go to the store and get Resident #1 and bring him back to the facility. The CNA went to the store and got Resident #1 and brought him back to the facility without incident. At approximately 9:50 PM, when the CNA entered the building with Resident #1 it was discovered that the wander guard worn by Resident #1 did not sound the alarm at the front door. Resident #1 and all residents with wander guards were assessed. Resident #1 was placed on one-to-one close observation, and he was checked every 15 minutes and then placed on hourly checks. Resident #1, as well as the other residents who wear wander guards, will remain on hourly visual checks until the front door wander guard system is replaced. The ADM stated that upon checking the wander guard system it was discovered that the system would not sound properly. The system would sound randomly and at times would not sound at all or it would sound for a short time

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and stop. The company came out to check the system and they also found that the system was not properly sounding at the front door. The wander guard system was properly sounding with the unit "hand-held" checking/monitoring system but would not properly sound at the front door when stepping on the floor mat. The ADM stated that she had obtained bids for repairs of the wander guard system and that the system would have to be completely replaced with a new system. Until the company can get the new system installed and properly working Resident #1 will remain on hourly visual checks as well as all of the other residents with wander guards. The ADM confirmed that the facility had 5 residents including Resident #1 that wore wander guard security systems. The ADM stated that there will be a staff member monitoring the front door 24/7 (24 hours a day and 7 days a week) at the facility until the wander guard system is replaced. The ADM stated that Resident #1 was not injured as a result of his elopement. The ADM stated that the weather on 01/30/24 at 7:00 PM was approximately 52 degrees Fahrenheit and there was no rain in the forecast.

An interview on 02/05/24 at 5:15 PM, with CNA #1 revealed that she had worked the 7:00 AM to 11:00 PM shift on 01/30/24 and she was not assigned to the hall that Resident #1 was living on. CNA #1 stated that she had observed Resident #1 in the hallway near the vending machines at approximately 6:00 PM and she verbally directed Resident #1 to go back to his room. CNA #1 never saw Resident #1 again after 6:00 PM on 01/30/24 inside of the facility. CNA #1 stated that she was familiar with Resident #1 and had been assigned to work directly with him in the past. CNA #1 stated that Resident #1 wore a wander guard on his ankle and was known to

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wander. She stated that Resident #1 had confusion at times but was able to ambulate independently. CNA #1 stated that Resident #1 was identified by the facility to be at risk for elopement and for being at risk for falling. CNA #1 stated that at approximately 9:30 PM the charge nurse Licensed Practical Nurse (LPN) #2 had asked her to go to the convenience store and pick up Resident #1 and bring him back to the facility. CNA #1 stated that it was very dark at 9:30 PM and the weather was a little windy and the temperature was cool but not freezing or extremely cold. She stated that Resident #1 had left the facility without the knowledge of the facility staff, and he had walked to the convenience store from the facility. CNA #1 stated that she went in her personal vehicle to the convenience store which was approximately 1 mile from the facility. When she arrived at the convenience store, Resident #1 was there drinking coffee with the store clerk wearing dark gym pants, brown house slippers, and a long sleeve shirt. CNA #1 stated that Resident #1 did not have on a jacket or coat and he did not have on street "walking" shoes. CNA #1 stated that upon returning to the facility at approximately 9:50 PM when Resident #1 went through the front door the wander guard system did not alarm. She stated that she reported the wander guard system not sounding to the nurse and they tested the alarm at the front door, and it would not sound with Resident #1's wander guard bracelet. CNA #1 stated that the facility ADM and the Director of Nursing (DON) came to the facility that night and they began the staff in-services and assessments of the residents. CNA #1 stated that Resident #1 was very tired when he returned to the facility but was not harmed or injured and went to his room and went to bed immediately.

Interview on 02/05/24 at 5:30 PM, with LPN #1

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revealed that she had answered the telephone at approximately 9:20 PM on 01/30/24 when a lady identified herself as the clerk at the convenience store. The clerk told LPN #1 that Resident #1 was drinking coffee at the store and needed to be picked up and taken back to the facility. The clerk told LPN #1 that Resident #1 would only reveal to her his name but would not give her any other information. The Clerk gave Resident #1 coffee to drink. The clerk told LPN #1 that Resident #1 had showed up at the store at approximately 8:00 PM on 01/30/24 and had been standing around outside and inside the store for a good long while and had gone outside and was talking to a man putting gas in a vehicle. The clerk stated that Resident #1 presented himself as a little confused and unsure of his whereabouts. The clerk asked if the facility could come and pick up the resident. CNA #1 left the facility and went to the convenience store and picked up Resident #1 and brought him back to the facility at approximately 9:50 PM on 01/30/24. LPN #1 conducted a head-to-toe assessment of Resident #1 and found him free of injury. Resident #1 went to sleep shortly after he was brought back to the facility. LPN #1 stated that no one at the facility had knowledge that Resident #1 had left the facility until the clerk at the convenience store called the facility. When Resident #1 returned to the facility his wander guard did not sound at the front door. LPN #1 stated that the facility began corrective action and in-services on 1/30/24 at approximately 9:50 PM.

