STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a Complaint Investigation (CI) MS# 26203 at the facility from 8/19/24 to 8/20/24. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid regarding CI MS# 26203 related to an elopement of a resident.

Resident # 1 was left on the front patio of the facility where she left the premises unnoticed and unsupervised until the resident was located at a grocery store approximately 0.3 miles away from the facility. Video surveillance revealed Resident #1 left the facility at 4:05 PM and was located at the grocery store at 4:25 PM.

The facility failed to provide supervision and implement an effective care plan to prevent an elopement.

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 SA identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which began on 8/15/24 when Resident #1 eloped from the facility unsupervised.

The SA notified the facility's Administrator of the IJ and SQC on 8/19/24 at 2:00 PM, and provided IJ templates to the Administrator.

IJ existed at:

42 CFR (s): 483.21(b) (1) (i)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 000	Continued From page 1 -Development/Implement Comprehensive Care Plan (F656) Scope/Severity = J IJ and SQC existed at: 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity-J The facility submitted an acceptable Removal Plan on 8/20/24, in which they alleged all corrective actions to remove the IJ were completed on 8/19/24, and the IJ removed on 8/20/24. The SA validated the Removal Plan on 8/20/24 and determined the IJ was removed on 8/20/24, prior to exit. Therefore, the scope and severity for 42 CFR (s): 483.21(b)(1)(i) - Comprehensive Care Plans (F656) - Scope and Severity "J." and 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity "J." was lowered from a "J" to a "D", 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 the facility census was 83 with a license for 106 beds.	F 000		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 2	F 656		

