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	25CG	A. BUILDING: _____ B. WING _____	06/06/2025

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey, as well as Complaint Investigations (CI), at the facility from 06/02/25 through 06/6/25. CI MS# 28868 and CI MS #28989 were investigated and cited M615 and M620. CI MS# 29026 was investigated and CI MS #29005 related to peri care, care plan implementation, accident hazards related to falls, wound care was investigated and cited M640 related to CI MS 29005. 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 and cited M500, M615, M620, and M1570. The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 6/04/25 when Resident #211, who had eloped from the facility and made her way to a busy intersection among moving vehicles, placing her in danger of potential harm, injury, impairment or death. The IJ and SQC existed at: Rule 45.17.2-Resident Rights-M500 Rule 45.21.8-Accidents-M640 The facility Administrator was notified of the IJ and SQC on 06/4/25 at 11:40 AM. The facility provided an acceptable Removal Plan on 6/6/25, in which they alleged all corrective actions to remove the IJ were completed on 6/5/25 and the IJ removed on 6/5/25. The SA validated the Removal Plan on 6/6/25 and determined the IJ was removed on 6/5/25, prior to exit. Therefore, the scope and severity for Rule 45.17.2-Resident Rights-M500 and Rule	M 000		

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M 000	Continued From page 1 45.21.8-Accidents-M640 was lowered from "Level IV" to "Level II" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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; 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; 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,	M 500		7/4/25

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M 500	Continued From page 2 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; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other 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; 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; 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; 7. is free from mental and physical abuse;	M 500		

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M 500	Continued From page 3 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 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);	M 500		

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M 500	Continued From page 4 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 by his physician or nurse practitioner/physician assistant in his medical record); 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 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. This Statute is not met as evidenced by: Level IV Based on observation, interviews, record review, and facility policy review, the facility failed to protect the resident's rights to be free from neglect when the resident eloped from the facility unsupervised and unmonitored and made her way to the middle of a busy intersection for (1) of 24 residents sampled. Resident #211 The facility's failure to ensure that Resident #211	M 500	1. On 06/04/2025, the facility failed to keep Resident #211 exited the building. Accident/Incident investigation initiated immediately by the Administrator. Upon returning to the facility, within 6 minutes and in visual range of staff, Resident #211 was assessed by Director of Nursing (DON) on 06/04/2025. The resident was found to be free of injuries.	

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M 500	Continued From page 5 was unable to exit the facility unsupervised resulted in her running into the middle of a busy intersection located at an intersection near the facility, placing the resident in a situation that was likely to cause serious injury serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 6/4/25, when Resident #211 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 6/5/25 at 11:40 AM. The SA validated the Removal Plan on 6/6/25 and determined the IJ was removed on 6/5/25, prior to exit. Therefore, the scope and severity for Rule 45.17.2-Resident Rights-M500 and Rule 45.21.8-Accidents-M640 was lowered from "Level IV" to "Level II" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy, "Freedom of Abuse, Neglect and Exploitation", November 2019, revealed, " ...This facility shall not condone any acts of resident ...neglect ..."Neglect" means failure of the facility, its employees, ...to provide ...services to a resident that are necessary to avoid physical harm ..." On 6/4/2025 at 3:15 PM, the State Agency (SA) observed several staff running across the parking lot. It was later determined that Resident #211 had eloped from the front door of the facility. The SA observed the resident had reached the intersection of two adjoining streets near the	M 500	Resident wandering/elopement assessment completed by Assistant Director of Nursing (ADON) on 6/4/2025 and resident determined to be at risk for wandering/elopement. Color picture of Resident #211 taken and placed in wandering/elopement binder at each nurse station and reception desk by Social Services on 6/4/2025. Door codes changed on 6/4/2025 by Maintenance Director. 2. On 6/04/2025, the ADON assessed all residents and determined 12 residents were at risk for wandering/eloping. No issues identified. 3. The QAPI Committee (Administrator, DON, Medical Director, Infection Preventionist/RN Educator, ADON, Human Resources, MDS Coordinator, Treatment Nurse, Wound Care, Business Office, Rehab Manager, Medical Records, Social Services #1, Social Services #2,Environmental Services, Maintenance Director, Activities Director, Staffing, RNA, Central Supply) met on 6/04/2025 to review Freedom of Abuse Standard and Wandering/Elopement Standard with no recommended changes to the standards. On 06/04/2025 facility staff educated on wandering/elopement process and procedures. On 06/04/2025 Social Services conducted 100% audit of wandering/elopement binders located at Unit A and Unit B nurse stations and front entrance to ensure	