Observation on 02/05/24 at 6:00 PM, revealed the facility was approximately eight- tenths of a mile from the convenience store where Resident #1 had been located. The streets were dimly lit and there were no traffic lights between the facility and the convenience store. In order for

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M 640	Continued From page 8 Resident #1 to get to the convenience store where he was located, he would have had to cross a 4- lane intersection on the highway. Record review of the "Departmental Notes" dated 01/31/24 at 12:09 AM and signed by Licensed Practical Nurse (LPN) #1 revealed: "@ (At) 07:07 PM writer last seen resident and gave resident medication. Resident accepted and tolerated medication well. As the resident was taking medication the resident stated, "do you know where the exit is?" Writer stated (name of Resident #1) you aren't allowed to go outside by yourself. You would need someone to go outside with you but how about we sit here in your room and tomorrow we'll see if a staff member can take you outside." Writer checked to see if the wander guard was in place. Wander guard was in place and intact on the right lower extremity around ankle. @ 09:30 PM A lady called and stated "I have male in the store at double quick on state street, he says his name is (name of Resident #1). Do you all have a patient by that name". Writer responded, "yes and someone will be up there to verify that it is him" and lady on phone stated, "We have him up here in the store ...." Staff member went to store to pick the resident up. @ 09:50 PM Once resident ambulated into the building with one female employee. Writer completed a head-to-toe assessment with no injury, bruising, or new lesions noted. Resident was confused and alert and oriented to name only ...Writer checked wander guard to see if it would go off when close to the door, it did not..." Observation and interview on 2/06/24 at 12:25 PM, revealed Resident #1 was sitting alone in his room watching television. Resident #1 had no recall of his walking to the convenience store on 01/30/24.	M 640		

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M 640	Continued From page 9 Observation and interview on 02/06/24 at 12:30 PM, with LPN #4 revealed that she was the first shift nurse and was the nurse for Resident #1 today. LPN #4 stated that the nurses tested the functioning of wander guards daily with a small square box that they placed next to the wander guard on the residents. She stated that the facility had 5 residents currently wearing wander guards. LPN #4 demonstrated how to test the wander guards with the device. The small box device was working properly to test the wander guards. LPN #4 stated that she had no knowledge of Resident #1 demonstrating exit seeking behaviors prior to 01/30/24. LPN #4 stated that Resident #1 had worn a wander guard since shortly after his admission to the facility. Observation on 02/06/24 at 1:20 PM, of the facility's video from the security cameras dated 01/30/24 beginning at 7:00 PM through 7:45 PM revealed a full view of Resident #1 seeking a way to exit the building for over 45 minutes. Resident #1 was seen at the front door standing on the black mat, staff was not present, and no staff came to the front door to summon Resident #1 away from the front door. Resident #1 was seen attempting to open the front door that was locked. After numerous attempts to open the door Resident #1 was seen on the video discovering a remote-control device lying on a tabletop next to the front door. Resident #1 made a few attempts to open the door with the remote control to no avail and then at approximately 7:45 PM Resident #1 opened the front door and left out of the facility. No staff were observed pursuing Resident #1. The video revealed a clock on the wall next to the front door with times ranging from 6:00 PM until 6:45 PM in which Resident #1 made exit attempts. The clock on the wall near	M 640		

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the front door revealed that Resident #1 left the facility at 6:45 PM. The video revealed that Resident #1 was wearing long dark sweatpants and a long sleeve dark t-shirt. Resident #1 had on brown house slippers, one white sock, one dark sock, and a cap on his head.

Interview on 02/06/24 at 1:45 PM, with the Maintenance Director confirmed that the clock on the wall next to the front door was displaying the correct time on 01/30/24. The Maintenance Director stated that he had to test the wander guard system at the front door on 01/30/24 and 01/31/24 and that he found that the system was not functioning properly. He stated that the facility had to call outside vendors to come and test the system and to give estimates for repairs. He stated that the wander guard system had to be totally replaced and that until the system was replaced there would be staff stationed at the front door 24/7 until the wander guard system was fully functioning. The Maintenance Director stated that he had calculated the convenience store where Resident #1 was located was approximately eight- tenths of a mile from the facility. Observed the wander guard system was not sounding when stepping on the black mat near the front door or when outside of the building.