§483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 3 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to implement effective comprehensive care plan interventions for a resident who was at risk for wandering and elopement for one (1) of three (3) residents at risk for wandering and elopement. Resident #1 Resident #1 was left on the front patio, where she subsequently exited the premises unnoticed and unsupervised. The resident was later found at a grocery store approximately 0.3 miles from the facility. Video surveillance footage revealed Resident #1 left the facility at 4:05 PM and was located at the grocery store at 4:25 PM. The facility's failure to implement effective care plan interventions placed Resident #1, and all other residents at risk for wandering and elopement, in a situation that was likely to cause serious harm, serious injury, serious impairment or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) which began on 8/15/24 when Resident #1 eloped from the facility unsupervised. The SA notified the facility's Administrator of the IJ on 8/19/24 at 2:00 PM, and provided IJ templates to the Administrator. The facility submitted an acceptable Removal Plan on 8/20/24, in which they alleged all corrective actions to remove the IJ were completed on 8/19/24, and the IJ removed on 8/20/24.	F 656	This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements and/or State licensure requirements. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law and the State licensure program. F656 1. Corrective actions for those residents found to have been affected by this deficient practice: Resident #1 was provided assistance back to the center by the Infection Control Preventionist on 8/15/24 at approximately 4:20 PM with no observed injury. Resident #1 received a body audit from a licensed nurse at approximately 4:40 PM on 8/15/24 with no findings of injury. Beginning at approximately 4:45 PM, Resident #1 was placed on hourly staff monitoring x 24 hours.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 4 The SA validated the Removal Plan on 8/20/24 and determined the IJ was removed on 8/20/24, prior to exit. Therefore, the scope and severity for 42 CFR 483.21(b)(1)- Comprehensive Care Plans (F656) - Scope and Severity "J." was lowered from a "J" to a "D", 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: Review of the facility's policy "Elopements and Wandering Residents" reviewed 8/19/24 revealed, "Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement ...receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk ..." Review of the facility's policy "Comprehensive Care Plans" undated, revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment..." Record review of the care plan for Resident #1, with a date initiated of 8/11/23 revealed "Focus: I am an elopement risk. Goal: I will not leave facility unattended through next review date (Target date 10/9/24). Interventions: Wander Guard to left ankle to notify staff to exit seeking.	F 656	Resident #1, who is alert and oriented, was provided education by the Director of Nursing on 8/16/24 at approximately 3:30 PM to notify staff anytime she wished to go outside or leave the center. Resident #1's care plan was updated on 8/19/24 by the Minimum Data Set (MDS) Coordinator with current interventions for wandering/elopement prevention. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The center acknowledges that all residents have the potential to be affected by this deficient practice. The Director of Nursing and a Registered Nurse completed 100% elopement risk assessments on all residents to determine their risk for elopement on 8/16/24. Care plans on all residents at risk for elopement were reviewed and updated by the Administrator and Director of Nursing on 8/19/24 to ensure they reflect individualized interventions for those residents at risk for wandering and elopement. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing initiated education on importance of accuracy of care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 5 Check placement and function q shift ..." During an interview on 8/19/24 at 10:05 AM, the Director of Nursing (DON) confirmed Resident #1 had been sitting unattended on the facility's front porch on 8/15/24, left the facility unsupervised and was located at the local grocery store at approximately 4:45 PM. She verified video surveillance footage indicated Resident #1 left the facility at 4:05 PM. She acknowledged a resident who is at risk for wandering/elopement should not have been left unattended and that staff should have been present with her. During an interview on 8/19/24 at 10:15 AM, Certified Nursing Assistant (CNA) #2 stated Resident #1 wears a Wandergaurd due to her risk of elopement. She mentioned that Resident #1 frequently sits outside on the porch unattended because she refuses to come back inside. In an interview on 8/19/24 at 10:20 AM, Licensed Practical Nurse (LPN) #1 also confirmed that Resident #1 is at risk for elopement but often sits unattended on the facility's front porch. An interview with the Minimum Data Set Nurse (MDS) on 8/19/24 at 12:27 PM, she verified that Resident #1's care plan was not followed when the resident was left on the front porch of the facility unsupervised and subsequently exited the premises unnoticed. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 7/21/23 with diagnoses that included Cerebral Vascular Accident.	F 656	interventions related to wandering/elopement prevention to Minimum Data Set (MDS) Nurses, Infection Control Preventionist, Registered Nurse Supervisors, and Medical Records Coordinator on 8/19/24 at 4:00 PM. 4. How the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 8/20/24, the Director of Nursing or Administrator will review all new admissions and readmissions in the daily clinical meeting for their wandering/elopement risk to ensure appropriate care plan interventions are in place to prevent elopement. Beginning 8/20/24, Director of Nursing or Administrator will audit all medical records of residents at risk for elopement weekly x 4 weeks, then monthly x 2 to ensure accurate and effective care plan interventions are in place related to wandering/elopement. All education and audit findings will be brought to the Quality Assurance Performance Improvement (QAPI) Committee for review and discussion of the effectiveness of interventions monthly x 3 months beginning 9/10/24. If any findings of noncompliance are identified, the Committee will ensure the plan of correction is adjusted with updated or new interventions accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 6	F 656		

Record review of Resident #1's Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/15/24 revealed a Brief Interview of Mental Status (BIMS) score of 14 , indicating that the resident is cognitively intact. Section P-Restrains and Alarms revealed "An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. This section was code that an alarm was "used daily."

The facility submitted the following removal plan:

On 8/15/24 at approximately 4:15 PM, a passerby notified Certified Nursing Assistant #1 (CNA) at that she observed an individual walking up the hill that she suspected to be a resident of the center. CNA #1 immediately came into the facility and notified the receptionist. A search by staff was initiated.

At approximately 4:20 PM on 8/15/24, the Center's Infection Control Preventionist got in her car to go off premises to look for Resident #1. Resident #1 was observed by the Infection Control Preventionist approximately a quarter mile from the facility outside a local grocery store and successfully encouraged to get in the car on 8/15/24 at 4:24 PM.

On 8/15/24 at approximately 4:25 PM, Resident #1 returned to the facility.

On 8/15/24 at 4:40PM, the Licensed Practical Nurse completed a body audit on the resident with no injuries noted.

Beginning 8/15/24 at 4:45 PM, Resident #1 was placed on hourly staff monitoring for 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 7	F 656		

On 8/15/24 at approximately 5:00 PM, Licensed Nurses ensured all residents were in-house via visual observation.