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M 500	Continued From page 6 facility. The distance from the front door of the facility to the intersection is estimated to be 600 feet. Resident #211 was sitting on the back of a trailer that was attached to a pick-up truck that was stopped at the traffic light. Approximately seven (7) cars were observed to be in the street at the time Resident #211 sat in the intersection. Several staff were engaged in removing the resident from the truck's trailer and getting her back to the facility. The resident was initially carried by the staff, but a wheelchair was brought from the facility for the remainder of the trip back. The weather was 86 degrees and sunny. On 6/4/2025 at 3:27 PM an interview with Licensed Practical Nurse (LPN) #2 revealed she was starting her shift and was located at the nursing station, receiving information from the day shift nurse about another resident. LPN #2 stated at approximately 3:15 PM, she heard a Certified Nursing Assistant (CNA) yell, "The new lady is out". LPN #2 reported she proceeded to run after the resident with the other nurses. LPN #2 noted the resident was back in the facility at approximately 3:20 PM. LPN #2 denied seeing Resident #211 exit the building. On 6/4/2025 at 3:30 PM an interview with LPN #3 revealed she was at the nursing station providing information on another resident to the evening shift nurse. LPN #3 stated that at approximately 3:10 PM she heard yelling and some saying, "She's gone". LPN #3 reported seeing staff running out of the building and she ran behind them. LPN #3 noted she did not see Resident #211 leave the building. On 6/4/2025 at 3:37 PM an interview with the Director of Nursing (DON) revealed at approximately 3:00 PM she was in the	M 500	completeness and accuracy. On 06/04/2025 armbands were applied by Social Services to all residents assessed and determined to be at risk for wandering/elopement. All new admissions will have a wandering/elopement risk assessment completed by licensed nurse upon admission to ensure residents at risk are appropriately identified, armbands applied and photo added to binders located at Unit A and Unit B nurse stations and the front entrance. 4. Beginning 6/4/2025, Nurse Educator, DON or ADON will conduct Wandering/Elopement Drills once on every shift for 2 weeks, then once a week on every shift for the next 2 weeks, then monthly for 2 months to ensure at risk residents are appropriately identified and the staff are knowledgeable of wandering/elopement processes and responses. Beginning 06/04/2025, monthly audits for 3 months by Social Services and MDS Coordinator to ensure all residents at risk for wandering/elopement are appropriately identified in the wandering/elopement binders, armbands applied and main door codes have been changed at least once in the last 30 days. Beginning 06/04/2025, for 3 months the Administrator will audit the compliance of changing the main entrance door codes at least once per month.	

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M 500	Continued From page 7 Administrators office when she heard someone yell "The lady." The DON noted she ran outside with the other staff and went to the intersection to retrieve the resident and bring her back to the facility. The DON noted the resident refused to come with the staff and yelled and kicked them. The DON noted the staff had to physically pick up the resident and carry her while yelling for someone to bring a wheelchair for her. The DON reported that her assessment of the resident revealed no injuries. During the interview the Emergency Medical Transport (EMT) arrived. The DON noted the resident will be sent to a geri-psych unit. On 6/4/2025 at 3:49 PM, an interview with Assistant Director of Nursing (ADON) revealed she was in the Administrator's office when at approximately 3:15 PM she heard an inaudible yelling coming from the hallway. The ADON stated she walked out of the office and saw people running toward the door. The ADON noted she ran after them and noticed the resident at the intersection near the facility. The ADON reported the Resident #211 was combative and held on tightly to the trailer on which she was sitting. The ADON noted the resident yelled that she did not live at the facility and that she wanted to go home. The ADON noted the resident was returned to the facility at approximately 3:25 PM. On 6/4/2025 at 4:10 PM, an interview with the Administrator revealed she was in her office when at approximately 3:15 PM she was alerted by someone screaming, "The Lady" from the hallway. The Administrator stated she ran to the front door and then to the location of the resident. The Administrator stated the resident was found at the intersection near the facility, sitting the back of a trailer that was attached to a pickup	M 500	Findings from the drills, audits and door codes will be reviewed monthly during QAPI for 3 months starting July 3, 2025. Administrator and Director of Nursing will be responsible for monitoring and compliance to ensure the solutions are sustained. Any issues identified by the QAPI Committee related to the cited deficiencies will be addressed immediately with an appropriate action plan for improvement implemented.	

