STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255207	A. BUILDING _____ B. WING _____	C 07/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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		

Initial Comments

AMENDED 8/23/21
The State Agency (SA) conducted Complaint Investigations (CI) MS# 17869, MS# 17884, and MS# 17935 on 7/08/21 through 7/17/21 at the facility. During the survey, the facility was determined not to be in compliance with the requirements of participation for Medicare and Medicaid. The SA substantiated CI MS# 17869 and MS# 17935 related to elopements, when the facility failed to provide adequate staff supervision to prevent Resident #1 and Resident #5's elopements. The SA substantiated CI MS#17884 related to a fall with an injury for Resident #6..

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/1/21, when the facility failed to provide adequate supervision to prevent the elopement of Resident #1, who was gone from the facility unsupervised for approximately 88 minutes and found lying on his back on the asphalt parking lot of the building next door to the facility. Resident #1 had minor abrasions of the left arm and leg, a bruise on the top of the left hand and a skin tear on the left knee. During the survey on 7/14/21, Resident #5 eloped from the facility for approximately 16 minutes and was found approximately 0.6 miles from the facility. On 7/2/21, Resident # 6 sustained a fall resulting in a displaced right femoral neck fracture.

The facility's failure to provide supervision to prevent the elopements of Residents #1 and #5 and a fall for Resident #6 placed these residents and other residents at risk, in a situation that was

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

Electronically Signed | 08/11/2021

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F 000	Continued From page 1 likely to cause serious harm, injury, impairment, or death. On 7/12/21 at 1:15 PM, the SA notified the Administrator of the IJ and SQC and provided the facility with the IJ Template. An additional IJ Template was provided on 7/14/21, when Resident #5 eloped. The IJ and SQC existed at: 42 CFR(s): 483.25(d)(1)(2)-Free of Accident Hazard/Supervision/Devices. (F 689) Scope and Severity "J". The facility submitted an acceptable Removal Plan on 7/15/21, in which they alleged all corrective actions to remove the IJ were completed on 7/15/21, and the IJ removed on 7/16/21. The SA validated the Removal Plan on 7/17/21, and determined the IJ was removed on 7/16/21, prior to the exit. Therefore, the scope and severity for 42 CFR(s): 483.25(d)(1)(2)-Free of Accident Hazard/Supervision/Devices. (F 689) was lowered to a "G", 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. The SA cited F600, F609, F610 and F657. These deficiencies were not at the IJ level. At the time of the survey, the facility had a census of 87 and held a license for 120 beds.	F 000		
F 600 SS=G	Free from Abuse and Neglect	F 600		8/24/21

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F 600	Continued From page 2 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from neglect, related to a fall with injury for one (1) of five (5) residents reviewed. Resident #6. Findings include: Review of the facility "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" revealed "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined below. This includes but not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms... Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff of other agencies	F 600	1. On 7/7/21, the Administrator completed a one-on-one in-service with Registered Nurse (RN) # 7 regarding falls-classifications, interventions, risk management, and notifications to Director of Nursing (DON) and Administrator. The DON and Administrator suspended RN # 7 and Certified Nursing Assistant (CNA) # 7 on 7/7/21. The DON and Administrator terminated CNA # 7 and RN # 7 on 7/15/21. The Administrator reported RN # 7 to the MS Board of Nursing on 7/8/21. 2. All residents in the facility have the potential to be affected by this practice. On 7/8/21 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Minimum Date Set (MDS) nurses completed new body audits and pain assessments on 100% of all residents in	

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F 600	Continued From page 3 serving the resident, family members or legal guardians, friends, or other individuals. ...Neglect- failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress ... Staff will be supervised to identify inappropriate behaviors such as derogatory language; rough handling; ignoring residents while giving care; directing residents who need toileting assistance to urinate or defecate in their beds ..." Record review of the "Admission Record" revealed Resident #6 was admitted on 8/12/20, with diagnoses that included Dementia, Transient Ischemic Attack (TIA), and Schizoaffective disorder. Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/04/2021 revealed Residen#6 had a Brief Interview for Mental Status (BIMS) score of 3 that indicated Resident #6 has severe cognitive impairment. Record review of the facility's "CES Quarterly Evaluation Bundle (Clinical-V11)" dated 5/12/21 revealed "2. Fall Risk Evaluation Instructions: If the score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan." Resident #6's Fall Risk Score was 21." Record review of the facility's "Progress Notes" dated 7/2/2021, revealed "Resident heard screaming out in her room @ (at) 15:23 (3:23 PM). Upon entering room, resident noted to have copious amount of vomit in her bed ...Resident	F 600	the facility. No similar findings or negative effects have been identified by this alleged deficient practice. 3. On 7/6/21 the administrative team completed an in-service with all staff on abuse, neglect, misappropriation. On 7/8/21 the Administrator, Director of Nursing (DON), Nurse Supervisor, and Business Office Manager (BOM)/ HR completed an in-Service with all nurses regarding incidents/accidents, assessing, documentation, and reporting. On 7/8/21 the Administrator, DON, Nurse Supervisor, and BOM/HR completed an in-service with all staff regarding reporting accidents, reporting abuse, neglect, chain of command, and when to call protocol. The DON and Administrator suspended RN # 7 and Certified Nursing Assistant (CNA) # 7 on 7/7/21. The DON and Administrator terminated CNA # 7 and RN # 7 on 7/15/21. The Administrator reported RN # 7 to the MS Board of Nursing on 7/8/21. 4. The Administrator, Director of Nursing (DON), Minimum Data Set (MDS) Nurses, Social Services Director (SSD), Business Office Manager (BOM)/Human Resources (HR), or Life Connections Coordinator (LCC) will perform random audits to ensure residents rights are adhered too and residents are free from abuse, neglect, misappropriation, and exploitation. These audits will be in the form of staff and Resident interviews regarding abuse, neglect, misappropriation, and exploitation policy	

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F 600	Continued From page 4 assisted out of bed to wheelchair ...Resident continues to cry out. Resident states that her back hurts ...Order received to send to (Proper name of local hospital) ..." Record review of the local hospital progress note dated 7/6/21 revealed " Patient was seen and examined today. Patient is a terrible historian. She constantly yells out with any movement of her right leg. Case was discussed with physical therapy. Imaging obtained." Record Review of the local hospital x-ray report dated 7/6/21 revealed a displaced right femoral neck fracture. Record review of the facility investigation dated 7/6/21, revealed there were no recent falls or incidents documented from the hospital. The investigation at the facility revealed that there was an incident regarding Resident #6 on 7/2/21. RN #7 and CNA #7 reported two different stories. RN #7 changed her story multiple times, did not document, and was reported to the state Board of Nursing by the facility. No other staff members were identified to have witnessed the incident. During an interview on 7/13/2021 at 10:30 AM, with RN #7 revealed she was called to Resident #6's room by CNA #7 on 7/2/2021 at 8:00 AM. RN #7 said Resident #6 was sitting in the wheelchair crooked. RN #7 said CNA # 7 helped her straighten the resident up in the wheelchair. RN # 7 said she suspected Resident # 6 must have fell and put herself in the wheelchair crooked. RN #7 said she did not do an incident report or notify anybody because she wasn't for sure if the resident fell. RN # 7 said Resident #6 has had several falls and complains of pain all the time.	F 600	including reporting and investigating. The Administrator, DON, MDS Nurses, SSD, BOM/HR, or LCC will complete an audit to begin on 7/19/21 and will interview three (3) staff members and three (3) Residents weekly for thirty (30) days then three (3) staff members and three (3) Residents monthly for three (3) months. Any concerns related to abuse, neglect, misappropriation, and exploitation will be addressed immediately. The results of the audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 4 months to end on November 19, 2021. The first QAPI meeting to review such audits will be held in August 2021. If the QA team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed. Completion date as of 8/24/21.	

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F 600	Continued From page 5	F 600		

RN # 7 said Resident #6 vomited later during the day and complained of pain. RN #7 said she gave Resident #6 Zofran for nausea and a pain pill.

Interview on 7/13/21 at 10:45 AM, with CNA #7 revealed on 7/2/21 at 7:00 AM she heard a resident scream "help.". CNA #7 said she saw Resident #6 on the floor. CNA # 7 said she called for RN#7. RN #7 asked CNA #7 if the resident hit her head. CNA #7 said she thinks she did because her head was against the wall. RN #7 said "I don't have time for this. I am not sending her out because she falls all the time. She's, ok". CNA #7 said she took the resident to the dining room after assisting RN #7 with putting her back in the wheelchair. CNA # 7 said Resident #6 was very confused, would not eat and complained of pain to her arm. CNA # 7 said CNA #8 was in the dining room. CNA #8 asked CNA #7 if Resident #6 was OK. CNA #7 told CNA #8 that Resident #6 fell this morning in her room. CNA #7 also said RN #7 did not write an incident report, nor send the resident to the hospital for an x-ray. CNA #8 told CNA #7 to go back to RN #7 and write a statement to cover herself. CNA #7 said CNA #9 also asked during breakfast, what is wrong with Resident #6. CNA #7 said Resident #6 fell, and RN #7 did not write an incident report or send the resident to the hospital to be evaluated. CNA #9 also told CNA #7 to write a statement and keep it because the Administrator or somebody will come to her to find out what happen. CNA # 7 said Resident #7 continued to complain of pain. CNA #7 went to the nurse and said Resident #6 continues to complain of pain. CNA #7 told RN #7 that Resident #6 probably needs to go to the hospital. RN #7 refused to send her out. CNA # 7 said after lunch the resident vomited and continued to complain of pain to her back. CNA

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#7 said she cleaned the resident up and let RN #7 know the resident had vomited and complained of pain. RN #7 gave the resident something for pain and nausea. CNA #7 said when she came back to work the next day, she was told Resident #7 was sent to the hospital for vomiting and pain. CNA #7 said RN #7 came to her saying they need to get their story together. CNA #7 said she told the RN #7 that she wrote a statement. CNA #7 said a couple of days later the Administrator called her and ask if Resident #6 had a fall. CNA #7 said "no" Resident #6 did not fall. The Administrator asked her to write a statement and bring it to the facility. CNA # 7 said she came to the facility and talked to the Administrator. CNA #7 said she told the Administrator that she needed to tell the truth because she did not realize the resident had a fractured hip. CNA # 7 said she told the Administrator that she heard Resident # 6 scream "help me." CNA #7 said she found Resident #6 on the floor. CNA #7 said she called RN #7 to the room. CNA #7 also stated that she told the Administrator that RN #7 refused to send the resident out to the hospital because she didn't have time and the resident always falls and complains of pain. CNA # 7 said she felt bad because RN #7 told her the Resident did not receive any broken bones and the Resident was ok. When she realized Resident #6 had a right hip fracture, she had to tell the truth. CNA #7 said Resident #6 suffered several days before the hospital realized her right hip was fractured because she failed to notify the Administrator.

During an interview on 7/13/21 at 11:00 AM, with CNA #8 revealed CNA #7 came to her and told her Resident #6 fell in her room on 7/2/21. CNA #7 told CNA #8 that RN #7 did not write an

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incident report or send Resident #6 to the hospital. CNA #8 told CNA #7 to write a statement and keep it just in case something happens to the Resident.

During an interview on 7/13/21 at 11:15 AM, with CNA #9 revealed CNA #7 told her that Resident #6 fell on the floor in her room on 7/2/21. CNA #7 said RN #7 would not send the resident to the hospital to be evaluated. RN #7 also did not write an incident report. CNA #9 said she told CNA #7 to write a statement to cover herself. CNA #9 said CNA #7 came to her because she has worked at the nursing home for a long time.