On 8/15/24 at approximately 5:30 PM, education was initiated by the Director of Nursing and a Registered Nurse Supervisor on the elopement prevention policy to include the provision that any resident at risk for elopement will receive ongoing staff supervision while outside the center for all staff. No staff will be allowed to work until in serviced.

The State Survey Agency and Attorney General's office was notified on 8/15/24 at 6:10 PM and 6:20 PM respectively by the interim Director of Nursing.

On 8/16/24 at approximately 3:30 PM, Resident #1, who is alert and oriented, was provided education by the Director of Nursing to notify staff anytime she wished to go outside or leave the center.

The Director of Nursing and a Registered Nurse Supervisor completed elopement risk assessments on all residents to determine their risk of leaving the center without adequate staff supervision on 8/16/24 at 4:00 PM.

On 8/16/24 at 5:15 PM, the Quality Assurance and Performance Improvement (QAPI) Committee attended by the Director of Nursing, the Medical Director via phone, Infection Control Preventionist, and the Nursing Home Administrator updated the facility's policy on Elopement Prevention to include any resident at risk for elopement would receive ongoing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 8	F 656		

supervision while outside the center.

A new Nursing Home Administrator started 8/19/24 at 8:00 AM.

A Resident Council meeting was held on 8/19/24 at 3:30 PM, by the Activities Director to provide education to residents to notify their licensed nurse and to sign out prior to leaving the center.

On 8/19/24 beginning at approximately 4:00 PM, care plans on all residents at risk for elopement were reviewed and updates initiated by the Administrator and Minimum Data set (MDS) Coordinator to ensure they reflect individualized interventions for those residents at risk for wandering and elopement.

On 8/19/24 at 4:00 PM, the Director of Nursing initiated education on importance of accuracy of care plan interventions related to wandering/elopement prevention to Minimum Data Set Nurses (MDS), Infection Control Preventionist, Registered Nurse Supervisors, and Medical Records Coordinator.

On 8/19/24 beginning at approximately 4:00 PM, a 100 percent (%) Care Plan audit was conducted by the Administrator and MDS Nurses with updates for current interventions made to care plans to ensure compliance for residents at risk for elopement.

On 8/19/24 at approximately 4:00 PM, Resident #1's care plan was updated by the MDS Coordinator with current interventions for elopement prevention.

