STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a complaint investigation (CI), CI MS #17823 on 6/9/2021 through 6/10/2021. The SA substantiated the facility reported MS CI #17823 related to an elopement, when the facility failed to provide supervision to prevent Resident #1, who was diagnosed with Alzheimer's Disease and Dementia with Behavioral Disturbance from leaving the facility without supervision on 5/31/2021.

Resident #1 was allowed to exit the facility at 5:54 AM, when Dietary Aide #1 entered the building and held the door for the resident to exit. When breakfast trays were being delivered to the residents, Resident #1 was not in her room. Licensed Practical Nurse (LPN) #1 called a Dr. Wander and the staff began to search for the resident. When Resident #1 was not located within the building or on the immediate facility grounds, Maintenance Staff #1 and Housekeeper Staff #1 got into their vehicles and began to search the surrounding roads for the Resident. When Maintenance Staff #1 located Resident #1 at the corner of a major intersection approximately 0.5 miles from the facility at 7:26 AM, he called Registered Nurse (RN) #2. RN #2 drove her vehicle to the location of Resident #1 and assisted her into her vehicle without incident and returned Resident #1 to the facility. Resident #1 was assessed by RN #2 with no adverse findings. Resident #1 was placed on 15 minute checks until Resident #1's primary care physician examined her on 5/31/2021 at 12:00 noon, at which time the physician deemed that the Resident had suffered no harm during her unattended absence from the facility. Resident

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/09/2021

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

#1's elopement risk was reassessed, the care plan was updated and per physician's orders, a wander guard was placed on Resident #1's wrist.

During the investigation of the complaint, the SA identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) was identified on 6/9/2021, which occurred on 5/31/2021 and existed at:

42 CFR(s): 483.25(d)(1)(2)-Free of Accidents Hazards/Supervision/Devices (F689)-Scope/Severity "J".

The facility failed to provide supervision to prevent an elopement for Resident #1, who was diagnosed with Alzheimer's Disease and Dementia with Behavioral Disturbance. Resident #1 was allowed to leave the facility, unnoticed and unsupervised until Maintenance Worker #1 found Resident #1 standing at the corner of a major intersection approximately 0.5 miles from the facility.

This situation placed Resident #1 and other residents at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death.

Based on the facility's implementation of corrective actions on 5/31/2021, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed 6/1/2021, prior to the SA's entrance on 6/9/2021.

The SA notified the facility's Administrator of the PNC IJ and SQC on 6/9/2021 at 3:35 PM. At the time of the investigation, the facility had a census of 80, and held a license of 100 beds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The State Agency (SA) conducted a complaint investigation (CI), CI MS #17823 on 6/9/2021 through 6/10/2021 and substantiated CI MS #17823 related to an elopement due to the facility's failure to provide adequate supervision to prevent Resident #1's elopement from the facility on 5/31/2021 at approximately 5:54 AM. Resident #1 was away from the facility and unsupervised for approximately one (1) hour 28 minutes. The facility staff were unaware of Resident #1's absence until the breakfast trays were being delivered and discovered that Resident #1 was not in her room. The facility completed a facility wide search and began to search the surrounding roads. The Resident was located at 7:26 AM by Maintenance Staff #1 approximately 0.5 miles from the facility standing at the corner of a major intersection. Resident #1 was returned to the facility by Register Nurse (RN) #2 and assessed for any signs and symptoms of injury or distress without concerns. The facility's immediate investigation revealed Resident #1 exited the facility through the front door when Dietary Aide #1 entered the building and held the door open for the Resident #1 to exit the door. Resident #1 was placed on 15 minute checks until her primary physician arrived at the facility and completed a	F 689	Past noncompliance: no plan of correction required.	7/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

physical exam and determined there was no harm to Resident #1 while away from the facility and unattended.

During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 6/9/2021 and existed at:

42 CRF(S): 483.25 (d)(1)(2)- Free of Accidents, Hazards/Supervision/Devises (F689).

The facility's failure to provide adequate supervision to prevent the elopement for Resident #1, who was diagnosed with Alzheimer's Disease and Dementia with Behavioral Disturbance, allowed Resident #1 to exit the facility unnoticed and unsupervised until Maintenance Worker #1 found Resident #1 standing at the corner of a major intersection, approximately 0.5 miles from the facility. This situation placed Resident #1 and other residents with diagnoses for Alzheimer's and Dementia with Behavioral Disturbance at risk for elopement and the likelihood for serious injury, harm, impairment, or death.