Interview on 02/06/24 at 2:00 PM, with LPN #2 revealed that she had been told by LPN #1 that Resident #1 had eloped and was at a convenience store. LPN #2 asked CNA #1 to go to the convenience store and pick up Resident #1 and bring him back to the facility. LPN #2 stated that she saw Resident #1 at the front door at approximately 6:20 PM- 6:30 PM on 01/30/24 and that she redirected Resident #1 to go to his room away from the front door. She stated that she did

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not see Resident #1 again until he was returned to the facility at approximately 9:50 PM on 01/30/24.

Observation on 02/06/24 at 2:30 PM, on the route to the convenience store where Resident #1 was located revealed there were 12 street intersections between the facility and the convenience store with no traffic lights. There were three (3) intersections with four way stop signs. The mileage between the facility and the convenience store was measured at eight-tenths of a mile. The convenience store was located across a four-lane highway. The streets contained a school, a liquor and tobacco store, and numerous residential houses and apartments and commercial properties.

Interview by telephone on 02/06/24 at 4:20 PM, with CNA #3, revealed on 1/30/24 she was assigned as Resident #1's CNA and was responsible for his care during the evening shift on 01/30/24. She stated that she had been assigned to Resident #1 numerous times since his admission and that she was very familiar with Resident #1. She stated that she last saw Resident #1 at approximately 7:00 PM on 01/30 24 standing near the drink machine but did not think anything of his standing there and had not talked to Resident #1. She stated that she had no knowledge that Resident #1 had left the facility until he was returned at approximately 9:50 PM.

Record review of the Electronic Medication Administration Record (EMAR) for January 2024 revealed "Check wander guard to right ankle function daily" with an order and start date of 8/9/23. Elopement Risk Check wander guard placement to right ankle Q (every) shift with an order and start date of 8/9/23. The EMAR was

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documented with staff initials that wander guard checks were completed per order for the entire month of January 2024.

Record review of the Face Sheet revealed Resident #1 was admitted to the facility on 08/07/23 with diagnoses that included Schizophrenia, Cognitive Communication Deficit, Lack of Coordination, Dementia, and History of Falling.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of of 11/14/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 for which indicated moderate cognitive impairment.

The facility implemented that following Corrective Action Plan prior to the SA entering the building on 02/05/24:

On 01/30/24 at approximately 9:50 PM, Resident #1 was assisted back to the facility via facility staff (CNA #1's) personal vehicle. Resident #1 was thoroughly assessed head to toe by LPN #1 and no adverse injuries/incidents were found. LPN #1 contacted the Resident Representative (RR), the Medical Director (MD), the facility Administrator, the facility DON, and placed Resident #1 on one-to-one close observation by facility staff. The elopement risk assessment was updated for Resident #1 and the care plan was revised. The elopement book kept at the nursing station was reviewed and updated. Facility staff conducted room to room audits of all 55 residents in the building to ensure safety. The facility conducted a Quality Assurance (QA) meeting with the MD in attendance via telephone on 01/30/24 at 10:30 PM. An elopement drill was conducted on 1/30/24 and 1/31/24 on all three (3) shifts. All

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	14RO	A. BUILDING: _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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residents with wander guard bracelets were checked for functionality and positioning. The ADM and the DON began in-services on 01/30/24 of all staff on elopement protocol, wander guard monitoring, care plans, and Abuse and Neglect. All doors and windows were checked for proper functioning and operation. The ADM began an investigation to determine how Resident #1 eloped. The ADM called the incident in to the State Agency 01/31/2024 at 2:57 PM. Resident #1 was placed on 15-minute checks for 24 hours and remained on hourly checks by staff until the wander guard system would be replaced by an outside vendor. The remote control to the front door lock was obtained and kept by the ADM and not left at the front door unattended. The facility obtained estimates to replace the malfunctioning wander guard system and alarms. There was a staff member placed at the front door to monitor the entrance and exits of the building and the staff would remain at the front door 24/7 (24 hours a day and 7 days a week) until the new wander guard alarm system is installed. No staff was allowed to work until they were in-serviced on elopements, Abuse/Neglect, care plans, and monitoring of wander guard systems.

Immediate Actions:

On 01/30/24 at 10:00 PM LPN #1 notified the ADM, the DON, the RR and the MD via telephone of the elopement of Resident #1.

On 01/30/24 at 10:00 PM the facility staff conducted a 100% head count of all residents to ensure they were all accounted for. All residents were found to be in the facility.