An Ad Hoc Quality Assurance meeting was held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 656	Continued From page 9 on 8/19/24 at 5:45 PM, to discuss the Immediate Jeopardy Removal Plan and corrective actions, interventions, and education to ensure compliance. As part of the Ad Hoc QAPI Meeting, in-service completion for both the all-staff education on the elopement prevention policy and the importance of accurate and effective care plan interventions related to wandering/elopement prevention education for the Interdisciplinary Team (IDT) was reviewed by the Administrator and QAPI Committee Members with further instruction that no staff will be allowed to work until in serviced. It was attended by the Medical Director, Director of Nursing, Infection Control Nurse, Administrator, and RN Supervisor. All corrective actions were completed by 8/19/24 and the facility alleges removal of the Immediate Jeopardy (IJ) 8/20/2024. Validation: The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #26203 through record review and interviews on 8/20/24. The SA determined all corrective actions were completed on 8/19/24 and the IJ was removed on 8/20/24.	F 656		
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	F 689		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 10 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record reviews, facility policy reviews, and the facility's investigation, the facility failed to provide adequate supervision to prevent Resident #1, who was identified as an elopement and wandering risk from leaving the facility unnoticed and unsupervised for one (1) of three (3) residents reviewed for wandering. Resident #1. The facility's failure to provide supervision resulted in Resident #1 being left on the front patio, where she subsequently exited the premises unnoticed and unsupervised. The resident was later found at a grocery store approximately 0.3 miles from the facility. Video surveillance footage revealed Resident #1 left the facility at 4:05 PM and was located at the grocery store at 4:25 PM. The facility's failure to provide supervision to a resident who was at risk for wandering and elopement placed Resident #1, and all other residents at risk for wandering and elopement, in a situation that was likely to cause serious harm, serious injury, serious impairment or death. The State Agency (SA) identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which began on 8/15/24 when Resident #1 eloped from the facility unsupervised. The SA notified the facility's Administrator (ADM) of the IJ and SQC on 8/19/24 at 2:00 PM, and provided IJ templates to the ADM. The facility submitted an acceptable Removal	F 689	F689 1. Corrective actions for those residents found to have been affected by this deficient practice: Resident #1 was provided assistance back to the center by the Infection Control Preventionist on 8/15/24 at approximately 4:20 PM with no observed injury. Resident #1 received a body audit from a licensed nurse at approximately 4:40 PM on 8/15/24 with no findings of injury. Beginning at approximately 4:45 PM, Resident #1 was placed on hourly staff monitoring x 24 hours. Resident #1, who is alert and oriented, was provided education by the Director of Nursing on 8/16/24 at approximately 3:30 PM to notify staff anytime she wished to go outside or leave the center. Resident #1's care plan was updated on 8/19/24 by the Minimum Data Set (MDS) Coordinator with current interventions for wandering/elopement prevention. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The center acknowledges that all residents have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 11 Plan on 8/20/24, in which they alleged all corrective actions to remove the IJ were completed on 8/19/24, and the IJ removed on 8/20/24. The SA validated the Removal Plan on 8/20/24 and determined the IJ was removed on 8/20/24, prior to exit. Therefore, the scope and severity for 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity "J." was lowered from a "J" to a "D", 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: Review of the facility's policy "Elopements and Wandering Residents" revealed, "Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk ..." Record review of the "Wandering Risk Scale" with an effective date of 4/27/24 revealed in Section E that Resident #1 "Has history of wandering". A review of the facility's investigation into the "Elopement" incident revealed that on 8/15/24, Resident #1 was allowed to sit on the facility's porch. At 4:16 PM, a staff member noticed that Resident #1 was missing from her wheelchair that sat on the front porch. Simultaneously, a family member reported that a resident had been	F 689	Licensed Nurses ensured all residents were in-house via visual observation on 8/15/24 at approximately 5:00 PM. The Director of Nursing and a Registered Nurse completed 100% elopement risk assessments on all residents to determine their risk for elopement on 8/16/24. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/16/24 at 5:15 PM, the Quality Assurance and Performance Improvement (QAPI) Committee attended by the Director of Nursing, the Medical Director via phone, Infection Control Preventionist, and the Nursing Home Administrator updated the facility□s policy on Elopement Prevention to include any resident at risk for elopement would receive ongoing staff supervision while outside the center. An all-staff education inservice was initiated on 8/15/24 at approximately 5:30 PM by the Director of Nursing and a Registered Nurse Supervisor on the elopement prevention policy to include the provision that any resident at risk for elopement will receive ongoing staff supervision while outside the center. Any staff on leave or not in the center at the time of the inservice will receive education prior to their next scheduled shift. New hires beginning on 8/19/24 will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 12 seen walking up the hill. A Code White (elopement) was immediately announced over the intercom, and staff began searching for the resident. The Infection Preventionist got into her vehicle and located the resident at a local grocery store at approximately 4:24 PM, 0.3 miles from the facility. Resident #1 was unharmed, standing upright, and cooperative when asked to get into the vehicle and return to the facility. A full assessment revealed stable vital signs and no injuries. A review of the camera footage revealed Resident #1 left the porch at 4:05 PM. Resident #1's daughter was notified of the elopement at 4:43 PM, and she stated that her mother had a history of wandering and had done so in the past and that was the reason she had placed her in a nursing home. On 8/19/24 at 10:05 AM, during an interview, the Director of Nursing (DON) confirmed that Resident #1 had been sitting unattended on the facility's front porch on 8/15/24, left the facility unsupervised and was located at the local grocery store at approximately 4:45 PM. She verified that video surveillance footage indicated Resident #1 left the facility at 4:05 PM. She acknowledged that a resident at risk for wandering/elopement should not have been left unattended and that staff should have been present with her. On 8/19/24 at 10:15 AM, during interview Certified Nursing Assistant (CNA) #2 stated that Resident #1 wears a Wandergaurd due to her risk of elopement. She confirmed that Resident #1 frequently sits outside on the porch unattended because she refuses to come back inside.	F 689	receive education regarding our elopement prevention policy to include resident safety provided by the Director of Nursing. A Resident Council meeting was held on 8/19/24 at 3:30 PM by the Activities Director to provide education to residents to notify their licensed nurse and sign out prior to leaving the center. A letter to resident families and responsible parties was sent out on 8/20/24 by the Administrator to inform them to alert the licensed charge nurse and ensure the resident is signed out prior to the resident leaving the center. The letter also informed the families and responsible parties not to allow any resident to go outside without checking with nursing staff. The center receptionist will provide monitoring to residents attempting to access the keypad coded door at the front entrance. 4. How the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 8/20/24, the Maintenance Director, Maintenance Assistant, or Administrator will complete outside walking rounds 2 x day x 4 weeks, then 1 x day x 4 weeks, then weekly x 4 weeks to ensure no resident at risk for elopement is outside the center without staff supervision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 13 On 8/19/24 at 10:20 AM, during an interview with Licensed Practical Nurse #1 (LPN) stated Resident #1 is at risk for elopement but often sits unattended on the facility porch. During an interview on 8/19/24 at 10:35 AM, Resident #1 recounted that on the afternoon of 8/15/24, she was sitting on the porch thinking about tobacco, which prompted her to walk to the store to buy some. She stated that she walked through parking lots without going near the street. She reported no injuries and said that staff eventually picked her up and brought her back to the facility. On 8/19/24 at 1:30 PM, in an interview with the Front Office Receptionist, the receptionist stated on 8/15/24 at approximately 3:30 PM, she turned off the door alarm to allow Resident #1 to go out and sit on the front porch. She admitted that no staff accompanied Resident #1 and that in the past, Resident #1 had been allowed to go outside without staff supervision. She also mentioned that she was not monitoring Resident #1, and no one had asked her to do so. On 8/19/24 at 1:35 PM, during an interview with the Infection Control Preventionist (ICP) she confirmed that she was working in the front office on 8/15/24 and was unaware that Resident #1 was still outside. She stated that no one had asked her to monitor Resident #1. At approximately 4:10 PM to 4:15 PM, a CNA informed her that Resident #1's wheelchair was on the porch, but the resident was missing. She joined other staff in searching for the resident and found Resident #1 standing near a local grocery store, talking to an acquaintance. The resident was returned to the facility at around 4:25 PM,	F 689	Beginning 8/20/24, an elopement drill will be conducted by the Maintenance Director or Administrator weekly x 4 weeks and then monthly x 2 months and then quarterly thereafter to ensure compliance and validate staff understanding of how to react when an elopement occurs. All education and audit findings will be brought to the Quality Assurance Performance Improvement (QAPI) Committee for review and discussion of the effectiveness of interventions monthly x 3 months beginning 9/10/24. If any findings of noncompliance are identified, the Committee will ensure the plan of correction is adjusted with updated or new interventions accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 14	F 689		

