MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BRANDON NURSING AND REHABILITATION CENTER | 355 CROSSGATE BLVD BRANDON, MS 39042 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted six (6) Complaint Investigations (CI MS #28816, CI MS #28798, CI MS #28762, CI MS #28763, CI MS #28882, and CI MS #28878) at the facility from 5/06/25 through 5/12/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated CI MS #28878 for elopement and cited M500 and M640. CI MS #28798, CI MS #28763, CI MS #28882, CI MS #28816, and CI MS #28762 were investigated with no deficiencies cited.<br><br>On 5/01/25 at approximately 3:00 PM, the facility failed to prevent Resident #5, a resident who had recently exhibited new exit-seeking behaviors from exiting the facility unnoticed and unsupervised. The facility was unaware of Resident #5's whereabouts for approximately fifteen (15) minutes until a staff member went to his car on break and located her sitting in the passenger seat of his car with the windows up in an unshaded parking space approximately five yards from the facility entrance at approximately 3:15 PM. The facility failed to ensure Resident #5 was adequately supervised to ensure vulnerable residents did not exit the facility unsupervised. The facility failed to initiate an investigation and report the incident to the required agencies within the appropriate timeframe and failed to identify the need for development of an elopement risk care plan.<br><br>During the investigation of the complaint, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/1/25 and existed at: | M 000 | | |

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| M 000 | Continued From page 1<br>Rule 45.17.2 Resident Rights - M500 - Level IV<br><br>Rule 45.21.8 Accidents - M640 - Level IV<br><br>The facility's failure to provide adequate supervision to prevent the elopement of Resident #5 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM.<br><br>The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed 5/10/2025 and the IJ removed on 5/11/2025.<br><br>The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of Rule 45.17.2 Resident Rights - M500 and Rule 45.21.8 Accidents - M640 was lowered to a Scope and Severity of Level II while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>At the time of survey, the facility was licensed for 230 beds and had a census of 217 residents. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: | M 500 | | 6/7/25 |

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| M 500 | Continued From page 2<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other | M 500 | | |

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| M 500 | Continued From page 3<br>residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours | M 500 | | |

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| M 500 | Continued From page 4 | M 500 | | |

of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented

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| M 500 | Continued From page 5<br>by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level IV<br>Based on observation, interviews, and record review the facility failed to protect the residents' right to be free from neglect by not ensuring staff implemented measures to mitigate the risk to prevent elopement for one (1) of six (6) sampled residents, Resident #5.<br><br>On 5/01/25 at approximately 3:00 PM, the facility failed to prevent Resident #5, a resident who had recently exhibited new exit-seeking behaviors from exiting the facility unnoticed and unsupervised. The facility was unaware of Resident #5's whereabouts for approximately fifteen (15) minutes until a staff member went to his car on break and located her sitting in the passenger seat of his car with the windows up in an unshaded parking space approximately thirty-five yards from the facility entrance at approximately 3:15 PM. The parked car was in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. | M 500 | 1. Wander guard was placed on Res#5 on 5/1/25 to safe guard resident from exiting facility without supervision. Resident assessed by Director of Nursing on 5/1/25 with no signs of injury. Resident seen by physician on 5/1/25 and received new order for urine culture with culture and sensitivity. Resident #5 placed on one on one observation on 5/2/25 and resident seen by pysch Nurse Practitioner. Resident #5 had no ill effects by this deficient practice.<br><br>2. All resident with wandering and exiting behavior have the potential to be effected by this deficient practice.<br><br>3. All staff in-services was initiated on 5/9/25 to educate on ensuring elopement evaluations initiated by Social Service for all 204 residents in-house and was completed on 5/10/25 with no additional | |