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M 500	Continued From page 8	M 500		

truck in the middle of the street. The Administrator stated Resident #211 was combative and resistant to coming back to the facility with the staff. The Administrator stated the resident was yelling, "I want to go home", "Don't touch me." The Administrator confirmed the resident was initially carried by the staff but was later placed in a wheelchair to get her back to the facility. The Administrator affirmed the resident was back in the facility at approximately 3:21 PM. The Administrator stated Resident #211 will be going to a geri psych unit.

On 6/4/2025 at 4:17 PM an interview with CNA #1 revealed that at approximately 3:15 PM she was at the back door, near the laundry room, clocking out when she saw the resident walking and heard another staff member yell "She got out." CNA #1 stated she ran back to the front of the building yelling for help. CNA #1 reported she ran out of the front door and proceeded to go along with the other staff toward the resident. CNA #1 confirmed the resident was located at the intersection near the facility, in the middle of the street, sitting on the back of a truck trailer. CNA #1 noted Resident #211 hysterical and combative. CNA #1 affirmed the resident was back in the building by approximately 3:20 PM.

On 6/5/2025 at 8:32 AM an additional interview with the Administrator revealed she had reviewed the surveillance video and confirmed that the resident was able to exit the facility through the front door because the receptionist pushed the button that unlocks the door, allowing Resident #211 to walk out. The Administrator acknowledged that no other staff or visitors were surrounding the resident at the time she exited the facility.

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M 500	Continued From page 9 On 6/5/2025 at 8:40 AM, an interview with the Receptionist acknowledged that on 6/4/25 she was located at the receptionist desk when Resident #211 approached the door. The Receptionist stated she then pushed the button that unlocked the door and Resident #211 was able to walk out. The Receptionist affirmed that she did not recognize the resident because she was admitted to the facility the previous day after she left work. On 6/06/25 at 10:30 AM, an interview with the Family Nurse Practitioner (FNP) revealed she was made aware of the incident and ordered the resident sent to the hospital for physical and mental evaluation. The FNP noted she does not take part in the preadmission process. On 06/05/25 at 09:56 AM an interview with the Admissions Coordinator (AC) revealed when she receives pre-admission information for a resident, she forwards the information to the DON, ADON, the Administrator, the Business office and the Director of Respiratory to review the information. The AC affirmed that no information in Resident #211's preadmission documents stood out to her as worthy of concern for the resident. The AC confirmed that the resident's daughter mentioned that the resident had become more difficult to have at home. On 06/06/25 at 9:21 AM, during a phone interview with the Resident Representative (RR) revealed she was contacted by the facility staff regarding her mother's elopement from the facility on 6/4/25. The RR affirmed that the facility explained that the receptionist let her out, not knowing she was a resident. The RR stated it had only been 24 hours since her mother was admitted to the facility, and she wants her mother to be safe.	M 500		

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The RR stated she has no other plan for her mother's care.

On 06/06/25 at 9:46 AM, an additional interview with The Receptionist revealed she recalled buzzing the resident out the front door at time between 3:00 PM and 4:00 PM. The Receptionist recalled it was during the shift change and the second shift had already arrived.

On 6/06/25 at 9:51 AM, an additional interview with the Administrator revealed when a resident is admitted to the facility it is the responsibility of the nurse assigned to that resident as well as the DON, ADON and the Nurse Supervisor to keep the resident safe until a care plan has been done. The Administrator confirmed that from the front door of the facility to the intersection where the resident was found was 250 steps approximately 600 feet.

On 6/06/25 10:53 AM, an interview with the DON revealed the facility's Wandering Risk Screen and Elopement Evaluation for resident #211 was completed by Registered Nurse (RN) #1. The DON noted all staff are responsible for monitoring newly admitted residents for safety until they have a care plan.

On 6/06/25 at 11:20 AM a phone interview RN #1 acknowledged that she is responsible for completing the Elopement Evaluation and the Wandering Risk Screen for Resident #211. RN #1 noted at the time of admission her impression of the resident came from the diagnoses of Altered Mental Status and Urinary Tract Infection (UTI). RN #1 stated she noticed the resident behaving in a confused state and even addressing her as if she were her daughter. RN #1 reported she believed Resident #211's

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confusion was due to the UTI. RN #1 affirmed that she did not have knowledge of the RR's statement regarding Resident #211 leaving home and wandering in the streets.

