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
	300S	A. BUILDING: _____ B. WING _____	C 02/13/2025

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OCEAN SPRINGS HEALTH & REHABILITATION CENTI	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #27927, a Facility Reported Incident (FRI), at the facility from 2/11/25 through 2/13/25, related to an elopement. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The facility failed to provide supervision to prevent Resident #1, who was identified as a risk for wandering and elopement, from leaving the facility without supervision. The facility's failure to provide supervision resulted in Resident #1 exiting the facility unsupervised and unnoticed by facility staff. On 2/8/25, Resident #1 exited the facility and was unsupervised for approximately 30 minutes, walked approximately 0.8 miles and crossed a four-lane highway. During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 2/8/25 existed at Rule 45.21.8 - Accidents (M640). This situation placed Resident #1 and other residents at risk for wandering and elopement, at risk for serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJs and SQC on 2/12/25 at 5:30 PM and provided the Administrator with the IJ Templates. Based on the facility's implementation of corrective actions on 2/9/25, the SA determined the IJs and SQC to be Past Non-Compliance (PNC) and the IJs were removed on 2/10/25,	M 000		

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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, interviews, record review, facility policy review, and facility investigation review, the facility failed to provide adequate supervision and assessment and monitoring of a wandering alarm device to prevent Resident #1, who was identified as an elopement and wandering risk, from exiting the facility unnoticed and unsupervised for one (1) of four (4) residents reviewed. Resident #1 On 2/08/25, at approximately 3:00 PM, Resident #1 exited the facility while unsupervised wearing a wander alarm device that was found to be inoperable. The resident was out of the facility unsupervised and walked approximately 0.7 miles for approximately thirty (30) minutes before being located by facility staff and returned to the facility, crossing a four-lane highway. The facility's failure to adequately assess and monitor the resident's wandering alarm device and provide adequate supervision for Resident #1, who was an elopement risk, put this resident and all other residents at risk for wandering and	M 640	The Medical Director was notified on 02/08/2025 at approximately 1525 and I self reported to the Mississippi Board of Nursing Home Administrators on 02/26/2025 at approximately 1510 for the substandard care deficiency and IJ, IAW the SOD Letter dated 02/24/2025.	2/27/25

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elopement, at risk for serious injury, serious harm, serious impairment, or death.

The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 2/08/25, when Resident #1 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 2/12/25 at 5:30 PM and provided an IJ Template.

Based on the facility's implementation of corrective actions on 2/9/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 2/10/25, prior to the SA's entrance on 2/11/25.

Findings include:

A review of the facility's policy, "Elopement/Wandering Risk Guideline" revised 08/01/2020 revealed, " Overview:
To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions ... Process ...If utilizing a wander monitoring system device check placement of the device every shift and functionality every day ..."

A record review of the facility's, "Verification of Investigation", revealed it was discovered at approximately 3:00 PM on 2/8/25, that Resident #1 exited the facility. A silver alert was announced and all staff began looking for the resident. A new Certified Nurse Aide (CNA) who had just reported for her 3 PM to 11 PM shift showed a video of an individual she saw walking long the highway. By this time, the resident's girlfriend was in the facility. As soon as they knew where he was, the girlfriend and three (3) CNAs jumped in the car to go to the place where the resident was last seen. Resident #1 was

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discovered .7 mile from the facility. He was returned to the facility and no injury was noted.

Record review of the weather conditions in Ocean Springs, MS on 2/08/2025 according to www.weatherspark.com revealed at 2:53 PM, the temperature was 75 degrees Fahrenheit, and clear, with 9.21 miles per hour wind.

On 2/11/25 at 3:00 PM, during an observation of the facility grounds, the side and back doors of the facility were inside a fence with locked gates. The front door opened to a front porch with a ramp that descended to the well-maintained driveway and front parking lot. It was two hundred (200) feet from the front door to the road in front of the facility. The speed limit for the road was fifteen (15) miles per hour and the SA observed for fifteen (15) vehicles in one minute traveling on the road at 3:00 PM. It was 0.2 miles west from the entrance into the facility driveway to the red light where the road intersected with the six-lane highway. One block west of the intersection the highway changed to four (4) lanes. There were no crosswalks observed across the highway. The local business where Resident #1 was located was 0.7 miles from the entrance into the facility driveway across the highway on the west side of the highway.

