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

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PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

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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 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and policy review, the facility failed to provide wound care in a manner to promote healing and prevent infection for one (1) of three (3) residents reviewed for wound care. Resident #98. Findings Include: A record review of the facility's policy titled Skin Management Standards, revised April 2021, revealed "Bacteria are present on all skin surfaces. When the primary defense provided by intact skin is lost, bacteria will reside on the wound surface. Follow infection control policies to prevent self-contamination and cross-contamination in individuals with pressure ulcers." Record review of the facility policy "Skin Management Standards "dated 04/2021 revealed " ...Protocol ...3. Change dressing as ordered per	M 615	1. On 06/05/2025, the facility failed to provide Resident #98 with incontinence care to resident per the care plan. All bed linens for Resident #98 checked. Bed linens found soiled; bed changed with fresh linen. A full wound assessment for the resident was completed on 6/3/2025 by the Wound Care Nurse and reviewed by the Director of Nursing (DON). The resident's care plan was updated to reflect a specific peri-care protocol prior to all wound care procedures. A care conference was held 6/25/25 with the residents responsible party to discuss the incident and corrective actions being taken. 2. On 6/5/2025, Wound Care Supervisor assessed all residents and determined 24	7/4/25

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M 615	Continued From page 2 physician ..." An observation and interview on 06/05/25 at 9:45 AM, revealed Licensed Practical Nurse (LPN) #1, assisted by LPN #6, providing wound care for Resident #98. LPN #6 removed the resident's bed linens and brief, which were heavily soiled with yellow and brown urine. LPN #1 removed the wound vacuum and dressing, which was saturated with urine and completed the wound care as ordered. Following the procedure, LPN #1 stated he had not noticed the soiled brief and linens until after completing care. He acknowledged that peri-care should have been performed prior to wound care and that failure to do so could result in infection, deterioration of the wound bed, and delayed healing. He further stated that the urine appeared to have been present for a prolonged period, indicating the resident had not been changed recently. On 06/05/25 at 2:30 PM, Resident #98 stated she was typically changed only once at night and could not recall when she was last changed. She stated that staff do not check on her during the night, and she remains wet for long periods. On 06/05/25 at 2:50 PM, an interview with LPN #6 (wound care nurse) revealed she did not check the resident's brief prior to the procedure. She stated that wound care was initiated despite the resident being visibly soiled and confirmed that care is typically performed with CNA assistance to provide peri-care beforehand. She acknowledged that proceeding with wound care prior to hygiene could result in infection. On 06/06/25 at 3:09 PM, the Director of Nursing (DON) confirmed that peri-care should have been completed before wound care and that failure to	M 615	residents have wound care orders and have the potential to be affected. No further negative issues were identified. On 6/6/2025, an air mattress audit was conducted and determined all residents are on the appropriate mattress setting. No negative issues were identified. 3. On 6/24/2025, QAPI Committee met and reviewed the Skin Management Standard with no recommended changes to the policy. On 6/14/2025, all nursing staff including Licensed Practical Nurse #1 and Licensed Practical Nurse #6 were in serviced by Nurse Educator on proper wound care protocols, infection prevention, and the importance of peri-care prior to wound dressing changes. On 06/14/2025, Nurse Educator conducted in service for licensed nursing staff on Proper wound care protocols per facility policy, Infection control standards related to wound care, Importance of peri-care prior to wound dressing changes, Resident dignity and continence care. The "Skin Management Standards" policy was reviewed on 6/14/25and reinforced during training. Staff were required to sign an acknowledgment form after training. A communication protocol was established on 6/14/25 requiring nurses to verify with CNAs that peri-care has been completed prior to wound care procedures. Wound Care Consultant Nurse provided education to licensed nurses on 6/22/2025 and 06/27/2025 regarding appropriate documentation	

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M 615	Continued From page 3 do so could lead to contamination and further skin breakdown. She stated that all wound care should be provided per facility policy. Record review of the "Order Summary Report" with active orders as of 6/3/25 revealed an order dated 4/07/25 for wound vacuum application to the sacral ulcer with normal saline cleansing, pat dry, and dressing changes twice weekly and PRN (as needed) for dislodgement. Documentation of wound vac output was to be recorded each shift. A record review of the "Admission Record" for Resident #98 revealed an admission date of 04/07/25 with diagnoses including a stage 4 pressure ulcer to the sacral region. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment.	M 615	which included transcription and entering of treatment orders on the physicians order sheet in the Electronic Medical Record and the residents Treatment Administration Record. 4. Beginning 06/05/2025, the Wound Care Supervisor began observing wound care performed by Registered Nurse (RN) or Licensed Practical Nurse (LPN) for 5 incontinent residents with wounds weekly for 4 weeks and then monthly for 2 months to ensure wound care and incontinence care are provided according to the individualized care plan and the standards of practice. Any issues with non-compliance will be immediately corrected and addressed by the DON or Nurse Educator for additional staff education. The findings of the observations will be reviewed in the QAPI Committee Meeting for 3 months starting with the QAPI Committee conducted July 3, 2025. DON and Wound Care Supervisor will be responsible for monitoring and compliance to ensure the solutions are sustained.	
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections.	M 620		7/4/25