Upon return to the facility on 01/30/24, LPN #1 assessed Resident #1 from head to toe and

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found no injuries or incidents.

On 01/30/24 beginning at 10:00 PM all doors were monitored by staff 24/7 until the wander guard system was found fully functioning.

On 01/30/24 at 10:30 PM, five (5) residents with risks of elopement were re-evaluated and updated to ensure all residents for risk for elopement had appropriate interventions in place. No negative findings were identified on 1/30/24.

On 01/30/24 at 10:00 PM, the facility staff and ADM began officially investigating and obtaining statements of the elopement of Resident #1.

On 01/30/24 at 10:30 PM, staff in-services were begun by the DON and ADM to include all staff on elopement protocols, wander guard checks, care plans, and abuse/neglect with no staff allowed to work until in-services were completed.

On 01/30/24 at 10:30 PM, a QA meeting was held via telephone with the MD, DON, ADM, MDS/Care Plan Nurses times (x) 2, Social Worker, and QA/Infection Control Nurse were present. All members of the QA committee who were not present at the facility for the meeting attended via telephone.

On 01/31/24 the Maintenance Director checked the functioning of the wander guard alarm/security system and found that the alarm was not functioning properly, and the alarm was not sounding. It was discovered that the malfunctioning alarm caused the alarm not to sound when Resident #1 exited the facility unsupervised and undetected. The vendor came to the facility on 02/01/24 and 02/02/24 and provided estimates for replacement of the entire

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M 640	Continued From page 15 wander guard system. The doors will be monitored by a staff member seated at the front door 24/7 until the wander guard system is functioning properly. On 01/31/24 at 2:57 PM the ADM contacted the State Agency (SA) and the MS Attorney General's Office (AGO) to report the elopement of Resident #1. All corrective actions were completed on 02/02/24 and the facility alleged removal of the Immediate Jeopardy (IJ) on 02/02/24. The State Agency (SA) validated the facility's Past Non-Compliance (PNC) Corrective Action Plan on 02/05/24 through 02/06/24: The SA validated through interviews and record reviews that at 10:00 PM the LPN #1 notified the ADM,DON, RR and the MD via telephone of the elopement of Resident #1. The SA validated through interviews and record reviews that at 10:00 PM the facility staff conducted a 100% head count of all residents to ensure they were all accounted for. All residents were found to be in the facility. The SA validated through interviews and record reviews that upon return to the facility LPN #1 assessed Resident #1 from head to toe and found no injuries or incidents. The SA validated through observations, record reviews, and interviews that beginning at 10:00 PM on 1/30/24 all doors were monitored by staff 24/7 until the wander guard system was found fully functioning.	M 640		

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M 640	Continued From page 16 The SA validated through observations, record reviews and interviews that on 01/30/24 at 10:30 PM five (5) residents with risks of elopement were re-evaluated, care plans reviewed and updated to ensure all residents for risk for elopement had appropriate interventions in place. No negative findings were identified on 1/30/24. The SA validated through record reviews and interviews that on 01/30/24 at 10:00 PM the facility and the ADM began officially investigating and obtaining statements of the elopement of Resident #1. The SA validated through interviews and record reviews that on 01/30/24 at 10:30 PM staff in-services were begun by the DON and the ADM to include all staff on elopement protocols, wander guard checks; care plans; and abuse/neglect with no staff allowed to work until in-services were completed. The SA validated through interviews and record reviews that on 01/30/24 at 10:30 PM a QA meeting was held via telephone with the MD. The DON, ADM MDS/Care Plan Nurses x 2, Social Worker, and QA/Infection Control Nurse were present. All other QA committee members who were not present in attendance at the facility attended the meeting via telephone The SA validated through interviews, and record reviews, and review of vendor estimates that on 01/31/24 the Maintenance Director staff checked the functioning of the wander guard alarm/security system and found that the alarm was not functioning properly, and the alarm was not sounding. It was discovered that the malfunctioning alarm caused the alarm not to sound when Resident #1 exited the facility	M 640		

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M 640	Continued From page 17 unsupervised and undetected. The vendor came to the facility on 02/01/24 and 02/02/24 and provided estimates for replacement of the entire wander guard system. The doors will be monitored by a staff member seated at the front door 24/7 until the wander guard system is functioning properly. The SA validated through interviews and record reviews that on 01/31/24 at 2:57 PM the ADM contacted the SA and the MS Attorney General's Office (AGO) to report the elopement of Resident #1. The SA validated through observations, record reviews, and interviews that all corrective actions were completed on 02/02/24 and the facility alleged removal of the immediate Jeopardy (IJ) on 02/02/24.	M 640		