On 2/11/25 at 3:45 PM, during an interview the Administrator revealed that the facility reported incident identified as "Elopement" was discovered on 2/08/25 at 3:00 PM when Resident #1's visitor inquired to his whereabouts and the resident could not be located in the facility. The Administrator reported that the facility staff initiated the Missing Resident protocol and Certified Nurses' Aide (CNA) #1, who arrived at the facility at 3:00 PM reported that she had

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observed the resident walking along the nearby highway. The Administrator reported that the visitor and two CNAs retrieved the resident in the visitor's vehicle and returned him to the facility at 3:30 PM. The Administrator said that staff assessed Resident #1 immediately upon return for injury and dehydration and encouraged fluids by mouth. He stated that staff had conducted a one hundred percent (100%) head count/room check with a resident census and performed a door check on all exit door to ensure they were closed and locked. The Administrator stated Licensed Practical Nurse (LPN) #1 notified the Director of Nurses (DON) who reported to the facility and initiated a thorough investigation and reported the incident to the SA Agency on 2/08/25 at approximately 5:37 PM. He said that LPN #2 notified the Resident Representative (RR) for Resident #1. He confirmed that the resident had been wearing a pair of athletic shorts and a sleeveless T-shirt, two pairs of socks, and one house slipper at the time of elopement. The Administrator explained that all the exit doors were closed and locked with wall-mounted numeric keypads next to each and required a code to be entered to open the door. He said that the front door could also be opened from the outside with the press of a red button. He said that in the absence of any evidence of point of exit, facility investigation concluded that the resident had exited the facility when visitors pressed the red button on the outside and entered the facility. The resident was gone from the facility unsupervised for "about half an hour". The Administrator stated that Resident #1 did not suffer any injuries of any kind during or due to the elopement. The Administrator revealed the facility conducted an ad hoc Quality Assurance and Assessment (QAPI) meeting on the evening of 2/08/25 in which the appropriate members were

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in attendance and policies were discussed with no changes recommended. He said the facility conducted in-service /training related to elopements in which staff would not be able to work until in-serviced. The Administrator said all residents assessed with wandering behaviors and at risk for elopement, including Resident #1, had their wander guard transmitters tested and it was discovered that the transmitters were not operating correctly. He said that a staff member was posted at the front door and residents at risk for elopement were provided with one-on-one supervision until the system components were received on 2/10/25 and testing confirmed the system functioned correctly.

On 2/11/25 at 4:30 PM, an observation and interview with Resident #1 revealed the resident was sitting on his bed in his room. He was wearing a wander guard transmitter on his right ankle. He was unable to answer questions or describe out he left the facility on 2/8/25.

On 2/11/25 at 5:30 PM, in an interview with CNA #3, she revealed she was working at the time of the elopement of Resident #1 on 2/08/25. She explained that a visitor of Resident #1 arrived and went to the resident's room, and he was not in his room. She said the visitor came out and inquired of staff where he was and the dining room and therapy gym were checked and the resident was not there. After a brief look at common areas LPN #1 called a "Code Silver" and CNA #1 had just arrived and said she thought she had seen the resident on a nearby highway on her way to the facility. She explained that she and another CNA accompanied the visitor to the area, located the resident and he willingly got into the visitors vehicle and returned to the facility. She said that he did not have any obvious injury.

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M 640	Continued From page 6 On 2/12/25 at 9:55 AM, during an interview, LPN #1 revealed she was working the 3:00 PM through 11:00 PM shift on 2/08/25 and observed Resident #1 in the lobby "minutes before 3:00 (PM)". She said she discovered at approximately 3:00 PM that Resident #1 could not be located when a visitor inquired about his whereabouts. She confirmed that the facility policy/procedure for Missing Resident was followed with a "Code Silver" announced using the overhead public announcement system. She stated that CNA #1 had just arrived and reported that she observed the resident walking along the nearby highway. She confirmed the resident was wearing athletic shorts and a sleeveless T-shirt, two black socks and one house slipper, she confirmed the second slipper had been located in his room upon return to the facility by his visitor and two (2) facility staff at 3:30 PM. She stated that she completed a body audit for Resident #1 immediately upon his return and observed no injuries or signs/symptoms of dehydration and encouraged fluid intake by mouth. She said she notified the resident's primary healthcare provider and received no new orders. She said that all residents at risk for elopement, including Resident #1, had their wander guard transmitter tested and none were functioning correctly. She confirmed that a staff member was posted at the front entrance and all residents at risk for elopement were provided with one-on-one supervision pending system replacement and proper function which was accomplished on 2/10/25. LPN #1 stated that nurses were supposed to test the functionality of the transmitters daily either using a hand-held tester or by taking the resident to the door and observing and documenting the test results in the Medication Administration Record but she had not	M 640		

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tested Resident #1's transmitter on 2/08/25.