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| M 500 | Continued From page 6<br><br>The facility failure to ensure Resident #5 was adequately supervised to ensure she did not exit the facility unsupervised placed her and other residents with wandering/exit seeking behaviors at risk for serious injury, harm, impairment, and/or death.<br><br>The State Agency (SA) identified Immediate Jeopardy and Substandard Quality of Care which began on 5/01/25 when Resident #5 exited the facility unnoticed and unsupervised. The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates.<br><br>The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/25 and the IJ removed on 5/11/2025.<br><br>The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of Rule 45.17.2 Resident Rights (M 500), was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include:<br><br>Cross Reference F609, F610, F656, and F689<br><br>Record review of the facility policy titled, "ABUSE PREVENTION" with Revision Date 1/25 (January 2025), revealed the policy stated, "The facility is committed to protecting the residents from abuse | M 500 | findings. All residents with wander guard signal devices were checked for placement and proper functioning of the device. Trauma screen was completed on 5/9/25 for resident#1 by the Social Services Director. Resident #1 had no ill effects from exiting the facility on 5/1/25 unaccompanied and unnoticed by staff resulting in lack of supervision. All exit doors were checked for proper closures on 5/9/25 and all doors with code alert alarms were checked for functioning by the Maintenance Director. No issues identified.<br><br>4. The Director of Nursing, Assistant Director of Nursing and/or Unit managers will review daily nurses notes, 24 hour report, and Accidents and Incidents Reports beginning on 5/12/25 then five times per week for six weeks, then weekly for six weeks for residents who are exhibiting any behaviors with verbalizing to leave, exit seeking, wandering, and packing belongings to ensure interventions are implemented and any concerns will be immediately addressed. Audits will be forwarded to Quality Assurance committee on 6.5.25 and monthly for three months. | |

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| M 500 | Continued From page 7<br>...DEFINITIONS ...Neglect: A failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain ...PREVENTION ...3. Identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility. 5. Examples of steps that the facility may put in place immediately to prevent further potential abuse includes, but are not limited to, staffing changes, increased supervision..."<br><br>Review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia and major depressive disorder.<br><br>Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls.<br><br>Record review of the Progress Notes for Resident #5 dated 4/25/25 through 5/06/25 revealed that the resident began going to the facility front door with small bags packed with her clothes and reporting family was coming to get her on 4/25/25 after report that she sat up all night with | M 500 | | |

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| M 500 | Continued From page 8 | M 500 | | |

increased confusion. According to Progress Note on 5/01/25 at 1:40 PM (13:40) by Licensed Practical Nurse (LPN) #9, Resident #5 had exit seeking behaviors that included confusion about her brother being outside to get her, constant redirection away from the front entrance and walking with a bag of her belongings and the Nurse Practitioner was notified with new order noted for urinalysis and change to insulin orders with family notified. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by LPN #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility unnoticed by staff and was observed by Certified Nursing Assistant (CNA) #9 sitting in his vehicle when the CNA went on break at approximately 3:00 PM and escorted the resident back into the facility. There was no incident report noted. Progress Note dated 5/03/25 at 10:30 AM documented that Resident #5 was on 1 on 1 observation related to elopement attempts.

On 5/08/25 at 1:08 PM during a telephone interview Contact #1 for Resident #5 stated that she was notified by LPN #9 on 5/01/25 at approximately 3:30 PM that Resident #5 had exited the facility and was found sitting in a staff member's car in the facility parking lot.

On 5/08/25 at 2:25 PM during an interview LPN #9 stated that she was familiar with Resident #5 and her care and the resident had exit seeking behaviors which included packing her belongings in bags and going to the front door of the facility and talking about leaving for several days at least since 4/24/25. She stated that she had documented her observations in the Progress Notes but had not updated the resident's care plan and there had been no orders for application of wander management device or other

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| M 500 | Continued From page 9<br><br>supervision resulting from the behavior until after the resident's elopement on 5/01/25 at approximately 3:00 PM. LPN #9 confirmed she was assigned to the care of Resident #5 on 5/01/25 during the day shift. She stated that at approximately 3:15 PM CNA #9 arrived at the nurses station with Resident #5 who was wearing a short-sleeved shirt, long pants and a pair of shoes. She said CNA #9 reported he had gone to his car and found Resident #5 seated in his front passenger's seat. LPN #9 said she had not known the resident had exited the facility and no one had reported the resident missing. LPN #9 confirmed that the Social Services Director was notified of the incident as well as Contact #1 and the primary healthcare provider for Resident #5 who issued new orders for a wander guard. She confirmed that she did not complete an incident report and had no request to participate in any investigation into the incident. LPN #9 said that she was not aware of any head count of residents, and she had not participated in any elopement drills since the 5/01/25 incident.<br><br>On 5/08/25 at 3:10 PM an interview with CNA #9 revealed that on 5/01/25 at approximately 3:15 PM he had gone out to his car, which was parked in the first parking spot to the right upon exit from the front door. CNA #9 stated, "I looked at my car and saw someone sitting in the passenger seat and thought it wasn't my car, then I realized it was my car, and I opened the drivers' door and asked, 'Mam, you in my car?' and she opened the door and said she thought it was her brother's car. I went around and helped her out and took her inside." CNA #9 reported that the weather was clear, dry and moderate temperature. He said he was not aware of any head count of residents, and he had not participated in any elopement drills since the 5/01/25 incident. | M 500 | | |