On 06/06/25 at 12:18 PM, during an interview the Social Services Director (SSD) #1 acknowledged that she is responsible for updating the book that contains residents who are prone to wander. SSD #1 confirmed that the book was not updated to include Resident #211 at the time of her elopement from the facility on 6/4/2025. SSD #1 stated that she adds residents who are prone to wander to the book based on the assessment from the nursing staff at the time of admission. SSD noted that at the time the resident was admitted on 6/3/25 she was off work and had planned to do the assessment the next day. SSD #1 reported she is not shown preadmission paperwork to assess prior to admission.

On 06/06/25 at 1:10 PM, an additional Interview with SSD #1 revealed she updated the wandering binder and included color photographs on 6/4/25.

A record review of the "Admissions Record" revealed the facility admitted Resident #211 on 6/3/25 with diagnoses including Unspecified Dementia and Altered mental status.

Removal Plan:

Corrective Actions Implemented Immediately

Resident Assessment:
Upon re-entry, a comprehensive full-body assessment was completed. No injuries were noted. There were no signs of bruising, bumps, skin tears, or lacerations. When asked about any discomfort, Resident #211 reported that her feet

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 12	M 500		

felt "a little sore." The Director of Nursing (DON) removed the residents' socks and observed no redness or open areas. Acetaminophen (Tylenol) was administered in accordance with the physician's order. Vital signs were obtained and found to be within normal limits.

Resident #211 became tearful and expressed a strong desire to return home, stating that her daughter was not adequately caring for her grandchildren and that she needed to be there for them. The Nurse Practitioner was promptly notified and provided an order for the Resident #211 to be transferred to the Emergency Room for further evaluation at a higher level of care.

Resident #211's Responsible Party (RP) was contacted and informed of the situation and the new medical order. An emergency response was called, and the resident was transported by ambulance and taken to the local emergency department. Resident #211 departed the facility on a stretcher at approximately 4:15 PM.

At 5:40 PM, a follow-up call was placed to the emergency department, where it was confirmed that the Resident #211 had been admitted to the Geri psych unit for continued evaluation and treatment.

Implementation Date: 6/4/2025
o Official report called to the State Agency on June 4, 2025
o Emergency Quality Assurance and Performance Improvement (QAPI) meeting held on June 4, 2025, with leadership to review failures and prevention strategies. Staff in attendance were Administrator, DON, ADON, Infection Preventionist/RN Educator, Maintenance Director, Medical Director via

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	25CG	A. BUILDING: _____ B. WING _____	06/06/2025

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M 500	Continued From page 13 telephone, Social Services #1, Social Services #2, MDS Coordinator, Wound Care, Wound Care Nurse, Rehab Manager, Environmental Services, Activities Director, RNA, Central Supply, Medical Records, Human Resources, Business Office, Staffing, Treatment Nurse Nurse Educator will conduct in-service training for all staff on wandering and elopement (new admits at risk) protocols on June 4, 2025. o Social Services will complete a 100% audit of the wandering binders to ensure all qualifying residents are included and that color photographs are added on June 4, 2025. o Central Supply Clerk, will order neon green armbands to identify residents at risk of wandering or elopement on June 4, 2025 o Maintenance Department will change the front entrance/exit door codes to prevent unauthorized exits on June 4, 2025. o DON and ADON will conduct elopement drills on every shift once a week for four weeks, then monthly thereafter, beginning on June 4, 2025. o DON and ADON will complete a 100% audit of care plans for residents identified as elopement risks to ensure their accuracy and completeness on June 4, 2025. o DON and ADON will complete a 100% audit of all resident assessments to identify those who meet criteria for wandering risk on June 4, 2025. o ADON will complete a 100% audit of the total number of residents in the facility on June 4, 2025. *No employees will be permitted to work until the assigned in-services have been completed. Validation: The SA validated on 06/06/25 through interview	M 500		