During an interview on 7/13/21 at 11:25 AM, with Licensed Practical Nurse (LPN) #2 said she received report from RN #7 on 7/2/21 at 3:00 PM. LPN #2 said while receiving report she heard somebody screaming. LPN #2 asked who is that? RN #7 said its Resident #6. RN #7 said Resident #6 was lowered to the floor today. RN #7 also said Resident # 6 vomited and complained of pain. LPN #2 said RN #7 gave Resident #6 something for pain and nausea. LPN# 2 said immediately after receiving report she checked on Resident #6 and noted she had vomited on her clothes. Resident #6 continued to yell out saying her back was hurting. LPN #2 called the Nurse Practitioner and received orders to send Resident #6 to the hospital to be evaluated.

During an interview on 7/13/21 at 11:40 AM, with the Administrator, revealed the Nurse Practitioner (NP) called her on 7/6/21 at 1:45 PM, from the local hospital stating Resident #6's x-ray results revealed a right hip fracture. The Administrator asked if Resident #6 had a fall during her stay at the hospital. The hospital records and staff did

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not report any falls or other incidents. The Administrator said she reported to the State Agency (SA) and Attorney General Office (AGO). The Administrator said she started an investigation immediately. The Administrator said the Director of Nursing (DON) called and questioned RN #7 and asked if Resident #6 had a fall on 7/2/21 before she went to the hospital. RN #7 told the DON that when she arrived on her shift the resident was in her wheelchair and had slid out but did not fall. Resident #6 was holding on to the chair with her bottom between the seat of the wheelchair and the floor. RN #7 said she did not do an incident report because she did not think it was a fall. RN #7 said CNA #7 helped her straighten Resident #6 in the wheelchair. RN # 7 was suspended pending investigation and was terminated after the investigation. RN# 7 was reported to the State Board of Nursing. The Administrator called CNA #7 and asked if Resident #6 fell on 7/2/21. CNA #7 said "no" Resident #6 did not fall. The Administrator asked CNA #7 for a statement in writing. The Administrator said CNA#7 came to the facility on 7/7/21 at 4:30 PM to talk to her. CNA #7 told the Administrator that on 7/2/21 around 8:00 AM, she was coming out of another resident's room when she heard Resident # 6 yell out "help me." CNA #7 said she found Resident #6 on the floor in her room by the bathroom door. CNA #7 called RN #7 to the room. RN # 7 asked if Resident #6 hit her head. CNA #7 stated " yes", because her head was against the wall. RN #7 said, "I don't have time for this, I'm not sending her out." CNA #7 and RN #7 assisted Resident #6 back in the wheelchair. Resident #6 continued to yell out in pain. Resident #6 was wheeled to the dayroom. CNA #7 said she checked on the resident all day. CNA #7 said she went back to RN #7 and asked

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F 600	Continued From page 9 if she would send Resident #6 out because she continues to complain of pain. RN #7 said she has had so many falls already, she doesn't have time to send her out. CNA #7 said after lunch Resident #6 vomited and complained of pain to her hip during Activities of Daily Living (ADL) care. CNA #7 told RN#7 and medication was administered for pain and nausea. CNA #7 also said RN #7 said the resident did not have any broken bones when she was sent out to the hospital. CNA #7 said when she found out Resident #6 had a right hip fracture, she knew she had to tell the truth. CNA #7 said she told CNA #8 and CNA # 9 about the situation. Both CNAs told her to write a statement and keep, just in case something happened. CNA #7 was suspended pending investigation. Both CNAs were interviewed and confirmed CNA #7 did talk to them about Resident #6 fall and RN #7 refusing to write an incident report or send Resident #6 to the hospital for an evaluation. Both CNA's advised CNA #7 to write a statement and to keep it. The Administrator said she interviewed LPN #2.LPN#2 said she received in report from RN #7 that Resident #6 was lowered to the floor. LPN #2 said she sent Resident #6 to the hospital because she continued to vomit and complain of back pain. The Administrator called an emergency Quality Assurance Performance Improvement (QAPI) meeting on 7/8/2021. Record review of the facility's in-service dated 3/16/21 and 5/24/21 revealed Registered Nurse (RN) #7 and Certified Nursing Assistant (CNA) #7 was educated on Abuse, Neglect, Misappropriation, and Exploitation.	F 600		
F 609 SS=G	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		8/24/21

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F 609	Continued From page 10 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility policy review the facility failed to report to the State Agency (SA) within two (2) hours, an incident of neglect, related to a fall of unknown origin for one (1) of five (5) residents reviewed. Resident #6 Findings include:	F 609	1. The Director of Nursing (DON) notified the State Agency on 7/6/21 of the allegation of abuse to Resident # 6 by Certified Nursing Assistant (CNA) # 7 and Registered Nurse (RN) # 7. The Administrator notified the Attorney General on 7/8/21 of the allegation of abuse to Resident # 6 by CNA # 7 and RN	

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F 609	Continued From page 11 Review of the facility "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Reporting/Response" policy revised 08/23/2017 revealed "It is the policy of this facility that persons employed by this facility with knowledge or reasonable cause to believe that any resident has been the victim of abuse, exploitation, neglect, or mistreatment must report or cause a report to be made to the appropriate state agencies as prescribed by laws of the state. Failure by staff (including management and supervisory staff) to report possible/alleged incidents of abuse/neglect to Administrator per policy, will result in disciplinary action up to and including immediate termination. All alleged violations or substantiated incidents involving mistreatment, exploitation, neglect, or abuse, including injuries of an unknown origin are reported to the Administrator of the facility. The Administrator and/ or Director of Nursing will notify appropriate officials including State Survey Agency and adult protective services where state law provides for jurisdiction in accordance with state law immediately but no later than 2 hours after the allegation/suspicion is formed if the events that cause the suspicion result in serious bodily injury ..." Record review of the facility's "Progress Notes" dated 7/2/2021, revealed "Resident heard screaming out in her room @ (at) 15:23 (3:23 PM). Upon entering room, resident noted to have copious amount of vomit in her bed ...Resident assisted out of bed to wheelchair ...Resident continues to cry out. Resident states that her back hurts ...Order received to send to (Proper name of local hospital) ..."	F 609	# 7. The DON and Administrator suspended RN # 7 and CNA # 7 on 7/7/21 pending investigation. The DON and Administrator terminated CNA # 7 and RN # 7 for abuse and neglect and failure to report abuse and neglect per facility policy on 7/15/21. The Administrator reported RN # 7 to the MS Board of Nursing on 7/8/21. 2. All residents in the facility have the potential to be affected by this practice. The Social Services Director (SSD) and Life Connections Coordinator (LCC) spoke with all interviewable residents on 7/8/21 regarding abuse and neglect to rule out any other incidents or concerns. No negative outcomes were reported. All Residents were assessed by the Minimum Data Set (MDS) nurses, Assistant Director of Nursing (ADON), and Director of Nursing (DON) on 7/8/21 for signs of abuse and neglect by completing body audits and pain assessments; no negative outcomes were documented. 3. On 7/6/21 The administrative team completed an in-service with all staff on abuse, neglect, misappropriation. On 7/8/21 the Administrator, Director of Nursing (DON), Nurse Supervisor, and Business Office Manager (BOM) / HR completed an in-Service with all nurses regarding incidents/accidents, assessing, documentation, and reporting. On 7/8/21 the Administrator, DON, Nurse Supervisor, and BOM/ HR completed an in-service with all staff regarding reporting accidents, reporting abuse, neglect, chain	

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F 609	Continued From page 12 Record review of the local hospital "Radiology Results" x-ray report dated 7/6/21, for Resident #6, revealed "Impression: Displaced right femoral neck fracture." Interview with CNA #7 on 7/13/21 at 10:30 AM, revealed Resident #6 was found on the floor of her room on 7/2/2021 at 8:00 AM. CNA #7 assisted RN #7 to put Resident #6 back in the wheelchair. RN #7 failed to write an incident report or notify the DON or Administrator. Interview with the Administrator on 7/13/21 at 11:40 AM, revealed she received a call from the local hospital Nurse Practitioner (NP) stating Resident #6 continued to complain of pain. An x-ray of Resident #6's right hip was done on 7/6/21 at the hospital resulting in a right hip fracture. The Administrator started an investigation by interviewing the staff that provided care of Resident #6 prior to the hospital stay. The Administrator interviewed CNA #7. CNA #7 confirmed Resident #6 fell at the facility on 7/2/21. The hospital records and staff revealed the resident did not fall at the hospital. RN #7 and CNA #7 was terminated for failing to report the fall to the DON or Administrator. The Administrator reported the fall of unknown origin to the State Survey Agency on 7/7/21 at 7:24 PM. The Administrator said this incident was not reported within 2 hours because RN #7 and CNA #7 did not report the fall to her or the DON. The Administrator said RN #7 has been in-serviced on reporting. Record review of the facility in-service titled, "When to Call Protocol" dated 5/26/21, revealed Registered Nurse (RN) #7 was in-serviced to notify the Director of Nursing (DON) and	F 609	of command, and when to call protocol. 4. All staff will continue to receive in-service training regarding abuse and neglect including reporting of abuse and neglect upon hire. The Social Services Director (SSD), Business Office Manager (BOM)/HR, Director of Nursing (DON), or Administrator will perform random audits to ensure residents rights are adhered too and residents are free from abuse, neglect, misappropriation, and exploitation. These audits will be in the form of staff interviews regarding abuse, neglect, misappropriation, and exploitation policy including reporting and investigating. The Social Services Director (SSD), Business Office Manager (BOM)/HR, Director of Nursing (DON), or Administrator will complete an audit to begin on 7/19/21 and will interview three (3) staff members weekly for thirty (30) days then three (3) staff members monthly for three (3) months. Any concerns related to abuse, neglect, misappropriation, and exploitation will be addressed immediately. The results of the audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 4 months to end on November 19, 2021. The first QAPI meeting to review such audits will be held in August 2021. If the QA team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed. Completion date as of 8/24/21.	

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F 609	Continued From page 13 Administrator for falls (especially with injury).	F 609		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility policy review the facility failed to investigate a fall of unknown origin resulting in injury for one (1) of five (5) residents reviewed for falls Resident #6. Findings include: A review of the facility's "Investigation Policy", undated revealed ... "All injuries or bruises that are suspicious in any way or injuries of an unknown origin must be investigated. An injury is classified as injury of unknown origin when both of the following conditions are met. 1. The source	F 610	1. A thorough investigation was completed by the Administrator and Director of Nursing (DON) on 7/11/21. The DON notified the State Agency on 7/6/21 of the allegation of abuse and neglect to Resident # 6. The Administrator notified the Attorney General on 7/8/21 of the allegation of abuse to Resident # 6. 2. All residents in the facility have the potential to be affected by this practice. 3. The Administrator, Director of Nursing (DON), MDS Nurses, Social Services	8/24/21

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F 610	Continued From page 14 of the injury was not observed by any person, or the source of the injury could not be explained by the resident. 2. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or incidence of injuries over time." On 7/7/21, the facility reported to the State Survey Agency an allegation that occured on 7/2/21 of suspected neglect and poor quality of care from Registered Nurse (RN) #7 and Certified Nursing Assistant (CNA) #7 by failing to report a fall. This fall resulted in a displaced right femoral neck fracture. RN #7 did not report Resident #6's fall to the Administrator, Medical Doctor, or family. RN #7 did not write an accident or incident report. Record review of the final report submitted by the facility to the State Survey Agency revealed the investigation was completed on 7/11/21. During an interview on 7/13/21 at 10:45 AM, with Certified Nursing Assistant (CNA) #7 confirmed she failed to notify the Director of Nursing (DON) and the Administrator of Resident #6's fall when Registered Nurse (RN) #7 failed to follow the facility fall protocol by not writing an incident report or reporting the fall to the DON. During an interview with the Administrator on 7/13/21 at 11:40 AM, revealed she did not investigate Resident #6's fall until 7/6/21, when she received a call from the Nurse Practitioner (NP)at the local hospital. The NP stated Resident #6 continued to complain of pain and an x-ray was ordered which revealed a right hip fracture. The Administrator said she did not know the resident had a fall. The Administrator started an investigation by interviewing the staff that	F 610	Director (SSD), or Business Office Manager/HR (BOM/HR) will perform random audits to ensure residents are free from abuse, neglect, misappropriation, and exploitation, or mistreatment. These audits will be in the form of staff interviews regarding abuse, neglect, misappropriation, and exploitation policy including reporting and investigating. The Administrator, DON, MDS Nurses, SSD, or BOM/HR will complete an audit to begin on 7/19/21 and will interview three (3) staff members weekly for thirty (30) days then three (3) staff members monthly for three (3) months. Any concerns related to abuse, neglect, misappropriation, exploitation, and mistreatment will be addressed immediately. 4. The results of such audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 4 months to end on November 19, 2021. The first QAPI meeting to review such audits will be held in August 2021. If the Quality Assurance Team identifies concerns or non-compliance, the team will review policies and procedures and submit solutions and/or changes to make as needed. Completion date as of 8/24/21.	