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| M 500 | Continued From page 10<br><br>On 5/09/25 at 11:00 AM an interview with the Executive Director revealed that at approximately 3:30 PM on 5/01/25 he was notified by the Receptionist that Resident #5 left the facility unnoticed by staff and was outside unsupervised for approximately fifteen minutes and located in a staff members car.<br><br>On 5/09/25 at 1:36 PM an interview with the facility Receptionist revealed she was familiar with Resident #5 because she had developed the behavior of packing her belongings in bags and coming to the front door prior to the 5/01/25 elopement. She stated that she had redirected Resident #5 several times, including on 5/01/25 with mixed results, explaining that sometimes the resident would return to her unit and sometimes she wasn't easily redirected and that CNAs had to come to the front and escort the resident back to her room. The Receptionist stated that on 5/01/25 around 3:00 PM she had taken a break and asked someone to fill-in for her but that she could not recall whom. She stated that she returned to her desk and shortly thereafter (could not recall time) CNA #9 came in with Resident #5 and said he had found her sitting in his car in the parking lot. She stated that the Executive Director was notified approximately five to ten minutes after CNA #9 and Resident #5 came back into the facility.<br><br>On 5/09/25 at 3:00 PM observation revealed the first parking space on the right approximately fifty-five feet from the front entrance. Observation revealed one ambulance and six other vehicles traveling through the parking lot. The sidewalk which led from the facility's front porch/portico area, along the front of the parking spaces led to a busy four lane boulevard with a speed limit of | M 500 | | |

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|---|---|---|---|---|
| M 500 | Continued From page 11 | M 500 | | |

thirty-five miles per hour and no cross walks; observation revealed one hundred twenty-five (125) vehicles traveling on the boulevard between 3:00 PM and 3:05 PM.

Record review of the local weather history according to WWW.Wunderground, Copyright The Weather Channel, for the facility for 3:00 PM on 5/01/25 revealed the temperature was eighty-one degrees Fahrenheit, with zero precipitation, eight mile per hour winds and partly cloudy.

On 5/12/25 at 4:26 PM during a telephone interview with the former DON revealed that she confirmed that she became aware that Resident #5 had exited the facility unnoticed and unsupervised on 5/01/25 at approximately 3:15 PM when CNA #9 escorted the resident back into the facility. She said there was no head count done to confirm the safety of other residents, and said she was not aware of any elopement drills or initiation of missing resident protocol. She confirmed that the care plan for Resident #5 had not been updated for wandering or exit seeking behaviors prior to the elopement.

Removal Plan - IJ
The facility was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies.

The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689.

On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a

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|---|---|---|---|
| | 61CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| M 500 | Continued From page 12<br>care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to report the allegation of neglect within the required time frame and complete a thorough investigation.<br><br>On May 1. 2025. at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay". The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1.<br><br>An interview with Resident (Proper Name) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out. | M 500 | | |

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| M 500 | Continued From page 13<br><br>Corrective Actions:<br><br>The Vice President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented.<br><br>On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff.<br><br>On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses.<br><br>On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge.<br><br>The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription.<br><br>Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility | M 500 | | |

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| M 500 | Continued From page 14<br>unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes thoughts of the leaving the facility.<br><br>The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who mans the receptionist area was in-serviced on 05/10/25 by the Executive Director.<br><br>100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk.<br><br>An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: Vice President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social Seri vice Assistants and Medical Director. The IP nurse was present by phone.<br><br>The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25.<br><br>On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit. | M 500 | | |