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M 500	Continued From page 14 and record review that all actions to remove the immediacy were completed on 06/05/25. The Immediate Jeopardy was removed on 06/05/25 prior to the SA exit.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on observation, interviews, record review, and facility policy review, the facility failed to provide adequate supervision, monitoring, and preadmission risk assessment to prevent a resident from exiting the facility unsupervised and without staff awareness or intervention for one (1) of twenty-four (24) sampled residents. (Resident #211). This failure resulted in Resident #211 eloping from the building on 6/4/25, for an estimated 600 feet, and being found seated on the back of a trailer in a public intersection surrounded by traffic, thereby placing the resident in Immediate Jeopardy (IJ) for serious injury, harm, impairment, or death. This situation was determined to be IJ and Substandard Quality of Care (SQC), which began on 06/04/25 when Resident #211 eloped from the facility. The State Agency (SA) notified the	M 640	1. On 06/04/2025, the facility failed to keep Resident #211 exited the building. Accident/Incident investigation initiated immediately by the Administrator. Upon returning to the facility, within 6 minutes and in visual range of staff, Resident #211 was assessed by Director of Nursing (DON) on 06/04/2025. The resident was found to be free of injuries. Resident wandering/elopement assessment completed by Assistant Director of Nursing (ADON) on 6/4/2025 and resident determined to be at risk for wandering/elopement. Color picture of Resident #211 taken and placed in wandering/elopement binder at each nurse station and reception desk by Social Services on 6/4/2025. Door codes changed on 6/4/2025 by Maintenance Director.	7/4/25

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M 640	Continued From page 15 Administrator of the Immediate Jeopardy on 06/05/25 at 11:40 AM and provided an IJ template. The facility provided an acceptable Removal Plan on 06/05/25, in which they alleged all corrective actions to remove the IJ were completed on 06/05/2025 and the IJ removed on 06/05/2025. The SA validated Removal Plan on 06/06/25, and determined that the IJ was removed on 06/05/25, prior to SA exit. Therefore, the scope and severity for CFR 483.25(d)(1)(2) Accidents/Hazards - F689 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: A review of the facility's policy titled "Wandering/Elopement Risk" (Revised November 2017) revealed "It is the standard of this facility to identify those residents at risk for wandering/elopement and to take the appropriate steps to minimize the risk of elopement. All residents are assessed for the potential to wander prior to or upon admission." A record review of the "Admission Record" for Resident #211 revealed an admission date of 06/03/25 with diagnoses including Unspecified Dementia and Altered Mental Status. During an observation on 06/04/25 at approximately 3:15 PM, the SA observed several staff running through the facility parking lot. It was later confirmed that Resident #211 exited the facility through the front door after the receptionist	M 640	2. On 6/04/2025, the ADON assessed all residents and determined 12 residents were at risk for wandering/eloping. No issues identified. 3. The QAPI Committee (Administrator, DON, Medical Director, Infection Preventionist/RN Educator, ADON, Human Resources, MDS Coordinator, Treatment Nurse, Wound Care, Business Office, Rehab Manager, Medical Records, Social Services #1, Social Services #2,Environmental Services, Maintenance Director, Activities Director, Staffing, RNA, Central Supply) met on 6/04/2025 to review Freedom of Abuse Standard and Wandering/Elopement Standard with no recommended changes to the standards. On 06/04/2025 facility staff educated on wandering/elopement process and procedures. On 06/04/2025 Social Services conducted 100% audit of wandering/elopement binders located at Unit A and Unit B nurse stations and front entrance to ensure completeness and accuracy. On 06/04/2025 armbands were applied by Social Services to all residents assessed and determined to be at risk for wandering/elopement. All new admissions will have a wandering/elopement risk assessment completed by licensed nurse upon admission to ensure residents at risk are appropriately identified, armbands applied and photo added to binders located at Unit	

