STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255226	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATCHEZ REHABILITATION AND HEALTHCARE CENTER	**344 ARLINGTON AVENUE , NATCHEZ, Mississippi, 39120**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted a compliant survey at the facility from 10/14/25 through 10/15/25. The SA investigated Incident 2641285 for Accidents/Incidents related to the elopement of Resident #1 and cited F689 at Immediate Jeopardy (IJ) as past noncompliance. Based on the facility's implementation of corrective actions on 10/13/25 the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The SA identified IJ and Substandard Quality of Care (SQC) that began on 10/10/25 when facility staff failed to provide adequate supervision for a cognitively impaired resident, Resident #1, which resulted in the elopement of the resident from the facility van during transportation. IJ and SQC existed at: CFR 483.25(d)(2) Accidents/Hazards - F689 - Scope/Severity "J" The facility Administrator was notified of the IJ and SQC on 10/14/25 at 3:15 PM and was presented with the IJ Template. The facility provided an acceptable Corrective Action Plan on 10/14/25 in which they alleged all corrective actions to remove the IJ and SQC were completed on 10/13/25, prior to arrival of SA and the IJ removed on 10/14/25. The SA validated the Corrective Action Plan on 10/15/25 and determined that the IJ was removed on 10/14/25, prior to entrance. The facility had a license for 58 beds, with a census of 51 residents.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0689 SS = SQC-J	Continued from page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, facility policy review, record review and interviews, the facility failed to ensure a cognitively impaired resident received adequate supervision to prevent elopement when Resident #1 was left unattended and unsupervised in the facility van at a local gas station. Resident #1 exited the facility van and was unsupervised by facility staff for (40) minutes until the resident was observed by a community member 0.8 miles from the gas station where the resident had exited the van and was walking along the sidewalk. This was 1.3 miles from the facility. Resident #1 was returned to the facility. This was for one (1) of four (4) sampled residents dependent on the facility for transportation. Resident #1. The facility's failure to provide adequate supervision to prevent the elopement of Resident #1 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. The facility's failure to identify the need for adequate supervision and ensure a secure environment contributed to Resident #1's elopement and placed all residents who were admitted with or developed wandering/exit seeking behaviors at risk. This failure resulted in Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 10/10/25. The SA notified the facility's Administrator of the IJ and SQC on 10/14/2025 at 3:15 PM and provided the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 10/13/25, the State Agency (SA) determined the IJ and SQC to be Past Non-compliance (PNC) and the IJ removed on 10/14/25. Findings Included: Record review of the facility policy titled, "Driver and Vehicle Safety Policy" revised 3/2025, revealed	F0689		

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F0689 SS = SQC-J	Continued from page 2 "…Employees driving the company vehicle shall also: Have another employee ride with the driver if transporting residents who need assistance, including, but not limited to, lifting or medical assistance; Never leave a resident unattended in a vehicle…" Record review of the facility policy titled, "Wander Management, Monitoring System & Resident Elopement Protocol" revised 7/01/25, revealed, "Purpose To monitor safety of residents at risk for elopement. To provide a system to alert staff that a resident may be attempting to leave the facility. Policy It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible…" Record review of the final facility investigation, dated 10/13/25 revealed that on 10/10/25 at approximately 1:30 PM, Resident #1 was left unattended and unsupervised in the facility van during transportation back to the facility from a physician appointment and exited the van without knowledge of the facility Transportation Aide (TA) who discovered that he was missing from the van at approximately 1:38 PM. According to the Facility Investigation Resident #1 was located by a community member at approximately 2:14 PM, walking along a sidewalk approximately 0.8 miles from the gas station and returned to the facility at approximately 2:17 PM; the resident was unsupervised by facility staff for approximately (40) minutes. Record review of the "Wander Data Collection" assessment dated 9/27/25 revealed the facility assessed Resident #1 as low risk for unsafe wandering/elopement. On 10/14/25 at 11:00 AM, during an interview the Director of Nursing (DON) stated that she was notified of the elopement of Resident #1 by the Transportation Aide (TA) at approximately 1:47 PM on 10/10/25. She reported that the State Agency (SA) was notified of the elopement on 10/10/25 at 4:45 PM, and thorough investigation was conducted. She stated that based on security camera footage at the gas station it was confirmed Resident #1had exited the van unaccompanied and unsupervised at approximately 1:38 PM. The DON stated that a community member familiar with the resident was driving in the area and observed Resident #1 walking along a sidewalk approximately 0.8 miles from the gas station and returned him to the facility. The DON confirmed that the Quality Assurance (QA) committee met and determined that the root cause of the elopement was determined to be that the cognitively impaired resident was left unsupervised in the facility van during transport and the during the QA meeting on	F0689		