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| M 640 | Continued From page 15 | M 640 | | |
| M 640 | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level IV<br>Based on observation, interviews, record review and facility policy review, the facility failed to provide adequate supervision and a secure environment to prevent the elopement of one (1) of six (6) sampled residents, Resident #5.<br><br>On 5/01/25 at approximately 3:00 PM Resident #5 who had documented new wandering and exit seeking behaviors for at least a week exited the facility unnoticed and was outside unsupervised for approximately fifteen minutes until a staff member located the resident sitting in his unlocked car in an unshaded parking space approximately thirty-five feet from the facility entrance with windows up. The car was in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. Documentation of the resident's change of behavior, including wandering had been reported to her primary healthcare provider with new orders noted for a urinalysis to check for urinary tract infection, but the facility failed to identify exit seeking and elopement risk or provide adequate supervision to prevent elopement. The resident was admitted on 5/23/25 with diagnoses of bipolar disorder, anxiety, schizophrenia and history of fall and was assessed by the facility as at risk for falls and requiring supervision for walking. | M 640 | 1. Wander guard was placed on Res#5 on 5/1/25 to safe guard resident from exiting facility without supervision. Resident assessed by Director of Nursing on 5/1/25 with no signs of injury. Resident seen by physician on 5/1/25 and received new order for urine culture with culture and sensitivity. Resident #5 placed on one on one observation on 5/2/25 and resident seen by pysch Nurse Practitioner. Resident #5 had no ill effects buy this deficient practice.<br><br>2. All resident with wandering and exiting behavior have the potential to be effected by this deficient practice.<br><br>3. All staff in-services was initiated on 5/9/25 to educate on wandering elopement procedures to include implementing intervention of 1:1 and notifying the Executive Director and Director of Nursing when residents exhibit exit seeking, wandering, packing of belongings and verbalizing intent to leave facility. Elopement evaluations initiated by Social Service for all 204 residents in-house and was completed on 5/10/25 with no additional findings. All residents | 6/7/25 |

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|---|---|---|---|
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| M 640 | Continued From page 16<br><br>The facility's failure to provide adequate supervision to prevent the elopement of Resident #5 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death.<br><br>The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/1/25 and existed at Rule 45.21.8 Accidents (M640) Level IV<br><br>The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates.<br><br>The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/2025 and the IJ removed on 5/11/2025.<br><br>The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of Rule 45.21.8 Accidents (M640) was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings:<br><br>Record review of the facility policy titled, "MISSING RESIDENT/ELOPEMENTS" with Revision Date 8/04 revealed the policy stated, "The Unit charge Nurse is responsible for knowing the location of their residents | M 640 | with wander guard signal devices were checked on for placement and proper functioning of the device. Trauma screen was completed on 5/9/25 for resident#1 by the Social Services Director. Resident #1 had no ill effects from exiting the facility on 5/1/25 unaccompanied and unnoticed by staff resulting in lack of supervision. All exit doors were checked for proper closures and all doors with code alert alarms were checked for functioning by the Maintenance Director on 5/9/25. No issues identified.<br><br>4. The Director of Nursing, Assistant Director of Nursing and/or Unit managers will review daily nurses notes, 24 hour report, and Accidents and Incidents reports beginning on 5/12/25 then five times per week for six weeks, then weekly for six weeks for residents who are exhibiting any behaviors with verbalizing to leave, exit seeking, wandering, and packing belongings to ensure interventions are implemented and any concerns will be immediately addressed. Audits will be forwarded to Quality Assurance committee on 6.5.25 and monthly for three months. | |

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| M 640 | Continued From page 17<br>...RESPONSIBILITY: The Charge Nurses and all other staff."<br><br>Review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia, repeated falls and major depressive disorder.<br><br>Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls.<br><br>Record review of the Progress Notes for Resident #5 dated 4/25/25 through 5/06/25 revealed that the resident began going to the facility front door with small bags packed with her clothes and reporting family was coming to get her on 4/25/25 after report that she sat up all night with increased confusion. According to Progress Note on 5/01/25 at 1:40 PM (13:40) by LPN #9, Resident #5 had exit seeking behaviors that included confusion about her brother being outside to get her, constant redirection away from the front entrance and walking with a bag of her belongings and the Nurse Practitioner was notified with new order noted for urinalysis and change to insulin orders with family notified. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by LPN #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility | M 640 | | |

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| M 640 | Continued From page 18 | M 640 | | |

unnoticed by staff and was observed by C.N.A. #9 sitting in his vehicle when the C.N.A. went on break at approximately 3:00 PM and escorted the resident back into the facility. There was no incident report noted. Progress Note dated 5/03/25 at 10:30 AM documented that Resident #5 was placed on one-on-one observation related to elopement attempts.

Telephone interview on 5/08/25 at 1:08 PM Contact #1 for Resident #5 stated that she was notified by LPN #9 on 5/01/25 at approximately 1:30 PM that the resident had new orders for a urinalysis due to new behaviors that included wandering and making statements about leaving and again at 3:30 PM LPN #9 notified her that Resident #5 had exited the facility and was found sitting in a staff member's car in the facility parking lot.