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M 640	Continued From page 16 pushed the door release button. The resident was found seated on the back of a trailer at the intersection near the facility, an estimated 600 feet from the front entrance of the facility. The resident was combative, yelling, "I want to go home," and had to be carried by staff until a wheelchair arrived. Record review of weather records from Jackson, MS on 06/04/25 at 3:15 PM documented a temperature of 86°F and clear skies. During an interview on 06/04/25 at 3:27 PM, Licensed Practical Nurse (LPN) #2 stated she was at the nurses' station receiving report when she heard a Certified Nursing Assistant (CNA) yell, "The new lady is out." She ran outside with other staff and saw the resident being retrieved, but did not witness the elopement. On 06/04/25 at 3:30 PM, LPN #3 stated she heard shouting and followed staff outside, confirming the resident was found at the intersection but she did not witness her leaving the building. On 06/04/25 at 3:37 PM, the Director of Nursing (DON) stated she was in the Administrator's office when she heard yelling. She ran outside and saw the resident sitting on the trailer in traffic. The DON confirmed the resident was combative, refused to return, and had to be physically carried while another staff retrieved a wheelchair. During an interview on 06/04/25 at 4:10 PM, the Administrator stated she heard someone yelling "The lady" and ran to the front door. She saw the resident sitting in the middle of the street on a trailer attached to a pickup truck. The resident was yelling, "I want to go home," and "Don't touch me." The Administrator confirmed the resident was carried until a wheelchair was brought. She stated the resident would be transferred to a	M 640	A and Unit B nurse stations and the front entrance. 4. Beginning 6/4/2025, Nurse Educator, DON or ADON will conduct Wandering/Elopement Drills once on every shift for 2 weeks, then once a week on every shift for the next 2 weeks, then monthly for 2 months to ensure at risk residents are appropriately identified and the staff are knowledgeable of wandering/elopement processes and responses. Beginning 06/04/2025, monthly audits for 3 months by Social Services and MDS Coordinator to ensure all residents at risk for wandering/elopement are appropriately identified in the wandering/elopement binders, armbands applied and main door codes have been changed at least once in the last 30 days. Beginning 06/04/2025, for 3 months the Administrator will audit the compliance of changing the main entrance door codes at least once per month. Findings from the drills, audits and door codes will be reviewed monthly during QAPI for 3 months starting July 3, 2025. Administrator and Director of Nursing will be responsible for monitoring and compliance to ensure the solutions are sustained. Any issues identified by the QAPI Committee related to the cited deficiencies will be addressed immediately with an appropriate action plan for improvement implemented.	

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M 640	Continued From page 17	M 640		

geriatric psychiatric unit.

During an interview on 06/04/25 at 4:17 PM, Certified Nursing Assistant (CNA) # 1 stated she was clocking out by the laundry area when she heard yelling. She ran to the front and joined other staff in retrieving the resident from the intersection. She described the resident as hysterical and combative.

During an inteview on 06/05/25 at 8:32 AM, the Administrator confirmed that video surveillance showed the receptionist unlocking the door, allowing the resident to exit without being accompanied by staff.

During an interview on 06/05/25 at 8:40 AM, the Receptionist stated she pushed the release button for the front door when Resident #211 approached, and she did not recognize the resident because she had been admitted the previous evening after the receptionist's shift.

On 06/06/25 at 9:21 AM, the Resident Representative stated she was notified of the elopement and told the receptionist to let the resident out, not realizing she was a new admission. She stated it had only been 24 hours since her mother's admission and she wanted to ensure her mother's safety.

During an interview on 06/06/25 at 9:46 AM, the Receptionist recalled unlocking the door for the resident between 3:00 PM and 4:00 PM during shift change.

During an interview on 06/06/25 at 9:51 AM, the Administrator stated that when a new resident is admitted, the assigned nurse, DON, Assistant Director of Nurses (ADON), and Nurse

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M 640	Continued From page 18 Supervisor are responsible for safety monitoring until a care plan is developed. During an interview on 06/06/25 at 10:30 AM, the Family Nurse Practitioner (FNP) stated she was notified of the elopement and ordered the resident to be transferred to a local hospital for evaluation. She confirmed she does not participate in preadmission screening. On 06/05/25 at 9:56 AM, the admissions Coordinator stated she forwarded the resident's preadmission information to the DON, ADON, Administrator, Business Office, and Respiratory Director. She did not identify any concerning information at the time, although she recalled that the daughter mentioned the resident had become difficult to manage at home. During an interview on 06/06/25 at 10:53 AM, the DON stated that the facility's Wandering Risk Screen and Elopement Evaluation were completed by RN #1. She stated that all staff are responsible for monitoring newly admitted residents until a care plan is in place. During an interview on 06/06/25 at 11:20 AM, RN #1 stated she assessed the resident as confused but attributed it to a Urinary Tract Infection (UTI). She acknowledged the resident addressed her as if she were her daughter but denied knowing about the history of wandering reported by the family. During an interview on 06/06/25 at 12:18 PM, the Social Services Director (SSD) #1 stated that she is responsible for updating the facility's wandering book based on nursing assessments. She confirmed that Resident #211 had not yet been added because she was off work at the time of admission.	M 640		