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F 610	Continued From page 15 provided care for Resident #6 on 7/2/21. The fall was confirmed by Certified Nursing Assistant (CNA) #7 that Resident #6 fell on 7/2/21 at 8:00 AM. RN #7 failed to write an incident report or notify the Administrator or Director of Nursing (DON). The Administrator said she reported the incident to the State Survey Agency 7/7/2021. The Administrator also said RN #7 and CNA #7 was terminated for not reporting Resident #6's fall with injury in a timely manner.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		8/24/21

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F 657	Continued From page 16 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review the facility failed to revise the care plan to reflect appropriate fall interventions for Resident #6's current cognitive status for one (1) of five (5) Resident care plans reviewed. Resident #6 Findings include: Record review of the facility's "Comprehensive Care Plan", undated revealed "It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs ... 4. Care plans are revised as changes in the resident's condition dictates. Reviews are made at least quarterly." Record review of the Fall Risk Management policy, undated, revealed "Residents will be assessed for fall risk potential. Interventions will be implemented as needed to help manage the potential for falls and assist in minimizing the risk. Interventions will be re-evaluated for effectiveness during care planning as needed." Record review of Resident #6's cognitive function care plan, undated, revealed "I am at risk for impaired cognitive function r/t (related to) dx (diagnosis) of dementia. My most recent BIMS (Brief Interview for Mental Status) score is 3/15 indication severe impairment." Interventions,undated, included "Cue,reorient, and supervise as needed."	F 657	1. Resident # 6 care plan was revised and updated on 7/19/21. to reflect current needs. 2. All residents in the facility have the potential to be affected by this practice. 3. On 7/16/21 the Minimum Data Set (MDS) Nurses were educated on comprehensive care plans regarding care plan timing and revisions by the Administrator and Director of Nursing (DON). 4. The MDS nurses, DON or Administrator will complete an audit to begin on 7/19/21 and will review three (3) resident care plans weekly for thirty (30) days then three (3) resident care plans monthly for three (3) months. Any concerns found will be addressed immediately. The results of the audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 4 months to end on November 19, 2021. The first QAPI meeting to review such audits will be held in August 2021. If the Quality Assurance Team identifies concerns or non-compliance, the team will review policies and procedures and submit solutions and/or changes to make as needed. Completion date as of 8/24/21.	

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Record review of Resident #6's current fall care plan, undated, revealed "I am at risk for falls related to weakness, history of falls, medication side effects, lack of coordination, and abnormalities of gait and mobility, dementia, vitamin d deficiency, spondylosis of cervical region." Interventions/Task included an intervention dated "8/19/20-Encourage use of chair with arm rest in an effort to stabilize herself when getting up to use FWW, (front wheel walker)." Interventions, undated, revealed "Encourage resident to lock the wheelchair before standing ... Encourage the resident to use the call light for assistance as needed." The goal, undated, revealed "I will not sustain serious injury r/t (related to) falls through the review date."

Record review of Resident #6's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/19/2020 revealed Residen#6 had a Brief Interview of for Mental Status (BIMS) score of 13 that indicated Resident #6 is cognitively intact.

Record review of the resident latest Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/04/2021 revealed Residen#6 had a Brief Interview for Mental Status (BIMS) of 3 which indicated Resident #6 has severe cognitive impairment.

Interview on 7/13/2021 at 11:32 AM, with Registered Nurse (RN) #3 confirmed the facility failed to revise Resident #6's care plan to include interventions that are appropriate to the resident's current cognitive status. RN #3 said the resident had a decline in cognitive status and is unable to call for assistance, unable to make safe decisions

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F 657	Continued From page 18 to choose the appropriate chair and unable to lock the chair before standing. The facility should have updated the resident's status each time she had a decline and/or fall to meet the resident's needs.	F 657		
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 observation, staff and resident interviews, record review, and facility policy review, the facility failed to provide adequate staff supervision to prevent the elopements of Resident #1 and Resident #5 from the facility and prevent a fall for Resident #6 for three (3) of ten (10) sampled residents identified at risk for wandering/elopement and falls. Resident #1 left the facility unsupervised and was away for approximately 88 minutes when he was found lying on his back on the asphalt parking lot of the building next door to the facility by a staff member who was walking by on the way to work and heard the Resident yell "hey". Resident #1 had minor abrasions of the left arm and leg, a quarter size bruise on the top of the left hand and a skin tear on the left knee. Resident #1 had been evaluated for wandering and elopement risk and identified as a resident with wandering behaviors and at risk for elopement by the facility prior to	F 689	1. Resident # 1 was assessed by Registered Nurse (RN) # 1 on 7/1/21 upon return to the facility with no signs of injury noted other than a few minor skin abrasions. Resident # 1 was placed on one-on-one monitoring from 7/1/21 until 7/2/21. On 7/2/21 Resident # 1 was placed on visual monitoring. Resident # 5 was assessed by RN # 1 on 7/14/21 upon return to the facility with no signs of injury noted. On 7/14/21 Resident # 5 was placed on one-on-one monitoring until he was transported and discharged to Oceans Behavioral Health. Resident # 6 was sent to Hospital on 7/2/21. Upon return, on 7/16/21, Resident # 6 was assessed by the Director of Nursing (DON) and safety measures were	8/24/21

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elopement. During the survey on 7/14/21, Resident # 5, admitted to the facility on 7/13/21 and identified as high risk for elopement, eloped from the facility for approximately 16 minutes and was found approximately 0.4 - 0.6 miles from the facility at his niece's house. To get to the location would have necessitated Resident #5 to walk along a row of commercial buildings on a busy road with continuous traffic and cross a four-lane highway.

The facility's failure to provide supervision to prevent the elopements of Residents #1 and #5 and a fall for Resident #6 placed these residents and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment, or death.

The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 7/1/21, when the facility failed to provide adequate supervision to prevent the elopement of Resident #1.
On 7/12/21 at 1:15 PM, the State Agency (SA) notified the Administrator of the IJ and SQC and provided the facility with the IJ Template. An additional IJ Template was provided on 7/14/21, when Resident #5 eloped. The facility submitted an acceptable Removal Plan on 7/15/21, in which they alleged all corrective actions to remove the IJ were completed on 7/15/21, and the IJ removed on 7/16/21.

The SA validated the Removal Plan on 7/17/21, and determined the IJ was removed on 7/16/21, prior to the exit. Therefore, the scope and severity for 42 CFR(s): 483.25(d)(1)(2)-Free of Accident Hazard/Supervision/Devices. (F 689) was lowered to a "G", while the facility develops a plan

put in place.

2. All residents in the facility with a risk for elopement have the potential to be affected by this practice.
On 7/2/21 all residents who were identified as an Elopement/Wander Risk were reassessed for elopement risk and care plans were reviewed. There were ten (10) residents who were identified as an Elopement/Wander Risk. All residents identified at risk for elopement were placed on visual monitoring on 7/2/21 by the Director of Nursing (DON) and Minimum Data Set (MDS) Nurses. The MDS nurses reviewed and revised the care plans for all residents identified at risk for elopement on 7/2/21.
On 7/2/21 the Maintenance Director secured the switch box cover located at the front door with a zip tie until 7/13/21 when a padlock was purchased and put in place of the zip tie to secure the front door.
On 7/14/21 the MDS Nurse, DON, and Social Services Director (SSD) reassessed all residents for elopement risk, care plans were reviewed and revised as necessary. There were eleven (11) residents who were identified as an Elopement/Wander Risk. All care plans were reviewed, one revision was made on Resident # 5's care plan to reflect the one-on-one. No other revisions were made.
On 7/14/21 the Maintenance Director secured the laundry room door. On 7/15/21 Southern Fire and the Maintenance Director secured the exit

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of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

A review of the facility's policy, "Elopement/Unsafe Wandering Plan", dated February 2012, revealed "It is the policy of this facility to protect the resident form harm while providing care in a manner that helps promote quality of life in a safe environment." Further review revealed, "Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary." Further review of the facility's policy, "Accidents and Incidents",(undated), revealed "It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible and those residents receive supervision and assistance devices to prevent accidents whenever possible." An interview with the Administrator on 7/15/21 at 8:44 AM revealed the facility did not have a policy for supervision.

Resident #1

Review of the facility's incident investigation dated and signed by the Administrator on 7/05/21, revealed on 7/01/21 at 10:41 PM CNA #1 phoned the facility to report that Resident #1 was outside the facility. Administrator's interviews with staff revealed Resident #1 had last been seen by staff at approximately 9:02 PM at the South Hall Nurses station where he came to get his evening medicine. Resident #1 was safety returned to the facility by staff. Resident #1 reported he exited the building to go to the pharmacy to get some pain medicine for right shoulder pain. Facility staff

door in laundry by a magnetic lock that requires a code to exit.
On 7/8/21, the Social Services Director (SSD) and Life Connections Coordinator (LCC) spoke with all interviewable residents on regarding abuse and neglect to rule out any other incidents or concerns. No negative outcomes were reported. All Residents were assessed by the Minimum Data Set (MDS) nurses, Assistant Director of Nursing (ADON), and Director of Nursing (DON) on 7/8/21 for signs of abuse and neglect or incidents including falls by completing body audits and pain assessments; no negative outcomes were documented.

