STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255271	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMUNITY LIVING CTR	323 INDUSTRIAL PARK DRIVE LIBERTY, MS 39645

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F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted an abbreviated complaint survey at the facility from 7/8/24 through 7/11/24.

The SA investigated CI MS #25672 for Accidents and Hazards related to a resident elopement and cited F689 as an Immediate Jeopardy (IJ) with Substandard Quality of Care (SQC).

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 6/29/24 when the facility staff failed to provide adequate supervision for Resident #1, allowing the resident to exit the front door without the knowledge of staff. The resident was off the facility grounds and unsupervised for approximately thirteen (13) minutes. The facility's failure to provide supervision and ensure the front door was monitored when remotely opened, put Resident #1 and other residents in a situation which was likely to cause serious injury, harm, impairment, or death.

IJ and SQC existed at:
CFR 483.25(d)(2) Accidents/Hazards - F689 - Scope/Severity "J"

The facility Administrator was notified of the IJ and SQC on 7/10/24 at 10:15 AM and was presented with the IJ template.

Based on the facility's implementation of corrective actions on 6/29/24 through 7/1/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 7/2/24, prior to the SA's entrance on 7/8/24.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/30/2024

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F 000	Continued From page 1 The SA investigated CI MS #25649 for Quality of Care/Treatment related to incontinent care and Physical Environment related to pests with no related deficiencies cited. The SA investigated CI MS #25741 related to Resident Abuse with no related deficiencies cited. The SA investigated CI MS #25756 related to Quality of Care/Treatment related to improper administration of medications and other, with no related deficiencies cited. At the time of the complaint survey, the facility held a license for 80 beds, with a census of 70 residents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to provide adequate supervision to prevent a cognitively impaired resident from exiting the facility unnoticed and unsupervised through a remotely opened front door for one (1) of three (3) residents reviewed. Resident #1 Resident #1 was able to exit the front door when	F 689	Past noncompliance: no plan of correction required.	

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the door was opened remotely by staff to allow visitors to enter the facility at approximately 2:49 PM on 6/29/24. The facility staff were unaware of Resident's absence until approximately 3:00 PM, when the family member of another resident called the facility to report they saw the resident beside a two-lane highway, approximately 0.44 miles from the facility. The facility staff located the resident at approximately 3:02 PM, at the described location and the resident was returned to the facility, without incident.

This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 6/29/24, when Resident #1 exited the facility unnoticed and unsupervised.

The facility Administrator was notified of the IJ on 7/10/24 at 10:15 AM and provided an IJ template. The facility provided an acceptable Removal Plan on 7/11/24, in which all corrective actions were completed by 7/1/24 and alleged the IJ was removed on 7/2/24.

Based on the facility's implementation of corrective actions completed by 7/1/24, the SA determined the and IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 7/2/24, prior to the SA's entrance on 7/8/24.

Findings include:

Record review of the facility policy titled "Emergency Procedure-Missing Resident" with review date 3/2023 revealed " ... 1. Residents at risk for wandering and /or elopement will be monitored and staff will take necessary precautions to ensure their safety ..."

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Record review of the facility policy titled "Elopement/Unsafe Wandering Plan" dated February 7, 2012, revealed " ...It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life in a safe environment ...Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary ..."

Record review of the "Facility Investigation," completed by the Administrator revealed on 6/29/24, at approximately 3:00 PM, the facility received a telephone call from another resident's family telling them that they saw Resident #1 down the road approximately 0.44 miles from the facility. Staff members located the resident at approximately 3:02 PM and returned the resident to the facility per automobile, without incident, at 3:04 PM. Through the facility's investigation, it was determined that the front door was opened remotely by office staff members and Resident #1 assisted the visitors by holding the door open at approximately 2:49 PM. The door was not monitored at that time, and Resident #1 left the facility unnoticed. When returned to the facility, the resident was assessed, and no signs of injury or distress were noted.

On 7/8/24 at 5:20 PM during an interview, Licensed Practical Nurse (LPN) #2 revealed on 6/29/24 she was on duty 7:00 AM through 7:00 PM at the facility and was assigned to the care of Resident #1. She stated that at 2:49 PM a resident's family was visiting and signed the resident out to go out on the front porch for a visit. She stated she believed that Resident #1 followed the family out of the front door unnoticed

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by the facility staff. She stated the last time she observed Resident #1 prior to the incident was "just a few minutes before, in the hallway, near the nurses station." LPN #2 said Resident #1 was just "hanging around". She described his demeanor prior to the elopement as calm and normal with no exit seeking behavior. She reported that at 3:00 PM, Certified Nurse Aide (CNA) #1 answered a telephone call from a family member of another resident and was told they had seen Resident #1 walking along the street outside the facility. She reported she and CNA #1 immediately took her personal vehicle and went to the area where the family member reported seeing the resident and observed him walking on the right side of the highway across from the post office. She said they stopped and asked the resident to get into the vehicle and he got in without complaint or delay and told the staff that he was walking to the store.

Record review of the Admission Record for Resident #1 revealed the facility admitted the resident on 3/15/21. The resident had diagnoses of Cerebral infarction (stroke), Dementia and Disorientation.