wearing a t-shirt, black leggings, non-skid socks, and a hair bonnet.

On 8/19/24 at 1:51 PM, during a telephone interview CNA #1 reported she went outside during her break and a resident's family member informed her that Resident #1 was walking up the street. She notified the Front Office and Nursing Supervisor. This triggered a Code White (resident elopement). By the time she reached the grocery store, the nurse had already arrived, and Resident #1 was in her car.

On 08/19/24 at 3:00 PM, during an observation of the route from the facility to the location where Resident #1 was found, the distance was determined to be 0.3 miles from the facility, mostly flat ground.

A record review of the weather report from the website https://www.localconditions.com/weather38668 revealed that on 8/15/24 it was 95 to 97 degrees from 3:35 PM to 4:35 PM.

Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 7/21/23 with diagnoses that included Cerebral Vascular Accident.

Record review of Resident #1's Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/15/24 revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating that the resident is cognitively intact. Section P-Restrains and Alarms revealed "An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected." This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 15	F 689		

section was coded that an alarm was "used daily."

The facility implemented the following removal plan:

On 8/15/24 at approximately 4:15 PM, a passerby notified Certified Nursing Assistant #1 (CNA) at that she observed an individual walking up the hill that she suspected to be a resident of the center. CNA #1 immediately came into the facility and notified the receptionist. A search by staff was initiated.