3. All staff were in-serviced beginning on 7/2/21 and ending 7/6/21 regarding elopement policies, yellow identification arm bands, elopement books, visual monitoring, and ensuring privacy when entering door codes by the Administrative Staff to include the Administrator, Director of Nursing (DON), Business Office Manager (BOM)/HR, Admissions Coordinator, Social Services Director (SSD), Restorative Licensed Practical Nurse, and 3-11 Supervisor Registered Nurse. All staff will receive in-service regarding elopement policies upon hire beginning 7/2/21. The Minimum Data Set (MDS) Nurses or DON will ensure all residents are evaluated upon admission for elopement risk and placed on visual monitoring beginning 7/2/21. The MDS nurses will evaluate all residents for elopement risk quarterly and with

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F 689	Continued From page 21 were able to determine the resident exited through the front door by using his came to disable the magnetic locking mechanism on the door. An immediate assessment by Registered Nurse (RN) #1 was completed and injuries included skin abrasions to the side of the left arm and leg, a quarter sized bruise on the top of the resident's left hand and skin tear to right knee, none of which required medical attention and were treated at the facility. Resident #1 had been evaluated for wandering and elopement risk and identified as a resident with wandering behaviors and at risk for elopement by the facility prior to elopement. Resident #1 was immediately assessed and placed on 1: 1 monitoring. The Administrator's interview with Resident #1 revealed he stated he went out the exit door next to the laundry, however, upon investigation the "security" switch on the front door was found to be capable of being manipulated into disarming the magnetic lock on the front door. Resident #1 then stated he went out the front door and propelled himself in his wheelchair along the sidewalks of the facility and the building next door and across the parking lot of that building. Resident #1 reported that in an effort to cross a grassy strip between the building next to the facility and the next building his wheelchair wheels got stuck in the moist ground causing him to slide out of the wheelchair and he could not get himself back into the wheel chair. The Maintenance Supervisor was able to identify a previously unknown characteristic of the "security" switch on the front door and was able to secure the "security" switch at the front door. Resident # 1 was changed from 1:1 monitoring to visual checks every thirty (30) minutes on 7/02/21 following Quality Assessment and Performance Improvement (QAPI) committee meeting. State	F 689	significant changes and place on visual monitoring as needed beginning on 7/2/21. The Administrator completed a one-on-one in-service with the Maintenance Director and the Maintenance Assistant on 7/15/21 regarding exit doors and barriers- if either of them finds an exit door or barrier is not functioning properly, they must report it to the Administrator immediately. On 7/8/21 the Administrator, Director of Nursing (DON), Nurse Supervisor, and Business Office Manager (BOM)/ HR completed an in-Service with all nurses regarding incidents/accidents, assessing, documentation, and reporting. On 7/8/21 the Administrator, DON, Nurse Supervisor, and BOM/HR completed an in-service with all staff regarding reporting accidents, reporting abuse, neglect, chain of command, and when to call protocol. An elopement drill was successfully completed on 7/13/21. 4. The Minimum Data Set (MDS) Nurses, Social Services Director (SSD), Director of Nursing (DON), or Administrator will audit wander bracelets of all residents identified at risk for elopement weekly for six (6) months beginning on 7/9/21. Any concerns found will be documented and addressed immediately. MDS Nurses will audit records of all residents identified at risk for elopement monthly to ensure visual monitoring is in place beginning August 2021. Any concerns found will be documented and	

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F 689	Continued From page 22 Agency was notified on 7/02/21 at 1:59 AM by the Administrator. After investigation, interview with the resident and staff revealed the resident was very knowledgeable and aware of his actions and able to exit the facility. Resident #1 was returned to the facility at Approximately 10:50 PM. Skin abrasions to Resident #1's left arm and leg, a quarter sized bruise on the top of the resident's left hand and skin tear to right knee were noted upon return to the facility. Resident #1 was assisted to return to the facility and placed on one on on (1:1) supervision. Resident #1 reported he left the facility to go to the pharmacy to get some pain medicine for his right shoulder. Resident #1 was immediately placed on one on one (1:1) monitoring with staff. The Medical Doctor (MD) was notified. Resident #1's Responsible Party (RP) was notified. Observations on 7/08/21 at 10:40 PM revealed well maintained sidewalks and parking lots with lots of street lights and signs that provided light to the fairly well lit area. The terrain was flat. The posted speed limit on the street was thirty-five miles per hour (35 mph). The traffic was light with eighteen (18) cars observed to pass the nursing home in three (3) minutes between 10:31 PM and 10:34 PM. The resident was located 44 feet from the street. Resident #1 propelled himself in his wheelchair 700 feet from the facility. Record review of AccuWeather, an Internet weather forecasting site, revealed the weather for the city on 7/01/21 was partly cloudy, seventy-three (73) degrees Fahrenheit with ninety-seven percent (97%) humidity. On 7/08/21 at 10:40 PM, an interview with RN #1, who was the resident's nurse on the evening	F 689	addressed immediately. The Administrator will conduct elopement drills on various shifts monthly for a period of 3 months beginning 8/5/21 to end on 11/5/21. Any concerns found will be documented and addressed immediately. It is the facility's practice to input all incidents as they occur in the risk management section of Point Click Care (PCC) by nursing and for it to be reviewed by the Minimum Data Set (MDS) Nurses, Director of Nursing (DON), Assistant Director of Nursing (ADON), Nurse Managers, or Administrator for interventions to be implemented to be reviewed for an ongoing basis. The Maintenance Director or Maintenance Assistant will complete an audit of door checks to include checking all exit door itself, the keypads, magnets, and alarms to ensure proper operational functions weekly to begin on 7/19/21. The results of the audits will be reviewed at the facility's Quality Assurance Performance Improvement (QAPI) meeting monthly to monitor compliance for a period of 6 months to end on January 2, 2022. The first QAPI meeting to review such audits will be held in August 2021. If the Quality Assurance Team identifies concerns or non-compliance, the team will review policies and procedures and submit solutions and/or changes to make as needed. Completion date as of 8/24/21.	

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7/01/21, revealed the last time RN #1 saw the resident was at approximately 9:02 PM at the South Hall nurses station when he came to get his evening medicine. RN #1 stated it was not unusual for the resident to come to the nurses desk for his evening medication. RN #1 stated that Resident #1 had not complained of pain. RN #1 stated she saw him roll away "down the hall" but did not notice where he went. RN #1 stated the resident habitually "wandered with purpose" in the facility, but not aimlessly and she had never seen him attempt to exit the facility unaccompanied. RN #1 stated when LPN #1 received call from CNA #1 at 10:41 PM and "shouted for the nurse" and told her Resident # 1 was outside, RN #1 and LPN #1 immediately went to the resident, did a quick assessment, assisted the resident to return to the facility, performed a more thorough assessment, and assisted the resident into bed per his request, notified the DON, began 1:1 monitoring of the resident, conducted a check of all exit doors and performed a one hundred percent (100%) headcount of all residents, and notified the Resident's Responsible Party and his doctor. RN #1 stated all exit doors were locked and secure and all residents were accounted for. RN #1 stated "he won't keep that I.D. bracelet on". RN #1 confirmed the only observation scheduled for Resident #1 prior to 7/01/21 was one time each shift "Resident is to wear yellow wander barcelet (bracelet). Check for Placement every shift." dated 2/14/19. RN #1 stated Resident #1's PRN (as needed) pain medicine had been discontinued on 7/01/21 and he had been upset about it earlier in the day. RN ##1 stated the PRN pain medicine was prescribed again for Resident #1 with instructions that the medicine be crushed prior to administration. RN #1 reported Resident

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#1 is now on "hourly visual checks that are documented on the MAR (Medication Administration Record)".

On 7/08/21 at 10:50 PM, an interview with CNA #1 revealed she was scheduled to work the 11:00 PM to 7:00 AM shift at the facility and was walking to work, as was her routine, on the evening of 7/01/21. CNA #1 stated at approximately 10:30 PM as she approached the building next to the facility she heard someone yell "Hey" and looked and recognized Resident #1 laying on his back on the asphalt parking lot of the building next to the facility. CNA #1 stated she immediately went to the resident, asked him if he was hurt, "looked him over for obvious injury", asked him why he was outside and how he got outside, stayed with the resident and phoned the facility. CNA #1 stated RN #1 and LPN #1 "were there almost instantly". CNA #1 reported having assisted the resident into his wheelchair and returning him to the facility without difficulty. CNA #1 stated she was familiar with Resident #1 and had seen him wandering in the facility but had never seen him attempt to exit the facility unaccompanied. CNA #1 stated she was scheduled to work in a different area and reported to her assigned area.

On 7/08/21 at 11:05 PM, an interview with LPN #1 revealed she was working North Hall on the evening of 7/01/21 and answered a telephone call at approximately 10:41 PM from CNA #1 who reported Resident #1 was outside in the parking lot of the building next to the facility. LPN #1 stated she immediately went to the South Hall nurses station shouted for the nurse and went immediately with RN #1 to the location described by CNA #1. LPN #1 stated Resident #1 was

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quickly assessed, assisted to return to the facility,more thoroughly assessed and assisted into bed per his request. RN #1 confirmed that all exits were checked and found to be locked and secure and a 100% head count was performed with all residents accounted for. LPN stated she was familiar with Resident #1 and his care and had seen him wander in the facility frequently but never saw him attempt to exit the facility unaccompanied.

On 7/08/21 at 11:20 PM, an interview with Director of Nurses (DON) revealed she had been notified by phone at approximately 10:45 PM that Resident #1 had been located outside at the building next to the facility. DON stated she immediately notified the Administrator. DON reported having seen Resident #1 wandering in the facility routinely but never saw him attempt to exit the facility unaccompanied. DON stated Resident #1 had visited her office earlier in the afternoon of 7/01/21 and indicated concern about the discontinuation of his PRN pain medicine. The DON stated she had explained the medicine change and Resident had "remained calm, indicated that he understood and not got upset".

On 7/09/21 at 10:20 AM, an interview with the Social Services Director (SSD) revealed she was involved in the development of the resident's care plan and attended his care plan meetings, was involved in the development of his behavior management plan to address the elopement, attended the QAPI meeting on 7/02/21 at 4:00 PM. SSD stated she was "responsible for maintaining the elopement books and identification bracelets". SSD stated she had seen Resident #1 wandering in the facility many times but had never seen him attempt to exit the

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facility unaccompanied. SSD stated that on 7/02/21 Resident #1 showed her the route he had taken after exiting the facility front door alone on the evening of 7/01/2. SSD stated Resident #1 indicated he left the facility to go to the pharmacy for some pain medicine. SSD stated she had been aware Resident #1 was not compliant with wearing the yellow identification bracelet and in response she had "encouraged him to wear it and got him to put it back on when he would".

On 7/09/21 at 10:28 AM, an interview with Resident #1 revealed he was calm, cooperative and oriented to date and time and recalled the elopement when he was asked and reported he had left the facility to go to the pharmacy and get some pain medicine for right shoulder pain. Resident #1 confirmed he had exited the front door of the facility and pantomimed use of his cane to manipulate the "security" switch and disable the magnetic lock and the use of his left arm to push the door open. Resident #1 confirmed he had exited the building shortly after taking his evening medicine. Resident #1 confirmed he did not report pain to staff on the evening of 7/01/21. Resident #1 stated he had lain on the asphalt a "long time". Resident #1 stated he had no lingering effects or bad feelings related to the elopement and staff had not treated him any differently since the elopement.

Record review of the Admission Record revealed Resident #1 was originally admitted to the facility on 1/27/12 with the most recent readmission of 1/12/18. Diagnoses included Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affected right dominant side, Unspecified Dementia without behavioral disturbance, Pain in right shoulder, Type 2

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Diabetes Mellitus and Epilepsy.

Record review of Resident #1's Order Summary Report dated 7/9/21 revealed Resident #1 had order for "Resident is to wear yellow wander bracelet. Check for Placement every shift" initiated 2/14/19.

Resident #1's most recent Minimum Data Set (MDS), dated 5/05/21 revealed a Brief Interview for Mental Status (BIMS) score was 15 which indicated no cognitive impairment

On 7/09/21/21 at 11:00 AM an interview with the Maintenance Supervisor revealed he had reported to the facility "right before midnight" on 7/01/21, assessed the locking system and "made sure all the exit doors opened and locked back" and then discovered "the switch above the front door that is used to lock the door on the outside could be switched off and back on and will unlock the door for ten (10) to fifteen (15) seconds. The Maintenance Supervisor stated he "put the zip tie in place to prevent the door housing the switch from opening without the code being punched into the keypad". The Maintenance Supervisor stated he kept a log to document the weekly checks performed on all exit doors weekly.