Interview on 5/08/25 at 2:25 PM LPN #9 stated that she was familiar with Resident #5 and her care and the resident had exit seeking behaviors which included packing her belongings in bags and going to the front door of the facility and talking about leaving for several days at least since 4/24/25. She stated that she had documented her observations in the Progress Notes but had not updated the resident's care plan and there had been no orders for application of wander management device or other supervision resulting from the behavior until after the resident's elopement on 5/01/25 at approximately 3:00 PM. LPN #9 confirmed she was assigned to the care of Resident #5 on 5/01/25 during the day shift. She stated that at approximately 3:15 PM C.N.A. #9 arrived at the nurses station with Resident #5 who was wearing a short-sleeved shirt, long pants and a pair of shoes. She said C.N.A. #9 reported he had gone

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|---|---|---|---|
| | 61CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

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|---|---|---|---|---|
| M 640 | Continued From page 19 | M 640 | | |

to his car and found Resident #5 seated in his front passenger's seat. LPN #9 said she had not known the resident had exited the facility and no one had reported the resident missing. LPN #9 confirmed that the Social Services Director was notified of the incident as well as Contact #1 and the primary healthcare provider for Resident #5 who issued new orders for wander guard. She confirmed that she did not complete an incident report and had no request to participate in any investigation into the incident. LPN #9 said that she was not aware of any head count of residents, and she had not participated in any elopement drills since the 5/01/25 incident. She confirmed that the Elopement Binder was missing from the Nurses Station. She confirmed upon review that there was not a Release During Pass form for Resident #5 in the Out on Pass binder at the Unit #1 Nurses' station.

On 5/08/25 at 3:00 PM observation and record review revealed the absence of an Elopement Binder at the Unit 1 nurses' station. Resident #5's Release During Pass form was not found in the Out on Pass form was not found in the Unit 1 binder. SA located the form in the binder at the Unit 4 nurses' station with documentation of the last time Resident #5 being signed out on 12/20/24 at 11:16 AM.

Interview with CNA #9 on 5/08/25 at 3:10 PM revealed that on 5/01/25 at approximately 3:15 PM he had gone out to his car, which was parked in the first parking spot to the right upon exit from the front door. CNA #9 stated, "I looked at my car and saw someone sitting in the passenger seat and thought it wasn't my car, then I realized it was my car, and I opened the drivers' door and asked, 'Mam, you in my car?' and she opened the door and said she thought it was her brother's car. I

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|---|---|---|---|
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|---|---|---|---|---|
| M 640 | Continued From page 20 | M 640 | | |

went around and helped her out and took her inside.". CNA #9 reported that the weather was clear, dry and moderate temperature. He said he was not aware of any head count of residents, and he had not participated in any elopement drills since the 5/01/25 incident.

Interview with LPN #7 on 5/08/25 at 3:50 PM (the assigned Unit Manager for Resident #5 on 5/01/25 on Unit 1) stated that the procedure for a resident to leave for out on pass was that the person picking the resident up and taking responsibility for the resident had to report to the resident's nurses station and sign them out with date, time, address and telephone number, name and signature prior to exiting the building with the resident. LPN #7 said she worked at least five days a week and had never known the family or any person to sign Resident #5 out on pass. LPN #7 confirmed that Resident #5 had not had any order or application of any wander alarm device and that she had not updated the resident's care plan due to change in behavior/development of wandering/exit seeking behaviors, and that she had not been involved in a head count of residents following the elopement of Resident #5 on 5/01/25 or any investigation into how the resident exited the facility or any elopement drills since. She confirmed that the DON had assessed the resident upon return to the unit and obtained orders for and applied a Wander Guard wander management device to the resident's left ankle and initiated one-on-one supervision for seventy-two hours.

Interview with the Executive Director on 5/09/25 at 11:00 AM revealed that the facility had investigated the 5/01/25 elopement of Resident #5 on 5/08/25. The Executive Director stated that the facility did not report the incident to the State

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|---|---|---|---|
| | 61CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

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| M 640 | Continued From page 21 | M 640 | | |

Agency because it was determined that it was not an elopement because the resident told staff that her brother was coming to pick her up. The Executive Director confirmed that the facility procedure was for any person taking a resident out on pass was required to go to the nurses' station and sign the resident out in a binder with the date and time. He said he had not been aware that Resident #5 had new wandering/exit-seeking behaviors. He stated that the facility did not have operational security cameras.