Record review of the Brief Interview for Mental Status (BIMS) for Resident #1 dated 7/1/24, revealed the resident had a BIMS score of 9, which indicated moderate cognitive impairment.

Record review of the weather history for 6/29/24 on Weather Underground (wunderground.com) revealed at 2:53 PM the ambient outdoor temperature in the area was approximately 93 degrees Fahrenheit the humidity was 66%, wind speed was approximately seven (7) miles per hour and weather conditions were partly cloudy

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with no rain noted for the day.

Record review of the "Elopement Risk Evaluation" dated 6/28/24 for Resident #1 (the most recent prior to his elopement) revealed Resident #1 had been assessed as "At Risk" for elopement.

On 7/11/24 at 2:30 PM, an interview with the Minimum Data Set (MDS) Nurse stated wandering/elopement risks were assessed upon admission, quarterly, and as needed, using the MDS assessment and documented in the MDS and in the resident's electronic chart. She reported Resident #1 had an assessment indicating a wandering/elopement risk on 6/28/24, because he was independent with walking and had cognitive impairment. The nurse explained when the MDS staff enter those two (2) assessments, it automatically triggers a risk for wandering/elopement.

On 7/11/24 during an interview at 3:00 PM, the Director of Nurses (DON) stated risk factors which contributed to the elopement of Resident #1 included the Resident #1's dementia and wandering behavior. She said that following the elopement Resident #1 told her that he had been trying to go to the store. She stated the facility Interdisciplinary Team (IDT) determined the cause of the elopement was that Resident #1, who had cognitive impairment, wanted to go to the store in town and his cognitive impairment caused a lack of safety awareness. The DON reported that circumstances around the incident included visitors and another resident's family members going in and out of the facility.

On 7/11/24 at 3:45 PM, an interview with the

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Administrator revealed he was notified by nursing staff on 6/29/24 that Resident #1 had eloped from the facility and was reported walking along the two-way highway perpendicular to the street on which the facility was located shortly after 3:00 PM. He stated that he reported to the facility and initiated a thorough investigation during which he determined Resident #1 had exhibited no exit seeking behaviors prior to the elopement. He confirmed Resident #1 was assessed on 6/28/24 and had been determined to be an elopement risk. He confirmed a Quality Assessment and Improvement (QAPI) committee, including the Medical Director, himself (Administrator), the DON and Infection Preventionist was held on 6/29/24. The QAPI meeting included audits of the elopement books and review of the facility policies regarding wandering and elopement.

Corrective Actions Taken:

The facility took the following actions to address the incident and prevent any additional cognitively impaired residents from being able to leave the facility unnoticed and unsupervised.

Upon return to the facility, on 6/29/24 at 3:04 PM, Resident #1 was placed on visual monitoring every 15 minutes and all other residents identified as an elopement risk were put on one-hour checks. On 6/29/23 at 3:15 PM, Resident #1's Resident Representative (RR) was notified of the incident. The Medical Director was notified of the elopement on 6/29/24 at 3:30 PM, and Resident #1's nurse completed a body audit. There were no signs and or/symptoms of injury, heat exhaustion, or dehydration, and the resident's vital signs were within normal limits.

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The Administrator arrived at the facility on 6/29/24 at 3:25 PM and checked all the exit doors for proper functioning and noted that all doors and windows were secure. The door codes were immediately changed as a precautionary measure and the perimeter was checked, including the outside of the building. The facility checked to make sure that there were no other residents unaccounted for on 3/29/24 at 3:30 PM.

On 6/29/24 at 3:35 PM, the DON and Administrator initiated in-services on elopement/missing resident policies and procedures, including door monitoring and the emergency procedures for missing residents and began elopement drills on every shift. The staff were not allowed to work until completion of the in-services and elopement drills. The in-services and elopement drills will continue monthly for the next three (3) months.

The DON, MDS Nurses, Licensed Nurses, and Social Worker began assessing all other residents for elopement risk on 6/29/24 at 3:52 PM. Assessments were completed by 6/30/24 at 4:30 PM and the 14 additional residents identified to be at risk for elopement were added to the facility's Elopement Books. The MDS Nurse updated the care plan for Resident #1 and all other residents identified as at risk for elopement.

On 6/29/24 at 4:05 PM, an emergency QAPI committee meeting was held regarding the elopement of Resident #1. The committee reviewed the incident, actions taken, and the facility's policy on Elopement and Wandering, with no recommendations for change in the policy.

Signs were placed on all exit doors on 6/29/24 at

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F 689	Continued From page 8 4:17 PM, instructing visitors to notify staff of any resident seeking assistance in exiting the facility. By 6/30/24 at 6:32 PM, the Social Services Director and the DON ensured pictures in the facility's Elopement Books were current. On 7/1/24 at 8:00 AM, Resident #1 was assessed by the Psychiatric Nurse Practitioner, and added a new medication to manage Resident #1's increased anxiety. The facility alleges all corrective actions to remove the IJ were completed by 7/1/24, and alleges the IJ was removed on 7/2/24. Validation: The State Agency (SA) validated the Removal Plan on-site for the Complaint Investigation (CI) MS #25672 through record review and interviews. The SA determined all corrective actions were completed by 7/1/24 and the IJ was removed on 7/2/24.	F 689		