On 2/12/25 at 12:36 PM, during a telephone interview the RR for Resident #1 confirmed that she had been notified "shortly after 3:30 PM" on 2/08/25 that the resident had left the facility unsupervised and returned to the facility at 3:30 PM with no injuries.

On 2/13/25 at 4:50 PM during an interview, the Maintenance Director explained that he tested the functioning of the wander guard system each week and the nurses were supposed to test the transmitters daily. He confirmed that the maintenance department had reported to the facility on 2/08/25, tested all exit doors and confirmed that all doors were closed and locked correctly but it was determined that the transmitters worn by residents at risk for elopement were not functioning correctly, specifically not preventing the door from opening or sounding alarm if a transmitter was within eight feet of the front door. He confirmed that the maintenance department changed all the numeric codes for wall-mounted keypads (magnetic locks) after 3:30 PM on 2/08/25. The Maintenance Director said that replacement transmitters were ordered on 2/08/25 and arrived at the facility on 2/10/25. He stated that he had tested the system with the newly received transmitters and the system functioned correctly.

On 2/13/25 at 5:00 PM, in an observation and interview with the DON, she revealed that the front entrance wander guard system was functioning properly. The DON demonstrated the function of the system was to prevent the door from opening if a wander guard transmitter was within eight (8) feet of the monitor at the door and if the door had been opened and was open and

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the transmitter was within eight feet an alarm sounded, which also sounded at both nurses stations. She confirmed that at the time of the elopement the system was not functioning properly. The DON confirmed that the police were not notified of the elopement, and the resident was not taken to the hospital and had no injuries or change of condition following the incident. She confirmed that she had attended the QAPI meeting on the evening of 2/08/25. She confirmed that the replacement transmitters for the wander guard system arrived at the facility on 2/10/25 and were replaced and the system was tested and functioned correctly. She confirmed that monitoring for placement every shift and functioning daily was on-going. She confirmed that all staff were provided with in-service with no staff allowed to work without participation in the training.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 1/28/25 with current diagnoses including Aphasia following Cerebral Infarction, Cognitive Communication Deficit and Legal Blindness.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/04/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 99 and required a staff assessment for his mental status. The staff assessment indicated Resident #1 had a long and short-term memory problem, and his cognitive skills for daily decision making was severely impaired. Further MDS review revealed the resident was assessed as needing partial/moderate assistance for surface-to-surface transfers and walking ten (10) feet.

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M 640	Continued From page 9 The facility submitted a corrective action plan as follows: 1. On February 8, 2025, at approximately 3:00 pm, CST, Resident #1 exited the center while unsupervised. The unsupervised resident leaving the facility represented an Immediate Jeopardy. The resident was wearing a wander guard device. The Resident was assessed upon return to the facility and had no injuries, the wander guard device was found to be inoperable, and Resident was placed on one-on-one supervision. The facility reviewed the wandering/missing resident policy, educated staff on the wandering/missing resident policy and held a quality assurance meeting. In addition, staff checked all exit doors out of the facility (including the door the Resident exited from). Also, the staff check all wander guards currently being utilized in the building and placed any not working on 1:1 supervision. Finally, staff performed a complete headcount (all residents were found to be in the building with one exception who had properly signed himself out) and the door codes were changed. Based on the steps the facility initiated and completed, the facility contends that the Immediate Jeopardy was removed and represents past noncompliance. This event was reported to the Mississippi State Department of Health via email on Sunday, February 9, 2025, at 2:37 pm. 2. On February 8, 2025, at 3:00 pm, Licensed Practical Nurse (LPN) #1, was notified that Resident #1 could not be accounted for. At 3:02 pm, the Director of Nursing (DON), Executive Director (ED), Social Services Director (SSD), Medical Director (MD) and Regional Director of Clinical Services (RDCS) were notified. At 3:03 pm, Certified Nursing Assistant (CNA) #1 reported to work for her 3-11 shift and upon	M 640		

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hearing that a resident was not accounted for, showed the nurse a video she had taken of a man she saw walking next to Hwy 90 on her way to work. The Resident's girlfriend arrived at the facility approximately 3:00 pm and as soon as she saw the video, she and 3 CNAs jumped in the car to go get Resident #1. LPN #2 called the Residents responsible party (Power of Attorney (POA)) and DON. The DON called the ED, MD, and SSD. At 3:30 pm Resident returned to the facility. At 3:36pm the DON was notified the Resident was located .7 of a mile from the facility and safely returned to the facility.