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M 640	Continued From page 19 During an interview on 06/06/25 at 1:10 PM, the SSD #1 confirmed that she added Resident #211 to the wandering binder on 06/04/25 with a photograph. Removal Plan: Corrective Actions Implemented Immediately Resident Assessment: Upon re-entry, a comprehensive full-body assessment was completed. No injuries were noted. There were no signs of bruising, bumps, skin tears, or lacerations. When asked about any discomfort, the resident (211) reported that her feet felt "a little sore." The Director of Nursing (DON) removed the residents' socks and observed no redness or open areas. Acetaminophen (Tylenol) was administered in accordance with the physician's order. Vital signs were obtained and found to be within normal limits. The resident (211) became tearful and expressed a strong desire to return home, stating that her daughter was not adequately caring for her grandchildren and that she needed to be there for them. The Nurse Practitioner was promptly notified and provided an order for the residents (211) to be transferred to the Emergency Room for further evaluation at a higher level of care. The resident's (211) Responsible Party (RP) was contacted and informed of the situation and the new medical order. An emergency response was called, and the resident was transported by ambulance and taken to the local emergency department. The resident (211) departed the facility on a stretcher at approximately 4:15 PM.	M 640		

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M 640	Continued From page 20 At 5:40 PM, a follow-up call was placed to the emergency department, where it was confirmed that the resident (211) had been admitted to the Geri psych unit for continued evaluation and treatment. Implementation Date: 6/4/2025 o Official report called to the State Agency on June 4, 2025 o Emergency Quality Assurance and Performance Improvement (QAPI) meeting held on June 4, 2025, with leadership to review failures and prevention strategies. Staff in attendance were Administrator, DON, ADON, Infection Preventionist/RN Educator, Maintenance Director, Medical Director via telephone, Social Services #1, Social Services #2, MDS Coordinator, Wound Care, Wound Care Nurse, Rehab Manager, Environmental Services, Activities Director, RNA, Central Supply, Medical Records, Human Resources, Business Office, Staffing, Treatment Nurse Nurse Educator will conduct in-service training for all staff on wandering and elopement (new admits at risk) protocols on June 4, 2025. o Social Services will complete a 100% audit of the wandering binders to ensure all qualifying residents are included and that color photographs are added on June 4, 2025. o Central Supply Clerk, will order neon green armbands to identify residents at risk of wandering or elopement on June 4, 2025 o Maintenance Department will change the front entrance/exit door codes to prevent unauthorized exits on June 4, 2025. o DON and ADON will conduct elopement drills on every shift once a week for four weeks, then monthly thereafter, beginning on June 4, 2025.	M 640		

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M 640	Continued From page 21 o DON and ADON will complete a 100% audit of care plans for residents identified as elopement risks to ensure their accuracy and completeness on June 4, 2025. o DON and ADON will complete a 100% audit of all resident assessments to identify those who meet criteria for wandering risk on June 4, 2025. o ADON will complete a 100% audit of the total number of residents in the facility on June 4, 2025. *No employees will be permitted to work until the assigned in-services have been completed. Validation: The SA validated on 06/06/25 through interview and record review that all actions to remove the immediacy were completed on 06/05/25. The Immediate Jeopardy was removed on 06/05/25 prior to the SA exit.	M 640		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the	M1570		7/4/25

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M1570	Continued From page 22 program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection during Percutaneous Endoscopic Gastrostomy (PEG) care for Resident #14 and during suprapubic catheter care for Resident #62 for two (2) of five (5) care observations. Findings include: A record review of the facility's policy "Incontinence Management Suprapubic Catheter Care" with a revision date of 1/2020 revealed "Objective To promote hygiene, comfort, and reduce migration of infectious organisms to the bladder ...Procedure: 8. Clean around the area where the catheter enters the abdomen in a circular motion, moving in a bullseye pattern out to 2-3 inches beyond where catheter enters abdomen ..." A record review of the facility policy "Infection Control Enhanced Barrier Precautions" dated 2024 revealed" ...The Centers for Disease control and Prevention (CDC) recommends using	M1570	1. On 06/04/2025, the facility staff failed to follow standards of care while donning Personal Protective Equipment (PPE) and performing perineal care while providing suprapubic catheter care. On 6/4/2025 Licensed Practical Nurse #4 was in serviced by Nurse Educator regarding donning and doffing PPE. On 6/4/2025 Licensed Practical Nurse #5was in-serviced by Nurse Educator regarding suprapubic catheter care. 2. Residents that require Enhanced Barrier Precautions (EBP) and perineal care have the potential to be affected by the deficient practice. 3. On 6/24/2025, the QAPI Committee met to review the Infection Control Standard and Incontinence Management Perineal Care Standard with no recommended changes to the policy. On 06/04/2025, Nurse Educator in serviced facility staff and skill check offs	

