MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	69SC	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

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M 000	Initial Comments 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 Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements for 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 showed 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 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 2:00PM. IJ and SQC existed at: Rule 45.21.8- Accidents M640- Level IV 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 was removed	M 000		

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M 000	Continued From page 1 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 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.	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 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	M 640	M640 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,	9/11/24

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M 640	Continued From page 2 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 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:	M 640	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. 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	

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M 640	Continued From page 3 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 ..." 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 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	M 640	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 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.	

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M 640	Continued From page 4 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 #2 (CNA) 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. 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	M 640	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. 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.	

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M 640	Continued From page 5 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, 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.	M 640		

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M 640	Continued From page 6 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 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.	M 640		

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M 640	Continued From page 7 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 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,	M 640		

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M 640	Continued From page 8	M 640		

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 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

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M 640	Continued From page 9 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 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.	M 640		