On 7/09/21 at 11:20 AM an interview with the Administrator revealed she and the Maintenance Supervisor met at the facility at approximately 12:00 AM on 7/02/21, assessed all exit doors to ensure they were locked and secure. The Administrator stated the Maintenance Supervisor "discovered the switch above the front door that is used to lock the door on the outside could be switched off and back on and will unlock the door for ten (10) to fifteen (15) seconds. The resident

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could reach that switch with his cane, just like he demonstrated.". The Administrator stated the Maintenance Supervisor secured the cover of the box the switch is in with a zip tie". The Administrator stated Resident #1 was placed on one on one (1:1) supervision to prevent further elopements.

On 7/09 at 3:00 PM an interview with facility Medical Director revealed he attended via teleconference a QAPI committee meeting on 7/02/21 at 4:00 and the committee reviewed the policy for elopement and missing persons to ensure it does not happen again.

On 7/09/21 at 10:20 AM an interview with SSD and the Administrator, and observation of the facility floor plan and the area surrounding the facility revealed there was a three inch wide, five inch long (3'x5') opaque plastic box with a hinged door mounted on the wall to the left inside the facility's front door six feet (6') above the floor. Inside the box was a switch that looked like a regular light switch that would be on the wall to turn the light in a room on/off. There was a zip tie which secured the door of the box closed which SA observed replaced by a lock which required a key to open. SSD explained how when asked to show her where he exited the building and where he had gone the resident took her on a tour beginning at the front door where he demonstrated how he had used his cane to manipulate the switch to open the door, pushed open the door, propelled himself along the sidewalk of the facility and the building next door and stopped at the grassy strip between the building next door and the building two doors down. Staff were not aware the resident was out of the building until they received a call from CNA

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#1 that the resident was in the parking lot of the building next door. The Administrator confirmed that the facility does not have cameras inside or outside the building. They determined the distance from the front door of the facility to the location where the resident was located was 700 feet.

Resident #5:

On 7/14/21 at 9:04 AM, observation revealed facility initiated a "Code Orange" Alert for Resident #5. SA was in the facility activity room when "Code Orange" was announced on the overhead announcement system. Staff was observed searching for the resident. SA spoke with Registered Nurse (RN) #7 who confirmed the event was an actual elopement of a resident.

7/14/21 at 9:08 AM observation revealed SA walking along the hallway was able to open the door to the laundry, walked inside the laundry room and did not see anyone in the laundry.

On 7/14/21 at 9:40 AM observation revealed the elopement binders labeled "wander books" at the South Hall nurses' station and at the North Hall nurses' station did not contain a sheet for Resident #5.

On 7/14/21 at 10:00 AM an interview with the Administrator revealed Resident #5 had been admitted on 7/13/21 and had been assessed and identified as an elopement risk. The Administrator stated that to her knowledge, Resident #5 had made no attempts to leave the facility. The Administrator acknowledged Resident #5's information and photo are not in the "Wander

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Books" (elopement binders) located at each nurses' station to alert staff of residents identified as elopement risks. The Administrator stated Resident #5 refused to wear the yellow identification bracelet but had agreed to wear a yellow lanyard with identification card.

On 7/14/21 at 10:08 AM an interview with the Care Plan Nurse, RN #3 revealed she had entered a care plan for risk of elopement for Resident #5 because when he arrived at the facility on 7/13/21 he was ready to leave and was trying to leave because he wanted to go home. RN #3 stated she had not witnessed Resident #5 going to the door but had seen him standing in the front area and he was wanting to leave. RN #3 stated Resident #5 refused to wear the yellow identification bracelet and was provided with a yellow lanyard and identification card. RN #3 stated staff knew which residents had wandering behaviors because staff were required to document hourly visual checks and that the yellow identification bracelet or lanyard was in place on the Medication Administration Record (MAR). RN #3 stated she was responsible for setting up the hourly checks on the MAR so staff could document hourly visual observations and she was also responsible for setting up the hourly checks on the Certified Nursing Assistant (CNA) Tasks so the CNA's could document visual checks.

On 7/14/21 at 10:15 AM, an interview with the Social Services Director (SSD) revealed it was her responsibility to update the elopement binders (labeled "Wander Book"). SSD stated it takes a while to get a new admission into the system and she was unable to get a photograph of Resident #5, so she did not get his information out to the

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nurses stations. The SSD admitted she did not put Resident #5's information in the elopement binders.

On 7/14/21 at 10:45 AM an interview with Resident #5 in his room revealed he was calm and cooperative and when asked about leaving the facility without notification he responded "I love to walk. I can go out and walk all over the place and not hurt nothing. All I did was touch the door and it opened". When asked if anyone exited before him Resident #5 answered "no". When asked if he had been told the code to the keypad to open the door Resident #5 answered "no". When asked if he had gotten hot while outside Resident #5 responded "No, I walk everywhere."

On 7/14/21 at 12:30 PM SA drove from the facility to the address where Resident #5 was located after elopement. The address was four tenths (0.4) of a mile away from the facility. SA observed a row of commercial building on a road busy with continuous traffic. There was no way for the Resident #5 to get to the address where he was located without crossing a four-lane road that was also busy with continuous traffic with no noted crosswalks. SA determined it was too dangerous to walk the route.

Record review of AccuWeather, an Internet weather forecasting site, revealed the documented weather temperature for the city on 7/14/21 was approximately 89 degree and sunny.

7/14/21 at 1:17 PM interview with Licensed Practical Nurse (LPN) #1 revealed worked on North Hall from 3:00 PM to 11:00 PM on Tuesday 7/13/21 and was Resident #5's nurse. LPN #1

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described Resident #5 on Tuesday 7/13/21 as "pretty much ready to leave." LPN #1 reported Resident #5 stated that he was "supposed to have been taken to Biloxi, not here". LPN #1 stated Resident #5 was acting anxious and restless on 7/13/21. LPN #1 reported "I gave the resident his medicine at around 9:30 PM then he went to his room and stayed in his room where he remained until I got off work and left". LPN #1 stated she arrived at work on 7/14/21 at 7:00 AM for an eight (8) hour shift on North green ("Resident's room is on North pink"). LPN #1 stated "the last time I laid eyes on him was about 8:55 AM and he was asking about where his room was. I showed him where his door was, and he went into his room." LPN #1 stated that on 7/14/21 "A Code Orange was called for him and it was about five (5) minutes that I looked for him before I was told he had been found at his niece's house." LPN #1 stated no one had made her aware Resident #5 was an elopement risk but that she would know if residents were elopement risks due to monitoring on the Medication Administration Record (MAR) and the "Wander Books", and by observing resident behaviors.

7/14/21 at 2:00 PM an interview with RN #7 along with observation revealed the facility had investigated the elopement of Resident #5 and had determined that Resident #5 was able to exit the building through the laundry due to a malfunction of the self-closing/self-locking mechanism on the door between the hallway and the laundry room. RN #7 demonstrated the door, shut but not completely closed, was able to be pushed open. Further observation revealed upon entering the laundry room from the hallway there was another door located to the right with a sign that stated, "Keep Door Closed". RN #7

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demonstrated how the second door led into the "dirty" area of the laundry department where an unlocked glass door directly to the left is located with no alarm or keypad that required a code for exit. The glass door exited directly outside to the backyard of the building in an area not fenced or gated.

7/14/21 at 2:11 PM, interview with CNA #3 revealed she was assigned to Resident #5 for the 7:00 AM to 3:00 PM shift on 7/14/21 and stated, "Soon as I got out of my car other staff members were out in the parking lot and told me that he was missing, and I immediately started looking for him". CNA #3 stated that she had gone with CNA #6 and the Admission Coordinator in the facility van "to pick him up from his niece's house" where the Admission Coordinator talked with him about returning to the facility. When asked, CNA #3 stated she would know if residents were elopement risks due to care instructions on the "CNA Tasks" on the kiosks.

On 7/14/21 at 2:30 PM, interview with Housekeeping Staff #1 (Laundry Supervisor) revealed she was aware the door did not always close completely and lock, and that it had been an occasional issue for the two years she had worked at the facility. Housekeeping Staff #1 stated she had seen the current Maintenance Supervisor work on the self-closing/self-locking mechanism of the door from the hallway into the laundry room at least twice and the previous Maintenance Supervisor at least once over the past two (2) years. Laundry Supervisor stated she "reported any problems with the door to the Maintenance Supervisor who would work on it and fix it". Laundry Supervisor stated she had never seen a resident in the laundry room.

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Laundry Supervisor stated she had never seen a resident open the door between the hallway and the laundry room.

On 7/14/21 at 2:35 PM interview with Housekeeping Staff #2 (Laundry Tech) revealed she was not aware the door did not always close completely. Housekeeping Staff #2 stated she had worked at the facility for eighteen (18) years and had been trained to "always pull the door handle to make sure it was locked after exiting the door from the laundry into the hallway". Housekeeping Staff stated she had never seen a resident in the laundry room. Housekeeping Staff stated she had never seen a resident open the door between the hallway and the laundry room.

On 7/14/21 at 2:36 PM, a telephone interview with the niece (of Resident #5) revealed Resident #5 had walked up to her home between 8:55 AM and 9:00 AM. She stated, "he seemed ok" and was holding a milk carton. The niece reported Resident #5 had always walked around town, but his family had noticed a recent increase in confusion.

On 7/14/21 at 2:42 PM, a telephone interview with the Responsible Party (RP) for Resident #5 revealed Resident #5 had started having issues with confusion and dementia and recently the family noticed a decline because of the dementia. The RP stated he had signed the admission paperwork and had talked with the Admission Coordinator. The RP stated he was told by the Admission Coordinator that the facility "had the capacity to keep him locked in" and that is why he was so surprised the resident had walked to his niece's house.

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7/14/21 at 2:42 PM, an interview with CNA #4 revealed she had delivered his breakfast tray to Resident #5 in his room at approximately 8:00 AM. Resident #5 immediately awoke and started putting on his shoes and CNA #4 went to continue to pass out breakfasts to residents. CNA #4 stated, "It was almost 9:00 (AM) and I was picking up the trays in the common area on North Hall and he walked by me and said he would rather be in jail. The nurse was looking for him about five (5) minutes later".

On 7/14/21 at 2:44 PM an interview with RN #1 revealed she arrived to work 7:00 AM to 3:00 PM on North Hall which included Resident #5. RN #1 reported after beginning the "7:00-10:00AM" medication pass she was at her medication cart and Resident #5 waked out of his room and was walking back and forth in the hallway and was talking to himself. RN #1 stated she did not recall seeing Resident #5 at the exit doors or involved in exit seeking behavior. The last time RN #1 saw Resident #5 was around 8:50 AM-8:55 AM on North wing. RN #1 stated she went into a resident room to provide care and upon returning to the hallway noted Resident #5 was not in the hall. RN #1 stated she went up to the office of the Admission Coordinator and asked if she had seen the Resident #5, but the Admissions Coordinator stated no she had not. RN #1 then told the DON she was looking for the resident. RN #1 stated "The staff searched for a few minutes and then the DON called the code". RN #1 stated she "kept on looking until he was located, and we got the all clear". RN #1 reported when Resident #5 returned to the facility she assessed him and found no injuries and the resident voiced no complaints. RN #1 stated that she would know if residents were elopement risks

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due to the "Wander Book", monitoring on the Medication Administration Record (MAR) and by observing resident behavior.