At approximately 4:20 PM on 8/15/24, the Center's Infection Control Preventionist got in her car to go off premises to look for Resident #1. Resident #1 was observed by the Infection Control Preventionist approximately a quarter mile from the facility outside a local grocery store and successfully encouraged to get in the car on 8/15/24 at 4:24 PM.

On 8/15/24 at approximately 4:25 PM, Resident #1 returned to the facility.

On 8/15/24 at 4:40 PM, the Licensed Practical Nurse completed a body audit on the resident with no injuries noted.

Beginning 8/15/24 at 4:45 PM, Resident #1 was placed on hourly staff monitoring for 24 hours.

On 8/15/24 at approximately 5:00 PM, Licensed Nurses ensured all residents were in-house via visual observation.

On 8/15/24 at approximately 5:30 PM, education was initiated by the Director of Nursing and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 16	F 689		

Registered Nurse Supervisor on the elopement prevention policy to include the provision that any resident at risk for elopement will receive ongoing staff supervision while outside the center for all staff. No staff will be allowed to work until in serviced.

The State Survey Agency and Attorney General's office was notified on 8/15/24 at 6:10 PM and 6:20 PM respectively by the interim Director of Nursing.

On 8/16/24 at approximately 3:30 PM, Resident #1, who is alert and oriented, was provided education by the Director of Nursing to notify staff anytime she wished to go outside or leave the center.

The Director of Nursing and a Registered Nurse Supervisor completed elopement risk assessments on all residents to determine their risk of leaving the center without adequate staff supervision on 8/16/24 at 4:00 PM.

On 8/16/24 at 5:15 PM, the Quality Assurance and Performance Improvement (QAPI) Committee attended by the Director of Nursing, the Medical Director via phone, Infection Control Preventionist, and the Nursing Home Administrator updated the facility's policy on Elopement Prevention to include any resident at risk for elopement would receive ongoing staff supervision while outside the center.

A new Nursing Home Administrator started 8/19/24 at 8:00 AM.

A Resident Council meeting was held on 8/19/24 at 3:30 PM, by the Activities Director to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 17	F 689		

education to residents to notify their licensed nurse and to sign out prior to leaving the center.

On 8/19/24 beginning at approximately 4:00 PM, care plans on all residents at risk for elopement were reviewed and updates initiated by the Administrator and Minimum Data set (MDS) Coordinator to ensure they reflect individualized interventions for those residents at risk for wandering and elopement.

On 8/19/24 at 4:00 PM, the Director of Nursing initiated education on importance of accuracy of care plan interventions related to wandering/elopement prevention to Minimum Data Set Nurses (MDS), Infection Control Preventionist, Registered Nurse Supervisors, and Medical Records Coordinator.

On 8/19/24 beginning at approximately 4:00 PM, a 100 percent (%) Care Plan audit was conducted by the Administrator and MDS Nurses with updates for current interventions made to care plans to ensure compliance for residents at risk for elopement.

On 8/19/24 at approximately 4:00 PM, Resident #1's care plan was updated by the MDS Coordinator with current interventions for elopement prevention.

An Ad Hoc Quality Assurance meeting was held on 8/19/24 at 5:45 PM, to discuss the Immediate Jeopardy Removal Plan and corrective actions, interventions, and education to ensure compliance. As part of the Ad Hoc QAPI Meeting, in-service completion for both the all-staff education on the elopement prevention policy and the importance of accurate and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 689	Continued From page 18	F 689		

effective care plan interventions related to wandering/elopement prevention education for the Interdisciplinary Team (IDT) was reviewed by the Administrator and QAPI Committee Members with further instruction that no staff will be allowed to work until in serviced. It was attended by the Medical Director, Director of Nursing, Infection Control Nurse, Administrator, and RN Supervisor.

All corrective actions were completed by 8/19/24 and the facility alleges removal of the Immediate Jeopardy (IJ) 8/20/2024.

Validation:

The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #26203 through record review and interviews on 8/20/24. The SA determined all corrective actions were completed on 8/19/24 and the IJ was removed on 8/20/24.