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M 620	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observations, interviews, record reviews, and facility policy review, the facility failed to provide incontinent care in an appropriate manner to related to bowel and bladder care for one (1) of 24 residents reviewed. Resident #98. Findings include: A record review of the facility's policy "Perineal Care" with a revision date of 12/20 revealed the purpose of the procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation..." On 06/04/25 at 11:20 AM, during an observation of perineal care provided by Certified Nursing Assistant (CNA) 2 and assisted by CNA #3 revealed the CNAs performed perineal care and applied a clean brief. The State Agency (SA) asked CNA #2 to remove the clean brief and recheck the resident for cleanliness. CNA #2 removed the clean brief and wiped the anus area a total of seven additional times. Each time, the peri wipe was smeared with a brown substance. On 6/4/25 at 11:33 AM, an interview with CNA #3 confirmed that CNA #2 did not provide proper care. She stated that CNA #2 should wipe until the peri cloth is clean. On 6/4/25 at 11:38 AM, an interview with CNA #2 confirmed that she did not clean Resident #98 thoroughly. She stated that she should keep wiping until the wipe is clean. She acknowledged that the resident could get a urinary tract	M 620	1. On 06/05/2025, Resident #98 did not receive incontinence care per the care plan. Bed linens for Resident #98 checked. Bed changed with fresh linen on 6/5/2025 by CNA. On 6/5/2025, Resident #98 assessed by DON. No negative outcomes identified. 2. Facility assessed all residents on 6/4/2025 and determined 24 residents are incontinent and have the potential to be affected. 3. QAPI Committee met on 6/24/2025 to review cited regulation. QAPI Committee reviewed the Resident Centered Care Planning Standard and Incontinence Management Standards with no recommended changes to the policy. All24 residents with incontinence have resident centered comprehensive care plan interventions for treatment of incontinence were determined to be up to date with physician orders on 6/6/2025. On 06/04/2025, Nurse Educator began educating clinical staff regarding incontinence care, perineal care, and suprapubic care. Nurse Educator(NE) conducted In-services on 6/18/2025 educating clinical staff on the location of the Individual Care Service Plan (ICSP) within Electronic Medical Record, Kardex and process of Charge Nurse to confirm that unit staff have reviewed Kardex at the beginning of each shift.	

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M 620	Continued From page 5 infection, yeast infection, or skin breakdown. An observation of perineal care for Resident #98 on 6/5/25 at 10:25 AM, after wound care was completed, revealed CNA #2, assisted by CNA #4, removed Resident #98's heavily soiled brief, turn pad, and draw sheet. All were soaked and had a putrid odor with yellow and brown staining from urine. On 06/05/25 at 2:32 PM, an interview with CNA #2 revealed that Resident #98 was not her assigned resident that day. She stated that the resident sometimes requests her care because she is used to her performing it. She stated that CNA #4 was the resident's assigned CNA for the day. CNA #2 confirmed that the resident was heavily soiled with foul-smelling urine. On 6/5/25 at 2:36 PM, an interview with Resident #98's Licensed Practical Nurse (LPN) revealed she had never been told that Resident #98 refused care. She stated only the nurse can change room assignments and she did not make any changes to the CNA schedule that day. On 6/5/25 at 2:40 PM, an interview with CNA #4 confirmed that Resident #98 was heavily soiled in urine. She stated the wound could get infected from being soaked in urine. She said the resident prefers CNA #2 to provide care and that CNA #2 is sometimes exchanged as the resident's caregiver. She stated she had not provided perineal care on Resident #98 that day. On 06/06/25 at 3:02 PM, an interview with the Director of Nursing (DON) stated CNA #2 should have continued to wipe until the resident was clean and used a clean wipe each time. She stated that when a resident is left unclean and	M 620	4. Beginning 06/05/2025 Minimum Data Set (MDS) Nurse will audit the resident care plan and Kardex of 5 incontinent residents to ensure they are current and resident specific weekly for 4 weeks and monthly for 2 months. ADON or Nurse Educator will observe 5 incontinent residents Activities of Daily Livings (ADLs) to validate they receive incontinent care per the individualized care plan weekly for 4 weeks and monthly for 2 months. Audit findings will be reviewed weekly by the DON and the findings will be reviewed in the QAPI Committee Meeting for 3 months starting on July 3, 2025. DON will be responsible for monitoring and compliance to ensure the solutions are sustained.	

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M 620	Continued From page 6 heavily soiled with urine, they are at risk of a possible infection. She further stated that perineal care should be performed every two hours. A record review of Resident #98's "Admission Record" revealed an admission date of 4/7/25 with a diagnosis of pressure ulcer of sacral region, stage 4. A record review of Resident #98's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 4/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicates severely impaired cognition. Section GG revealed Resident #98 is dependent for hygiene toilet care.	M 620		
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	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	7/4/25

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M 640	Continued From page 7 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 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."	M 640	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 completeness and accuracy.	

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M 640	Continued From page 8 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 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	M 640	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. Findings from the drills, audits and door	

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M 640	Continued From page 9 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 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	M 640	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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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 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 11 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. 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	M 640		

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 _____	C 06/06/2025

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M 640	Continued From page 12	M 640		

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.

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

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 _____	C 06/06/2025

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M 640	Continued From page 13	M 640		

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 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.