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F0689 SS = SQC-J	Continued from page 3 10/13/25 facility procedure for transportation of residents was changed to include two staff for all transportation of residents to ensure at least one staff would be present to always provide supervision of residents during transportation. She reported that Resident #1 had had a change of cognition for which a Significant Change Minimum Data Set (MDS) was completed on 9/29/25 with a Brief Interview for Mental Status (BIMS) assessment resulting in a score of 6, which indicated severe cognitive impairment. She stated that Resident #1 had no previous elopement behaviors and was assessed as low risk for elopement during 9/27/25 assessment. On 10/14/25 at 11:35 AM, an interview with the Administrator revealed that on 10/10/25 she was out of state and the Director of Nurses (DON) served as her designee at the facility during her absence. On 10/14/25 at 1:00 PM, an interview with the Transportation Aide (TA) revealed she had transported Resident #1 to a physician's appointment in a town approximately sixty (60) miles away and during transport back to the facility following his appointment, she stopped at a local gas station and put gas into the facility van. She stated that after putting gas into the van she went into the station to pay for the gas and left Resident #1 unattended and unsupervised in the facility van. She said that upon her return to the van approximately two (2) minutes after she left the resident seated in the front passenger seat of the van wearing his seatbelt, she observed that the resident was not seated in the van as she had left him. She said she had immediately searched the van and the outdoor area around the van and station and inside the station and its bathrooms without locating the resident. She said she then telephoned the facility DON as the Administrator was out of the state. On 10/14/25 at 1:30 PM, observation at the gas station where Resident #1 was last observed by facility staff prior to elopement on 10/10/25 revealed the station was situated between four streets with one traffic light in front and one traffic light behind and to the south of the building. The speed limit was (25) miles per hour with no noted crosswalks. The station had (12) pumping stations in front and (12) parking spots in front with one handicapped parking space. There were four (4) vehicles at pumping stations and six (6) vehicles in parking spaces. During a five (5) minute observation there were (15) vehicles that traveled the street to the north of the station and (26) vehicles that traveled the street to the south of the station. The concrete parking and pumping areas in front of the	F0689		

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F0689 SS = SQC-J	Continued from page 4 station were well maintained and even with a slight decline down to the street to the south. Observation revealed the place where Resident #1 was located was approximately 0.8 miles from the gas station on a mixed commercial/residential street with intact and well-maintained sidewalks and a (25) mile an hour speed limit. On 10/15/25 at 3:30 PM, an interview with the facility Administrator confirmed that all steps on the facility's Corrective Action Plan had been completed as of 10/13/25. Record review of the weather history according to Weather25.com, revealed the weather in the locale of and on the date of the elopement was overcast with no rain and seventy-seven (77) degrees Fahrenheit with winds at six (6) miles per hour. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 9/4/2018 with diagnoses that included undifferentiated schizophrenia and anxiety disorder. Record review of the Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/29/25 for Resident #1 revealed the resident had a BIMS score of 6, which indicated severe cognitive impairment. The facility assessed the resident with the ability to walk at least 150 feet in a corridor or similar space. Corrective Action Plan: 1. The facility failed to provide supervision to prevent the elopement of Resident #1, who was severely cognitively impaired and was left in the facility van unattended and exited the van unattended. This failure allowed Resident #1 to be unsupervised on October 10, 2025, from 1:36pm until 2:17pm, at which Resident #1 returned to the facility. Facility was immediately aware of Resident #1 exiting the van and immediately took appropriate action to locate the resident. 2. The following parties were notified of the incident: • Natchez Police Department was notified October 10, 2025 at 1:57pm. • Local Ombudsman was notified October 10, 2025 at 2:46pm. • Primary Physician was notified October 10, 2025 at 3:07pm.	F0689		