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M1570	Continued From page 23 Enhanced Barrier Precautions (EBP) with residents, regardless of Multidrug-resistant Organisms (MDRO) status, who have ... an indwelling medical device such as a feeding tube ...Post signs outside of residents 'rooms that state the required precautions and Personal Protective Equipment (PPE) and the resident care activities that need a gown and gloves ..." On 6/4/25 at 12:08 PM, during an observation Licensed Practical Nurse (LPN) #4, administered medications to Resident #14 via the PEG tube. LPN #4 did not don (put on) a gown as indicated on EBP prior to medication administration. On 6/4/25 at 12:22 PM, an interview with LPN #4 confirmed that she did not put on a gown before giving medication via PEG tube. She stated she was supposed to put on a gown prior to giving medication. She stated the reason for the gown is to protect the residents from her. She confirmed she had been trained on EBP and forgot to apply the gown. On 6/6/25 at 2:25 PM, during an interview with Registered Nurse #2 (RN)/Infection Preventionist (IP), she stated LPN #4 should have put on a gown prior to giving medication via PEG tube. She stated that by not wearing a gown, the nurse becomes a host and can transmit all types of infection from herself to other residents. On 6/6/25 at 3:24 PM, during an interview with the Director of Nursing (DON), she stated it was an infection control issue. She confirmed that LPN #4 should have worn a gown prior to beginning PEG tube care. She stated the gown prevents possible spread of infection and expects all staff to follow infection control guidelines.	M1570	conducted on donning and doffing PPE. Licensed staff in-serviced and skill checkoffs on donning and doffing PPE and suprapubic catheter care. On 6/9/2025 the Nurse Educator began conducting observation check offs of Perineal Care for nursing staff. 4. On 06/04/2025, Nurse Educator, Director of Nursing (DON) or Assistant Director of Nursing (ADON) began monitoring donning and doffing of PPE on 5 staff members per shift per week for 2 weeks, then 3 staff members per shift per week for 2 weeks, then 5 staff members 2 times monthly for 2 months. The findings will be reviewed in the QAPI Committee Meeting for 3 months starting on July 3,2025. Director of Nursing and Infection Preventionist are responsible for monitoring and compliance to ensure solutions are sustained. Any issues will be corrected immediately with additional education conducted as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25CG	A. BUILDING: _____ B. WING _____	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

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M1570	Continued From page 24 A record review of Resident #14's "Admission Record" revealed an initial admission date of 7/15/22 with diagnoses including neuromuscular dysfunction of bladder. A record review of Resident #14's "Medication Review Report" dated 6/6/25 revealed an order dated 7/24/2023 "Suprapubic cath (catheter) care - Clean with soap and H20 (water) every shift." A record review of Resident #14's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. Resident #62 On 6/4/25 at 10:38 AM, during an observation of LPN #5 providing catheter care for Resident #62 revealed LPN #5 began care using a wet soaped washcloth and cleaned the area at the entrance of the suprapubic catheter in a circular motion. She went around the site three times, flipped the cloth, and continued to clean in a circular motion two more times. She flipped the towel again and continued cleaning the site. On 6/4/25 at 10:53 AM, an interview with LPN #5 confirmed that she used the cloth in a circular motion several times before flipping to a clean section. She stated that performing care in this manner could transfer bacteria back into the clean area and increase risk of urinary tract or bladder infection. She stated she had been trained on catheter care. On 6/6/25 at 2:24 PM, during an interview with RN #2/IP nurse, she stated LPN #5 should have wiped once in a circular motion, then folded the	M1570		

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	25CG	A. BUILDING: _____ B. WING _____	06/06/2025

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M1570	Continued From page 25 washcloth to a clean section for each wipe. She stated that the technique used by LPN #5 could increase the chance of Resident #62 developing an infection, fever, or chills. On 6/6/25 at 3:18 PM, during an interview with the DON, she stated LPN #5 should have flipped the washcloth with each wipe. She confirmed that the method used placed the resident at increased risk for infection. A record review of Resident #62's "Admission Record" revealed an admission date of 4/6/22 with diagnoses of dysphagia following unspecified cerebrovascular disease. A record review of Resident #62's MDS with an ARD of 3/15/25 revealed a BIMS score of 99, which indicated the resident was unable to complete the interview.	M1570		