Based on the facility's implementation of corrective actions on 5/31/2021, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 6/1/2021, prior to the SA's entrance on 6/9/2021.

The SA notified the facility's Administrator of the PNC IJ and SQC on 6/9/2021 at 3:35 PM. At the time of the investigation the facility had a census of 80 and held a license of 100 beds.

Based on interviews, observations, record review, facility investigation review and policy review the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility on 5/31/2021 at 5:54 AM. The facility staff did not know that Resident #1 was off the facility grounds until breakfast trays were being delivered and Resident #1 was not in her room. This concern was identified for one (1) of four (4) residents reviewed for diagnoses of Alzheimer's Disease and Dementia (Resident #1).

Findings include:

Review of the facility's policy, "Missing Resident/Elopements," updated 7/18, revealed, it is the policy of this facility that all Unit Charge Nurses are responsible for knowing the location of their residents.

On 6/9/2021 at 9:00 AM, in an interview with the facility's Administrator, she stated that the facility admitted Resident #1 on 10/19/20. Upon admission, the resident had been assessed by the Director of Nursing (DON) and was not deemed an elopement risk. She further stated that Resident #1 had never exhibited any wandering behavior and had never attempted to exit any of the doors.

The facility's investigation revealed the Administrator had interviewed Dietary Aide #1 on the morning of Resident #1's elopement and provided the SA with a signed statement from Dietary Aide #1. The facility's investigation confirmed that Dietary Aide #1 opened the facility's front door on May 31, 2021, at 5:54 AM and held the door open for Resident #1 to exit the facility. The investigation revealed Dietary Aide #1 explained as she drove into the facility parking lot at 5:50 AM, she noticed a lady in the parking lot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

dressed in medical scrubs and a lab jacket. She stated Dietary Aide #1 explained that she also noted a medical cart beside the car door. Dietary Aide #1 said as she keyed her code into the door, opened the door and entered the facility, a lady was standing in the hallway and approached the door. Dietary Aide #1 stated that she noted the lady to be clean and neatly dressed wearing pants, a shirt, jacket, and a face mask. Dietary Aide #1 explained as she entered the building, the lady walked out the door. Dietary Aide #1 had told the Administrator she believed the lady to be with the person outside in the parking lot. The investigation revealed when the nursing staff realized Resident #1 was missing and called a Dr. Wander, Dietary Aide #1 told Licensed Practical Nurse (LPN) #1, she thought the missing resident had gone out the front door earlier that morning when she opened the door. The investigation revealed LPN #1 explained to Registered Nurse (RN) #2 that a Dietary Aide had said that she thinks she had let the Resident out of the building earlier that morning and the staff began to search the facility's grounds. It was during that time that Housekeeping Staff #1 and Maintenance Staff #1, got into their vehicles and begin to drive the surrounding area in search of the missing resident.

The Administrator stated the facility's investigation revealed Resident #1 was located at approximately 7:22 AM, standing at the corner of a major intersection approximately 0.5 miles from the facility. RN #2 reported that when Maintenance Staff #1 called and said that he had located the Resident, she got into her car, drove to the area, approached Resident #1, and asked her to ride with her back to the facility. RN #2 stated that Resident #1 walked to the car, got in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

and rode back to the facility with RN #2 without incident. RN #2 told the Administrator that during the ride back to the facility, Resident #1 was pleasant, her voice was calm, and her facial expression were relaxed. Once the Resident was safely returned to the facility, the Resident was examined by RN #2. RN #2 reported that there were no visible changes noted to Resident #1's balance or gait and no injuries were noted. At 7:50 AM, RN #2 stated that she notified Resident #1's primary physician of the elopement, with no visible signs of injury. RN #2 also told the Administrator that she had notified Resident #1's daughter of the incident. The Administrator stated Resident #1's physician arrived at the facility around noon and assessed Resident #1. She further stated that when the doctor assessed the resident, he found her to be alert, in no distress and without injuries.