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F0689 SS = SQC-J	Continued from page 5 • Medical Director was notified October 10, 2025 at 3:07pm • Mississippi State Department of Health was notified October 10, 2025 at 4:55pm. • Mississippi State Attorney General was notified October 10, 2025, at 4:55pm. 3. Resident #1 returned to facility at 2:17pm. 4. Fully body audit performed by Director of Nursing (DON) at approximately 2:20pm October 10, 2025, with no negative findings. 5. Wander Guard placed on Resident #1 at 2:20pm by Director of Nursing (DON). 6. On October 10, 2025, beginning at approximately 2:30pm the Unit Manager initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Elopement Policy with corresponding quiz, Abuse and Neglect Prohibition Policy, Resident Rights, Vulnerable Adult Act. Education was initiated with all authorized van drivers on Safe Transportation of Residents. 7. An elopement drill and 100% census verification was conducted by Director of Nursing (DON) at approximately 2:47pm October 10, 2025 for 2 shifts. The 3rd shift elopement drill and census verification was conducted by Director of Nursing (DON) at 7:00am October 11, 2025. 8. Resident was placed on 1:1 observation at 3:00pm October 10, 2025 and remained on 1:1 until 7:00am October 13, 2025. 9. Incident reported initiated by Director of Nursing (DON) at 3:04pm October 10, 2025. 10. Wander guard assessments were reviewed for accuracy by Director of Nursing (DON) at approximately 3:30pm October 10, 2025 for all residents to ascertain the risk for wandering, and to ensure appropriate interventions were implemented. 11. Wander Guard system checked at approximately 3:30pm October 10, 2025 on all exit doors by Director of Nursing (DON) with no negative findings. 12. Elopement Risks Binder was reviewed and updated as needed by Director of Nursing (DON) at approximately	F0689		

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F0689 SS = SQC-J	Continued from page 6 3:45pm 10/10/2025. 13. Care plans related to residents identified as elopement risk were reviewed and updated accordingly by Minimum Data Set Coordinator (MDS) at approximately 4:00pm October 10, 2025. 14. Certified Nursing Assistant #1 was issued a Disciplinary Action for not following policy at approximately 5:00pm October 10, 2025. 15. On October 13, 2025, at 10:44am, the Medical Director, Administrator, Director of Nursing, Unit Manager, Social Services Director, Activities Director, Business Office Manager, Director of Rehab, Minimum Data Set Coordinator, Wound Care RN, Medical Records Director, Dietary Manager, Environmental Services Manager, Human Resource Generalist held Quality Assurance Performance Improvement meeting to review steps initiated to prevent future reoccurrence. There were no new policy changes, but new procedures were put in place. 16. All corrective actions were completed on October 13, 2025, and the Immediate Jeopardy was removed on October 14, 2025. 17. In order to monitor current residents for potential risk, residents will be monitored by the Director of Nursing (DON) through incident report review, observations and communication with staff. The Administrator or Maintenance Director will conduct elopement drills quarterly for up to a year and then bi-annually thereafter. The Administrator or Maintenance Director will conduct staff training elopement drill monthly with rotating shifts until all shifts are completed for three(3) months and then quarterly thereafter. The facility Quality Assurance Committee will meet weekly for the next eight(8) weeks to review compliance with the Corrective Action Plan. If no further concerns are noted, we will continue to monitor as per routine facility Quality Assurance Committee. On 10/15/25, SA validations were completed onsite during the complaint investigation through interviews, observations and record reviews that all corrective actions had been taken by the facility on 10/13/25 to remove the IJ and the IJ was removed on 10/14/25.	F0689		