Interview with the Social Services Director (SSD) on 5/12/25 at 11:26 AM revealed she was made aware through visual observation and interaction with Resident #5 on 5/01/25 that the resident was anxious, made multiple, repeated trips to the front hall of the facility on 5/01/25 throughout the day and packing her belongings, but had not identified exit seeking behavior. She revealed she could clearly see that the resident had increased anxiety. She stated that Resident #5's behavioral changes were discussed on 4/25/25 during a Behavioral Meeting with the resident's primary healthcare provider notified of behavioral changes that at the time were not identified as elopement risk. She stated that on 5/01/25 she updated the Elopement Binders which were supposed to be located at each of the facility's four (4) nurses' stations and added Resident #5 but had not updated the resident's care plan with 'Focus' for elopement risk. She confirmed that there was 18 Residents identified as having wandering behaviors and at risk for elopement. She stated that a Trauma Screen was conducted for Resident #5 on 5/10/25.

Interview with the facility Receptionist on 5/09/25 at 1:36 PM revealed she manned the desk at the

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|---|---|---|---|---|
| M 640 | Continued From page 22 | M 640 | | |

front entrance and had a button she pressed which released the lock on the front door to allow entrance/exit. She stated that all the other doors required, and the front door could also be opened with numeric code entered into wall-mounted keypad on the inside or outside of the doors. She stated that she was familiar with Resident #5 because the resident had developed the behavior of packing her belongings in bags and coming to the front door prior to the 5/01/25 elopement. She said that Resident #5 had come to the front entrance at least three (3) separate times on 5/01/25 talking about going out, she said that she had to call the nurses station and a C.NA came and got the resident at least twice and escorted her back to her unit. The Receptionist stated that around 3:00 PM she had taken a break and asked someone to fill in for her but that she could not recall whom. She stated that she returned to her desk and shortly thereafter (could not recall time) and CNA #9 came in with Resident #5 and said he had found her sitting in his car in the parking lot. She stated that she notified the Executive Director approximately five to ten minutes later. She stated that the Executive Director checked the entrance door for proper locking on 5/01/25 following the return of Resident #5 and the locks were working correctly.

On 5/09/25 at 3:00 PM observation revealed the first parking space on the right approximately fifty-five feet from the front entrance. Observation revealed one ambulance and six other vehicles traveling through the parking lot. The sidewalk which led from the facility's front porch/portico area, along the front of the parking spaces led to a busy four lane boulevard with a speed limit of thirty-five miles per hour and no cross walks; observation revealed one hundred twenty-five (125) vehicles traveling on the boulevard between

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 61CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRANDON NURSING AND REHABILITATION CENTER | 355 CROSSGATE BLVD BRANDON, MS 39042 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| M 640 | Continued From page 23<br>3:00 PM and 3:05 PM.<br><br>Record review of the local weather history according to WWW.Wunderground, Copyright The Weather Channel, for the facility for 3:00 PM on 5/01/25 revealed the temperature was eighty-one degrees Fahrenheit, with zero precipitation, eight mile per hour winds and partly cloudy.<br><br>Interview with the former DON on 5/12/25 at 4:26 PM by telephone revealed that she confirmed that she became aware that Resident #5 had exited the facility unnoticed and unsupervised on 5/01/25 at approximately 3:15 PM when C.N.A. #9 escorted the resident back into the facility. She said there was no head count done to confirm the safety of other residents, and said she was not aware of any missing resident protocol. She confirmed that the care plan for Resident #5 had not been updated for wandering or exit seeking behaviors prior to the elopement.<br><br>Removal Plan - IJ<br>The facility was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies.<br><br>The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689.<br><br>On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to | M 640 | | |

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| M 640 | Continued From page 24<br>report the allegation of neglect within the required time frame and complete a thorough investigation.<br><br>On May 1. 2025 at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay". The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name Resident #5) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1.<br><br>An interview with Resident (Proper Name Resident #5) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out.<br><br>Corrective Actions: | M 640 | | |

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| M 640 | Continued From page 25<br><br>The Vice President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented.<br><br>On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff.<br><br>On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses.<br><br>On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge.<br><br>The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription.<br><br>Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes | M 640 | | |

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| M 640 | Continued From page 26<br>thoughts of the leaving the facility.<br><br>The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who mans the receptionist area was in-serviced on 05/10/25 by the Executive Director.<br><br>100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk.<br><br>An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: Vice President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social Seri vice Assistants and Medical Director. The IP nurse was present by phone.<br><br>The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25.<br><br>On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit. | M 640 | | |