On 7/14/21 at 3:28 PM, interview with CNA #5 revealed breakfast trays came out and she was passing out breakfast trays when Resident #5 approached her an began to tell her he had to "get out of here" but he went back to room his room and CNA #5 went to feed dependent residents. CNA #5 stated "it was only about five (5) minutes before his nurse was looking for him and said she was wanted to locate him because he was not in his room or the hallway". CNA #5 stated she searched the building and went outside and looked and did not stop looking until she heard the "all clear" that the resident had been located. CNA #5 stated no one told her the resident was an elopement risk. CNA #5 stated she would know if residents were elopement risks due to care instructions on the "CNA Tasks" on the kiosks. CNA #5 stated the facility is constantly having in-services about elopement.

On 7/14/21 at 4:40 PM interview with CNA #6 revealed she had clocked in at 8:35 AM and immediately encountered Resident #5 in the hallway near the time clock holding a milk carton "like the residents get with breakfast" CNA #6 stated Resident #5 told her "Someone has got to let me out of here". CNA #6 revealed she immediately went to the office of the Social Services Director and reported the resident's behavior. CNA #6 stated that 8:59 AM she was notified that the DON was looking for Resident #5 and she began to look for him also. CNA #6 reported having driven the facility van accompanied by the Admission Coordinator and CNA #3 to the resident's niece's home to return

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the resident to the facility. CNA #6 stated upon arrival at the facility Resident #5 had the demeaner of being calm and cooperative and returned to the facility for the nurse to do an assessment. CNA #6 stated Resident #5 was wearing dark blue jeans, a dark T-shirt, gray socks, and black tennis shoes.

On 7/15/21 at 8:40 AM interview with Administrator revealed she had been the Administrator for approximately one (1) year. The Administrator revealed Resident #5 was admitted from home following referral to the facility by his primary physician. The Administrator stated when the facility had a long-term care (LTC) referral, viability of the referral was determined by the facility staff. The Administrator stated she had not been made aware of any concerns related to Resident #5's risk of elopement prior to admission. The Administrator stated she had not been aware of any problems with the self-closing/self-locking mechanism of the door between the hallway and the laundry room.

On 7/15/21 at 9:00 AM interview with Director of Nurses (DON) revealed a "Risk Assessment" was performed on every new admission to the facility which included Resident #5. The DON revealed the "Risk Assessment" for Resident #5's result was "High Risk" for elopement. The DON stated the staff would have been made aware of Resident #5's "High Risk for Elopement" status by "implementation on Medication Administration Record (MAR) and "CNA Tasks" on the kiosks". The DON stated she does not remember being made aware of any problems with the self-closing/self-locking door between the hallway and the laundry, and she does not remember being aware of the Maintenance Supervisor

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working on the door. The DON stated she does not remember ever seeing the door between the hallway and the laundry not fully closed or ever seeing any resident inside the laundry. DON stated the (elopement) "Wander" books at the nurses' stations "should be kept updated" as a means of communication regarding residents that were elopement risks and that residents with orders for visual checks or elopement monitoring should have had doctor's orders which would be communicated to the nurses via the MAR and to the CNA's via the "CNA Tasks" on the kiosk.

Record review of the Wander Evaluation dated 7/14/21 at 10:46 revealed it was completed after the elopement and that Resident #5 was determined to be high risk for wandering.

Record review of the Admission Record revealed Resident #5 was admitted to the facility on 7/13/21 with diagnoses that included Unspecfied Dementia with Behavioral Disturbance and Other Frontotemporal Dementia.

On 7/15/21 at 9:42 AM, interview with Admissions Coordinator revealed Resident #5 was admitted from his home on 7/13/21 and was referred by his primary physician due to disease progression (dementia with behavioral disturbance). The Admissions Coordinator revealed Resident #5 agreed to his admission to the facility and she never saw Resident #5 attempt to leave the facility. Admissions Coordinator stated she had no awareness or information that Resident #5 displayed any behavioral concerns prior to admission. Admissions Coordinator stated on 7/14/21 Resident #5's family contacted the facility "at approximately 9:35 (AM)" and reported the resident was at his niece's house and she went

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with the CNA #6 and CNA #3 to pick the resident up and escort him back to the facility.

On 7/15/21 at 10:17 AM interview with the Maintenance Supervisor revealed he has worked at the facility since April 2019. He explained the "work order" process as follows: "blank work orders are kept at both nurses' stations and the front office; they are filled out anytime staff sees something that needs to be done". The Maintenance Supervisor revealed he had not received any work orders to repair the door between the hallway and the laundry, but he had "worked on" the door to "modify the latch" at least twice since April 2019 to make sure the self-closing/self-locking features were functioning correctly.

Review of the facility's Educational In-Service Record dated 7/02/21 revealed the facility provided all the staff an in-service on elopement which included "Elopement and Wandering Plan Policy and Procedure, Identifying and Supervision, Arm Bands, Elopement Books and Door Codes".

Resident #6

Review of the facility "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" revealed "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined below. This includes but not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's medical symptoms... Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents,

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consultant or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.
...Neglect- failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, mental anguish, or emotional distress ... Staff will be supervised to identify inappropriate behaviors such as derogatory language; rough handling; ignoring residents while giving care; directing residents who need toileting assistance to urinate or defecate in their beds ..."

Record review of the "Admission Record" revealed Resident #6 was admitted on 8/12/20, with diagnoses that included Dementia, Transient Ischemic Attack (TIA), and Schizoaffective disorder.

Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/04/2021 revealed Residen#6 had a Brief Interview for Mental Status (BIMS) score of 3 that indicated Resident #6 has severe cognitive impairment.

Record review of the facility's "CES Quarterly Evaluation Bundle (Clinical-V11)" dated 5/12/21 revealed "2. Fall Risk Evaluation Instructions: If the score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan." Resident #6's Fall Risk Score was 21."

Record review of the facility's "Progress Notes" dated 7/2/2021, revealed "Resident heard screaming out in her room @ (at) 15:23 (3:23 PM). Upon entering room, resident noted to have

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copious amount of vomit in her bed ...Resident assisted out of bed to wheelchair ...Resident continues to cry out. Resident states that her back hurts ...Order received to send to (Proper name of local hospital) ..."

Record review of the local hospital progress note dated 7/6/21 revealed " Patient was seen and examined today. Patient is a terrible historian. She constantly yells out with any movement of her right leg. Case was discussed with physical therapy. Imaging obtained."

Record Review of the local hospital x-ray report dated 7/6/21 revealed a displaced right femoral neck fracture.

Record review of the facility investigation dated 7/6/21, revealed there were no recent falls or incidents documented from the hospital. The investigation at the facility revealed that there was an incident regarding Resident #6 on 7/2/21. RN #7 and CNA #7 reported two different stories. RN #7 changed her story multiple times, did not document, and was reported to the state Board of Nursing by the facility. No other staff members were identified to have witnessed the incident.

During an interview on 7/13/2021 at 10:30 AM, with RN #7 revealed she was called to Resident #6's room by CNA #7 on 7/2/2021 at 8:00 AM. RN #7 said Resident #6 was sitting in the wheelchair crooked. RN #7 said CNA # 7 helped her straighten the resident up in the wheelchair. RN # 7 said she suspected Resident # 6 must have fell and put herself in the wheelchair crooked. RN #7 said she did not do an incident report or notify anybody because she wasn't for sure if the resident fell. RN # 7 said Resident #6 has had

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several falls and complains of pain all the time. RN # 7 said Resident #6 vomited later during the day and complained of pain. RN #7 said she gave Resident #6 Zofran for nausea and a pain pill.

Interview on 7/13/21 at 10:45 AM, with CNA #7 revealed on 7/2/21 at 7:00 AM she heard a resident scream "help.". CNA #7 said she saw Resident #6 on the floor. CNA # 7 said she called for RN#7. RN #7 asked CNA #7 if the resident hit her head. CNA #7 said she thinks she did because her head was against the wall. RN #7 said "I don't have time for this. I am not sending her out because she falls all the time. She's, ok". CNA #7 said she took the resident to the dining room after assisting RN #7 with putting her back in the wheelchair. CNA # 7 said Resident #6 was very confused, would not eat and complained of pain to her arm. CNA # 7 said CNA #8 was in the dining room. CNA #8 asked CNA #7 if Resident #6 was OK. CNA #7 told CNA #8 that Resident #6 fell this morning in her room. CNA #7 also said RN #7 did not write an incident report, nor send the resident to the hospital for an x-ray. CNA #8 told CNA #7 to go back to RN #7 and write a statement to cover herself. CNA #7 said CNA #9 also asked during breakfast, what is wrong with Resident #6. CNA #7 said Resident #6 fell, and RN #7 did not write an incident report or send the resident to the hospital to be evaluated. CNA #9 also told CNA #7 to write a statement and keep it because the Administrator or somebody will come to her to find out what happen. CNA # 7 said Resident #7 continued to complain of pain. CNA #7 went to the nurse and said Resident #6 continues to complain of pain. CNA #7 told RN #7 that Resident #6 probably needs to go to the hospital. RN #7 refused to send her out. CNA # 7 said after lunch the resident vomited and

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continued to complain of pain to her back. CNA #7 said she cleaned the resident up and let RN #7 know the resident had vomited and complained of pain. RN #7 gave the resident something for pain and nausea. CNA #7 said when she came back to work the next day, she was told Resident #7 was sent to the hospital for vomiting and pain. CNA #7 said RN #7 came to her saying they need to get their story together. CNA #7 said she told the RN #7 that she wrote a statement. CNA #7 said a couple of days later the Administrator called her and ask if Resident #6 had a fall. CNA #7 said "no" Resident #6 did not fall. The Administrator asked her to write a statement and bring it to the facility. CNA # 7 said she came to the facility and talked to the Administrator. CNA #7 said she told the Administrator that she needed to tell the truth because she did not realize the resident had a fractured hip. CNA # 7 said she told the Administrator that she heard Resident # 6 scream "help me." CNA #7 said she found Resident #6 on the floor. CNA #7 said she called RN #7 to the room. CNA #7 also stated that she told the Administrator that RN #7 refused to send the resident out to the hospital because she didn't have time and the resident always falls and complains of pain. CNA # 7 said she felt bad because RN #7 told her the Resident did not receive any broken bones and the Resident was ok. When she realized Resident #6 had a right hip fracture, she had to tell the truth. CNA #7 said Resident #6 suffered several days before the hospital realized her right hip was fractured because she failed to notify the Administrator.

During an interview on 7/13/21 at 11:00 AM, with CNA #8 revealed CNA #7 came to her and told her Resident #6 fell in her room on 7/2/21. CNA

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#7 told CNA #8 that RN #7 did not write an incident report or send Resident #6 to the hospital. CNA #8 told CNA #7 to write a statement and keep it just in case something happens to the Resident.

During an interview on 7/13/21 at 11:15 AM, with CNA #9 revealed CNA #7 told her that Resident #6 fell on the floor in her room on 7/2/21. CNA #7 said RN #7 would not send the resident to the hospital to be evaluated. RN #7 also did not write an incident report. CNA #9 said she told CNA #7 to write a statement to cover herself. CNA #9 said CNA #7 came to her because she has worked at the nursing home for a long time.

During an interview on 7/13/21 at 11:25 AM, with Licensed Practical Nurse (LPN) #2 said she received report from RN #7 on 7/2/21 at 3:00 PM. LPN #2 said while receiving report she heard somebody screaming. LPN #2 asked who is that? RN #7 said its Resident #6. RN #7 said Resident #6 was lowered to the floor today. RN #7 also said Resident # 6 vomited and complained of pain. LPN #2 said RN #7 gave Resident #6 something for pain and nausea. LPN# 2 said immediately after receiving report she checked on Resident #6 and noted she had vomited on her clothes. Resident #6 continued to yell out saying her back was hurting. LPN #2 called the Nurse Practitioner and received orders to send Resident #6 to the hospital to be evaluated.