3. On February 8, 2025, at 3:30 pm, Resident returned to facility. Once Resident #1 was back inside center, LPN #2, completed a head-to-toe body audit and no injuries were noted. Registered Nurse (RN) Supervisor #1 completed a head count of all residents, and all were accounted for. On February 8, 2025, at 4:15 pm, the Assistant Maintenance Director performed checks on all exterior doors and windows, along with the wander guard system. His findings determined that all doors were locked and while all alarms were functioning properly, the wander guard bracelet Resident #1 was wearing was not functioning properly. The resident was immediately placed on 1:1 supervision and a 24-hour door monitor put in place at front. The door monitor continued until the wander guard system was verified to function properly and the Quality Assurance monitoring begin (see bullet #8). The door monitor was discontinued on 02/10/2025. The door keypad codes were changed.

4. On February 8, 2025, RN #2/Unit Manager began educating staff on elopement wandering risk policy, missing resident policy, following care

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plans, abuse and neglect, and resident's rights. The Director of Social Services reassessed Resident #1 Brief Interview for Mental Status (BIMS), which had not changed and was noted to be 99, unable to determine. On February 8-10, 2025, wandering risk evaluation completed on all residents with no newly identified wandering risk. Elopement binders (identifying the 5 residents wearing wander guards) are located at both nurses' stations and up front. At 6:45 pm, an Ad hoc QAPI was held including the ED, DON, and MD to discuss incident and a plan of correction.

5. On Saturday, February 8, 2025, DON conducted interviews to learn of Resident #1's path. It was discovered that Resident #1 most likely exited the front door when a visitor entered the facility. Resident #1 confirmed by a positive head shake that he used the front door and answered "yes," that he was trying to go home.

6. On Monday, February 10, 2025, at 2:30 pm, the incident was taken to a quality assurance performance improvement (QAPI) meeting, attended by, Executive Director, Director of Nursing, Infection Preventionist, Medical Director via phone, Director of Dietary Services, Maintenance Director, Minimum Data Set (MDS) LPN #2 and LPN #3. No further action needed. No changes made to policies.

7. On February 8, 2025, in-servicing began on Wandering/Missing Resident, Prevention of Abuse and Neglect, and door alarms policies, and included 3 RNs, 1 LPN and 5 CNAs. On February 9, 2025, in-service continued including 6 LPNs, 2 RNs and 8 CNAs. On February 10, 2025, in servicing continued including 6 LPNs, 11 CNAs, and 3 RNs and 4 ancillary staff. On February 11, 2025, 4 LPN, 9 ancillary staff, 4 RNs. No staff

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was allowed to work before receiving education. 15 CNAs, 1 RN. Education is on-going until it was 100% complete. Furthermore, the system will be check daily by maintenance staff and the devices will be checked for placement each shift and checked for functionality daily by nursing staff. The daily checks of the door systems and placement of the patient devices, as well as the q shift checks of functionality of the patient devices, will be monitored by DON for completion. (see bullet #8)

8. The following monitoring has been put in place beginning February 10, 2025, and the findings will be evaluated by the Quality Assurance and Improvement Committee. All residents that are assessed and care planned as a potential for elopement will be evaluated for significant change in condition for elopement using the elopement risk evaluation, evaluated quarterly for elopement using the elopement risk evaluation, ensure the care plan reflects elopement risk status and any interventions (i.e., wander guard), wander guard check placement every shift that it is present on the MAR without omissions, order for wander guard check for functionality daily is present on MAR without omissions, elopement books have a current face sheet, resident photograph and risk alert form, binders are in an easily accessible location, staff has been educated on the elopement policy, location of the binders and notification process regarding an possible missing resident, transmitter bands are replaced per manufacturers recommendations if signs of manipulation and/or integrity of the band is compromised, exit doors monitoring system functioning appropriately with supporting documentation, and wand used to test function is easily accessible to check the transmitter function.(once these monitoring task

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300S	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTI	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 13 were initiated, we discontinued the door monitor) All the forementioned monitoring task will be conducted by the Director of Nursing enduring 3 times a week for 1 week, then 2 times a week for 2 weeks, then weekly for the next 2 months and then monthly. All results will be presented to the Quality Assurance Committee for evaluation and recommendations as necessary. The Quality Assurance Committee will continue to evaluate all monitoring for 90 days to monitor effectiveness and make changes as necessary. 9. All Corrective Actions were completed on February 9, 2025, and the Immediate Jeopardy was removed on February 10, 2025, prior to the State Agency's entrance on February 11, 2025. Validation: The SA validated on 2/13/25, through interview and record review, that all corrective actions had been implemented as of 2/9/25, and the facility was in compliance as of 2/10/25, prior to the SA's entrance on 2/11/25.	M 640		