During an interview on 7/13/21 at 11:40 AM, with the Administrator, revealed the Nurse Practitioner (NP) called her on 7/6/21 at 1:45 PM, from the local hospital stating Resident #6's x-ray results revealed a right hip fracture. The Administrator asked if Resident #6 had a fall during her stay at

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the hospital. The hospital records and staff did not report any falls or other incidents. The Administrator said she reported to the State Agency (SA) and Attorney General Office (AGO). The Administrator said she started an investigation immediately. The Administrator said the Director of Nursing (DON) called and questioned RN #7 and asked if Resident #6 had a fall on 7/2/21 before she went to the hospital. RN #7 told the DON that when she arrived on her shift the resident was in her wheelchair and had slid out but did not fall. Resident #6 was holding on to the chair with her bottom between the seat of the wheelchair and the floor. RN #7 said she did not do an incident report because she did not think it was a fall. RN #7 said CNA #7 helped her straighten Resident #6 in the wheelchair. RN # 7 was suspended pending investigation and was terminated after the investigation. RN# 7 was reported to the State Board of Nursing. The Administrator called CNA #7 and asked if Resident #6 fell on 7/2/21. CNA #7 said "no" Resident #6 did not fall. The Administrator asked CNA #7 for a statement in writing. The Administrator said CNA#7 came to the facility on 7/7/21 at 4:30 PM to talk to her. CNA #7 told the Administrator that on 7/2/21 around 8:00 AM, she was coming out of another resident's room when she heard Resident # 6 yell out "help me." CNA #7 said she found Resident #6 on the floor in her room by the bathroom door. CNA #7 called RN #7 to the room. RN # 7 asked if Resident #6 hit her head. CNA #7 stated " yes", because her head was against the wall. RN #7 said, "I don't have time for this, I'm not sending her out." CNA #7 and RN #7 assisted Resident #6 back in the wheelchair. Resident #6 continued to yell out in pain. Resident #6 was wheeled to the dayroom. CNA #7 said she checked on the resident all day.

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CNA #7 said she went back to RN #7 and asked if she would send Resident #6 out because she continues to complain of pain. RN #7 said she has had so many falls already, she doesn't have time to send her out. CNA #7 said after lunch Resident #6 vomited and complained of pain to her hip during Activities of Daily Living (ADL) care. CNA #7 told RN#7 and medication was administered for pain and nausea. CNA #7 also said RN #7 said the resident did not have any broken bones when she was sent out to the hospital. CNA #7 said when she found out Resident #6 had a right hip fracture, she knew she had to tell the truth. CNA #7 said she told CNA #8 and CNA # 9 about the situation. Both CNAs told her to write a statement and keep, just in case something happened. CNA #7 was suspended pending investigation. Both CNAs were interviewed and confirmed CNA #7 did talk to them about Resident #6 fall and RN #7 refusing to write an incident report or send Resident #6 to the hospital for an evaluation. Both CNA's advised CNA #7 to write a statement and to keep it. The Administrator said she interviewed LPN #2.LPN#2 said she received in report from RN #7 that Resident #6 was lowered to the floor. LPN #2 said she sent Resident #6 to the hospital because she continued to vomit and complain of back pain. The Administrator called an emergency Quality Assurance Performance Improvement (QAPI) meeting on 7/8/2021.

Record review of the facility's in-service dated 3/16/21 and 5/24/21 revealed Registered Nurse (RN) #7 and Certified Nursing Assistant (CNA) #7 was educated on Abuse, Neglect, Misappropriation, and Exploitation.

The facility provided an acceptable Removal Plan

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on 7/15/21 for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Immediate Jeopardy Removal Plan

On 7/14/21 at 5:1 the State Agency notified the Administrator that the facility failed to provide supervision to prevent an elopement for Residents # 1 and # 5, who were identified as elopement and wandering risks. Resident # 1 left the facility on 7/1/21 unnoticed and unsupervised until the resident was located at 10:30 PM which was approximately 88 minutes from the time he was last observed by staff. Resident # 5 left the facility on 7/14/21 unsupervised and was located at 9:21 am which was approximately 26 minutes from the time he was last observed by staff. This was cited as an Immediate Jeopardy.

On 7/1/21, Resident # 1 eloped from the facility and was found on the ground near the orthodontist building by Certified Nursing Assistant (CAN) # 1 who was walking to work around 10:30 PM. Resident # 1 was last seen by RN # 1 at 9:02 PM. CNA # 1 immediately found the resident and made sure he was okay, then called the facility for help. Resident # 1 told CNA # 1 that he was going to get medication. Registered Nurse (RN) # 1 quickly assessed Resident # 1 for injuries, she asked him if he was okay. Resident # 1 nodded yes. RN # 1, Licensed Practical Nurse (LPN) # 1, and CNA # 1 and CNA # 2 assisted Resident # 1 back into his wheelchair and brought him back into the facility. Resident # 1 was placed on one-on-one immediately.

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On 7/14/21, Resident # 5 eloped from the facility and was last seen by RN # 1 at 8:55 am. The DON called the emergency code at 9:04 am and started the search. Resident # 5 was found at 9:11 am at his Niece's house approximately 0.6 miles from the facility. Resident # 5 was returned to the facility by Transport CNA # 6, CNA # 3, and Admissions LPN at 9:53 am. RN # 1 assessed Resident # 5 for injuries. Resident # 5 was placed on one-on-one immediately.

1. On 7/1/21 at 10:45 pm, RN # 1 completed a body audit on Resident # 1.

2. On 7/1/21 at 10:45 pm, LPN #1 and LPN # 2 completed a head count; all Residents were accounted for.

3. On 7/1/21, Resident # 1 was immediately placed on one-on-one from 10:50 pm until 7/2/21 at 5:00pm.

4. On 7/1/21 RN # 1 notified Medical Director of incident at 11:00pm. No new orders received.

5. On 7/1/21 RN # 1 notified Resident's Conservator at 11:05 pm.

6. On 7/2/21 around 12:00 am, The Administrator, Director of Nursing, and Maintenance Director arrived at the facility to begin an investigation.

7. On 7/2/21 at 12:00 am, the Maintenance Director checked all exit doors and Resident # 1's window, he determined all were secure.

8. On 7/2/21 at 12:45 am the Maintenance Director secured the switch box cover located at

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the front door with a zip tie. A padlock was purchased and put in place of the zip tie on 7/13/21.

9. On 7/2/21 at 1:59 am the DON notified the State Agency of the incident.

10. On 7/2/21 at 2:00 pm the Social Worker audited the elopement books at each nurses' station to ensure all those residents identified as an elopement risk were in the book. All books were up to date.

11. On 7/2/21 at 2:40 pm the Maintenance Assistant checked all windows, he determined all were secure.

12. On 7/2/21 an emergency Quality Assurance and Performance Improvement Meeting (QAPI) was held at 4:00pm. In attendance was The Administrator, Minimum Data Set RN, The Interim Regional Director of Operations, Maintenance Director, DON, Admissions Coordinator, Life Connection Coordinator, Medical Director, and Social Services Director.
The committee reviewed the following:
a. Reviewed the Elopement Policy, no changes were recommended.
b. All residents who were identified as an Elopement/Wander Risk were 100 % reassessed for elopement risk and care plans were reviewed and revised, as necessary.
c. All residents identified at risk for elopement will be placed on every hour visual monitoring.
d. The physician will resume Resident's pain medication as previously ordered if resident agrees to crushing medication and nurse is able to ensure medication is taken at time of administration.

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e. Maintenance Director changed all door codes.
f. The Social Worker audited the elopement books at each nurses' station to ensure all residents identified as elopement risk were in the book.
g. The Administrative Staff will complete a 100% in-service to staff regarding elopement policies, arm bands, elopement books, visual monitoring, and ensuring privacy when entering door codes.

13. All residents who were identified as an Elopement/Wander Risk were 100 % reassessed for elopement risk and care plans were reviewed on 7/2/21. There are ten residents who were identified as an Elopement/Wander Risk. The only care plan that was revised was Resident # 1 to include the change from being one-on-one to every 30 min checks until reassessed and a new intervention was placed to prevent Resident # 1 from wanting to leave the facility. No other revisions were made.

14. On 7/2/21 at 5:00 pm, the Maintenance Director changed the codes on all doors.

15. On 7/2/21 at 5:00 pm, Resident # 1 was placed on every 30-minute visual monitoring; to be re-assessed on 7/6/21.

16. On 7/2/21 at 5:10 pm the DON spoke with Resident # 1 regarding resuming his pain medication if he agrees to let his nurses crush the pain medication to ensure it is taken at the time of administration. Resident agreed. The physician resumed Resident's pain medication as previously ordered.

17. On 7/2/21, starting at 8:00 am, through 7/6/21

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the Administrative Staff to include the Administrator, DON, Business Office Manager/ Human Resources, Admissions Coordinator, Social Services Director, Restorative Licensed Practical Nurse, and 3-11 Supervisor RN completed an in-service to all facility staff members regarding elopement policies, yellow identification arm bands, elopement books, visual monitoring, and ensuring privacy when entering door codes. All staff received in-service prior to working.

18. On 7/6/21, Resident # 1 was reassessed by the Administrator, DON, MDS RN, and Social Services, and it was determined that Resident # 1 was calm had no display of elopement or agitated behavior. The team determined that Resident # 1 could safely be moved to every 1-hour checks.

19. An elopement drill was successfully completed on 7/13/21 at 11:10 am.

20. On 7/14/21 around 9:30 am, The Administrator, Director of Nursing, and Maintenance Director began an investigation on Resident # 5.

21. On 7/14/21 at 9:45 am, the Maintenance Director and Maintenance Assistant checked all exit doors and windows, all were secure.

22. On 7/14/21 RN # 1 notified Medical Director of incident at 9:45 am. No new orders received.

23. On 7/14/21 RN # 1 notified the Resident's Responsible Party at 9:48 am.

24. On 7/14/21 9:53 am, Resident # 5 returned to the facility and was immediately placed on

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one-on-one until 5:30 pm.

25. On 7/14/21 at 10:00 am, RN # 1 completed a body audit on Resident # 5; no signs of injury noted.

26. On 7/14/21 at 10:00 am, MDS RN # 3 and floor staff completed a head count; all Residents were accounted for.

27. On 7/14/21 at 10:00 am the Maintenance Director and Maintenance Assistant changed all door codes.

28. On 7/14/21 at 10:25 am, the DON notified the State Agency of the incident.

29. On 7/14/21 from 11:00 am until 11:30 am, The Life Connections Coordinator held an activity and had 7 out of 11 elopement/wander risk residents attend. The other 4 residents were one-on-one during that time. From 11:30 am until 2:30 pm staff members were one-on-one with every exit door.

30. On 7/14/21 at 2:15 pm, it was determined that the laundry room door was not secured properly.

31. On 7/14/21 at 2:30 pm, The Maintenance Director secured the laundry room door.

32. On 7/14/21 at 4:25 pm, an emergency Quality Assurance and Performance Improvement Meeting (QAPI) was held. In attendance was The Administrator, Admissions Coordinator, DON, Rehab Director, Minimum Data Set RN, Life Connections Coordinator, Business Manager/Human Resources, Social Services

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Director, Maintenance Director, and Medical Director.
The committee reviewed the following:
a. Reviewed the incident of elopement regarding Resident # 5 and actions taken.
b. It was determined that Resident # 5 exited through the laundry door.
c. Reviewed the Elopement Policy, no changes were recommended.
d. Reviewed the visual monitoring, the team decided to add every hour monitoring to the CNA tasks in addition to the Medication Administration Record (MAR) for all residents identified as an elopement/wander risk.
e. MDS Nurse, DON, and Social Services Director to 100 % reassess all residents for elopement risk and care plans reviewed and revised, as necessary.
f. Maintenance Director and Maintenance Assistant changed all door codes.
g. The Administrator audited the elopement books at each nurses' station to ensure all residents identified as elopement risk were in the book.
h. Social Services will send a referral on Resident # 5 for inpatient psychological evaluation and treatment.

33. On 7/14/21 MDS RN, DON, and Social Services Director reassessed 100 % of all residents for elopement/wander risk and care plans were reviewed. There are 11 residents who were identified as an Elopement/Wander Risk. The only care plan that was revised was Resident # 5 to reflect one-on-one. No other revisions were made.

34. On 7/14/21 Resident # 5 was placed on one-on-one from 9:53 am until 5:30 pm when he

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was transported to Oceans Behavioral Health for inpatient psychiatric evaluation and treatment.

35. On 7/14/21, starting at 5:45 pm, the Administrative Staff to include the Administrator, DON, Business Office Manager/ Human Resources, and 3-11 Supervisor RN initiated an in-service to all facility staff members regarding elopement policy, immediate notifications to Administrator or DON if any exit door or barrier is non-functional, Nursing staff will put any resident displaying exit seeking behavior one-on-one and will notify DON or Administrator as soon as possible for further guidance, and laundry door will remain closed and locked at all times; a staff member is to remain in the laundry area at all times during work hours until further notice; when laundry staff leave for the day they must check that all doors are locked and secure and sign off on the log until further notice. All staff will receive in-service prior to working.

36. On 7/14/21 at 6:15 pm the Administrator audited the elopement books at each nurses' station, as well as the master copy book, to ensure all those residents identified as an elopement risk were in the book. Administrator added Resident # 5's face sheet with picture to all books.

37. On 7/15/21 at 2:30 pm, the exit door in laundry was secured by a magnetic lock that requires a code to exit.

The Facility alleges the Immediate Jeopardy was removed as of 7/15/21 at 2:30 pm.

On 7/17/21, the SA validated the facility's Removal Plan by staff interviews, record reviews,

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review of in-service sign-in sheets, and review of documents across all disciplines. The SA verified that the facility had implemented the following measures to remove the IJ:

Validation:

On 7/17/21 SA validated through record review of the body audit report and form 1576, and interviews on 7/01/21 at 10:45 PM, RN #1 completed a body audit on Resident #1. Documentation revealed minor injuries were documented and treated appropriately.

On 7/17/21 SA validated through record review of form 1576 and written statements, and interviews on 7/01/21 at 10:45 PM, LPN #1 and LPN #2 completed a head count; all residents were accounted for.

On 7/17/21 SA validated through record review of Progress Notes and Form 1576, and interviews on 7/01/21 Resident #1 was immediately placed on one-on-one (monitoring) from 10:50 PM until 7/02/21 at 5:00 PM.

On 7/17/21 SA validated through record review of facility's Investigation Check List and Form 1576, and interviews on 7/01/21 RN #1 notified Medical Director of incident at 11:00 PM.

On 7/17/21 SA validated through record review of facility's Investigation Check List and Form 1576, and interviews on 7/01/21 RN #1 notified Resident #1's Conservator at 11:05 PM.

On 7/17/21 SA validated through record review of facility's Investigation Check List and print out of email, and interviews on 7/02/21 around 12:00

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AM, the Administrator, Director of Nursing, and Maintenance Director arrived at the facility to begin an investigation.

On 7/17/21 SA validated through record review of print out of email and interviews on 7/02/21 at 12:00 AM the Maintenance Director checked all exit doors and Resident #1's window, he determined all were secure.

On 7/17/21 SA validated through record review of print out of email, observation and interviews on 7/02/21 at 12:00 AM the Maintenance Director secured the switch box cover located at the front door with a zip tie and a padlock was purchased and put in place of the zip tie on 7/13/21.

On 7/17/21 SA validated through record review of the incident report and fax cover sheets with verification of date and time the DON notified the State Agency of the incident.

On 7/17/21 SA validated through observation, record review of the "Order Listing Report" and elopement books, and interviews on 7/02/21 at 2:00 PM the Social Worker audited the elopement books at each nurses' station to ensure all those residents identified as an elopement risk were in the books. All books were up to date.

On 7/17/21 SA validated through interview and written statement dated 1/02/21 on 7/02 at 2:40 PM the Maintenance Assistant check all windows, he determined all were secure.

On 7/17/21 SA validated through interviews and record review of Quality Assurance and Performance Improvement (QAPI) meeting sign

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in sheet and minutes dated 7/02/21 on 7/02/21 an emergency QAPI meeting was held at 4:00 PM attended by the Administrator, Minimum Data Set (MDS) RN, the Interim Regional Director of Operations, Maintenance Director, DON, Admission Coordinator, Life Connection Coordinator, Medical Director, and Social Services Director.

On 7/17/21 SA validated through interviews and record review of Resident Elopement/Wander Evaluations, Care Plans and Progress Notes all residents who were identified as an Elopement/Wander Risk were 100% reassessed for elopement risk and care plans were reviewed on 7/02/21. Resident #1's Care Plan was revised to include the change from being one-on-one to visual observation every thirty (30) minutes until reassessed.

On 7/17/21 SA validated through interviews and record review of print out of email on 7/02/at 5:00 PM the Maintenance Director changed the codes on all the doors.

On 7/17/21 SA validated through interviews and record review of Medication Administration Record (MAR), Resident #1's Visual Monitoring Tool, Progress Notes, physicians orders on 7/02/21 at 5:00 PM Resident #1 was placed on every thirty (30) minute visual monitoring to be reassessed on 7/06/21.

On 7/17/21 SA validated through record review of progress notes, physician orders and MAR, and interviews on 7/02/21 at 5:10 PM the DON spoke with Resident #1 regarding resuming his pain medication if he agreed to let his nurses crush the pain medication to ensure it is taken at the

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time of administration; resident agreed; the physician resumed resident's pain medication as previously ordered.

On 7/17/21 SA validated through interviews and record reviews of In-Service sign in sheets on 7/02/21 through 7/06/21 the administrative staff In-Serviced to all facility staff members regarding elopement policies, yellow identification arm bands, elopement books, visual monitoring and ensuring privacy when entering door codes. All staff were In-Serviced prior to working.

On 7/17/21 SA validated through interviews and record reviews of progress notes, physician orders, care plans and Resident Visual Observation Monitoring Tool on 7/06/21 Resident #1 was reassessed by the Administrator, DON, MDS RN, and Social Services Director and determined Resident #1 was calm, had no display of elopement or agitated behavior, and could safely be moved to every one (1) hour checks (visual observation).

On 7/17/21 SA validated through interviews and observation on 7/14/21 around 9:30 AM, the Administrator, DON and Maintenance Director began an investigation on Resident #5 (elopement).

On 7/17/21 SA validated through interviews and written statements on 7/14/21 at 9:45 AM the Maintenance Director and Maintenance Assistant checked all exit doors and windows, all were secure.

On 7/17/21 SA validated through interviews and record review of progress notes and form 1576 on 7/14/21 at 9:45 AM the Medical Director was

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notified of the incident.

On 7/17/21 SA validated throught interviews and record review of progress notes and form 1576 on 7/14/21 at 9:48 AM the Responsible Party (RP) for Resident #5 was notified of the incident.

On 7/17/21 SA validated through observation, interviews and record review of progress notes and Resident Visual Observation Monitoring Tool on 7/14/21 Resident #5 returned to the facility and was immediately placed on one-on-one (observation) until 5:30 PM on 7/14/21.

On 7/17/21 SA validated through interviews and record review of Resident's Body Audit Report and Progress Notes on 7/14/21 at 10:00 AM, RN #1 comleted a body audit on Resident #5; no signs of injury noted.

On 7/17/21 SA validated through observation, interviews and record review of written statements on 7/14/21 at 10:00 AM RN #3 completed a 100% head count; all residents were accounted for.

On 7/17/21 SA validated through observation, interviews and record review of written statements on 7/14/21 at 10:00 AM Maintenance Director and Maintenance Assistant changed all door codes.

On 7/17/21 AS validated through interviews and record review of form 1576 on 7/14/21 at 10:25 AM the DON notified the State Agency of the incident.

On 7/17/21 SA validated through observation, and interviews on 7/14/21 from 11:00 AM until 11:30

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AM, the Activity Coordinator held an activity and had seven (7) out of eleven (11) elopement/wander risk residents atteded. The other four (4) elopement/wander risk residents were one-on-one with staff during that time. From 11:30 AM until 2:30 PM staff members were one-on-one with every exit door.

On 7/17/21 SA validated through observation and interviews on 7/14/21 at 2:15 PM it was determined the laundry room door was not secured properly.

On 7/17/21 SA validated through observation, interviews and record review of written statements on 7/14/21 at 2:30 PM, the Maintenance Director secured the laundry room door.

On 7/17/21 SA validated through interviews and record review of Quality Assurance and Performance Improvement (QAPI) meeting sign in sheet and minutes dated 7/14/21 on 7/14/21 an emergency QAPI meeting was held at 4:25 PM attended by the Administrator, Minimum Data Set (MDS) RN, Maintenance Director, DON, Admission Coordinator, Activities Coordinator, Buisness Manager, Medical Director, and Social Services Director.

On 7/17/21 SA validated through interviews, observations and record review of elopement binders ("Wander Book"s"), care plans and resident Elopement/Wander Risk Evaluations on 7/14/21 RN #3, SON and Social Services Director reassessed one hundred percent (100%) of all residents for elopement/wander risk and care plans ere reviewed. There are eleven (11) residents who were identified as an

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Elopement/Wander Risk. The only care plan revised was Resident #5's to reflect one-on-one (monitoring).

On 7/17/21 SA validated through interviews, observations and record review of Progress Notes, Transfer Forms and Physician Orders on 7/14/21 at 9:53 AM until 5:30 PM Resident #5 was placed on one-on-one (monitoring) when he was transported to a behavioral health unit for inpatient psychiatric evaluation and treatment.

On 7/17/21 SA validated through interviews and record review of In-Service Sign In Sheets and form 1576 on 7/14/21 starting at 5:45 PM the Administrative staff to include the Aministrtor, DON, business office Manager and RN #6 initiated an IN-Service to all facility staff members regarding elopement policy, immediate notifications to Administrator or DON if any exit door or barrier was non-functional, nursing staff were to put any resident displaying exit seeking behavior one-on-one (monitoring) and notify DON or Administrator as soon as possible for further guidance, and laundry door will remain closed and locked at all times; a staff member was to remain in the laundry area at all times during work hours until further notice; when laundry staff leave for the day they must check that all doors were locked and secure and sign off on the log until further notice. All staff will receive In-Service prior to working.

On 7/17/21 SA validated through observation, interviews and review of elopement books ("Wander Book"s) at each nurses' station and master copy book in the office of the Social Services Director on 7/14/21 at 6:15 PM the Administrator audited the elopement books at

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F 689	Continued From page 62 each nurses' station, as well as master copy, to ensure all those residents identified as an elopement risk were in the books. Administrator added Resident #5's face sheet with picture to all books. On 7/17/21 SA validated through observation and interviews on 7/15/21 at 2:30 PM the exit door in the laundry was secured by a magnetic lock that requred a code to exit. The SA validated that all corrective actions to remove the IJ had been completed as of 7/15/21 and the IJ was removed on 7/16/21, prior to the exit.	F 689		