Upon completion of her investigation, the Administrator stated that the allegation of Resident #1 walking out of the building was substantiated, and she contacted the State and Attorney General's office and reported the incident. The Administrator stated that they held a Quality Assurance and Performance Improvement (QAPI) meeting and began to put corrective actions into place. The Administrator stated the facility began to have additional elopement drills and began in-servicing all employees on elopement and supervision of residents. The Administrator stated that she had suspended Dietary Aide #1, pending investigation, but after the day of the elopement, Dietary Aide #1 never returned to the facility. The Administrator provided the State Agency (SA) with copies of the statements received regarding the investigation, the sign-in page of the QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

meeting that was held on the afternoon of the incident to discuss the incident and steps that needed to be taken to prevent this from happening again. The Administrator stated that during the in-services held immediately after the incident, the importance of employees stopping anyone attempting to exit a door and have them identify themselves prior to allowing them to exit.

On 6/9/2021, at 9:30 AM, the SA walked throughout the facility. No residents were noted to be wandering into other rooms or common areas. There were no residents seen standing at exits or attempting to exit the building. The staff were observed assisting residents with morning care. No call lights were noted to be unanswered and there were no foul odors noted. Signs were noted on both sides of the front door that reminded staff not to allow residents to exit the doors unattended.

On 6/9/2021, at 9:45 AM, Resident #1 was observed sitting up in her bed. During a brief interview, it was noted that the Resident was only oriented to person. The Resident was very pleasant and appeared well groomed. She was unable to recall any information regarding her whereabouts and stated that she lived in another city and was only at the facility until they could find out what was wrong with her and then she would be going back home.

On 6/9/21 at 10:00 AM, in an interview with Housekeeping Staff #1, he revealed that on the morning of 5/31/21 when he came to work the nurses had already called Dr. Wander for Resident #1. He stated that the nurses were outside looking, so he immediately got into his vehicle and started driving toward the local

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

hospital. He stated that he got a call saying that the Resident had been found and he turned around and drove back to the facility. He stated that he has never seen Resident #1 wandering around the building or standing at the doors looking outside like she wanted to go out the door. Housekeeping Staff #1 stated he is responsible for conducting the elopement drills and they have them every quarter. He stated on the day of the elopement, they had a meeting with the staff, and he had held an elopement drill. He further stated after Resident #1's elopement, all the employees, including himself, had to attend an in-service on elopement and supervision before they were allowed to work.

On 6/9/21 at 11:10 AM, in an interview with LPN #1, she stated that on the morning of 5/31/21, she was working on Unit A when RN #2 walked onto Unit A asking if she had seen Resident #1. She stated that she had told RN #2 that she had not seen Resident #1 that morning. At that time, RN #2 called Dr. Wander for Resident #1. LPN #1 stated that not long after Dr. Wander was called, Dietary Aide #1 approached her and stated that she was afraid that she had let Resident #1 out when she came in that morning for work. LPN #1 said that after helping the Certified Nursing Assistants (CNA's) search the rooms, she and RN #2 went outside and started searching the grounds. She further stated that she had never noticed Resident #1 wandering or attempting to get out of a door. LPN #1 confirmed that she had attended an in-service about elopement and supervision and took part in an elopement drill after Resident #1 eloped before she was allowed to work.

On 6/9/21 at 11:20 AM, in an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

Certified Nursing Assistant (CNA) #1 when asked by the State Agency (SA) to recall the events that occurred the morning on 5/31/21 when Resident #1 eloped, she stated she was working on Unit A when LPN #1 asked if she had seen Resident #1 that morning. CNA #1 stated that she told LPN #1 no. She further stated that it was at that time that Dr. Wander was called, and all the staff started going from room to room searching for the Resident. CNA #1 stated said that she has worked on Unit B in the past and had assisted with the care of Resident #1, but she never recalls the Resident wandering in the halls or attempting to leave the building. CNA #1 stated that she had been required to attend an in-service about elopement and had been involved in an elopement drill after Resident #1 eloped prior to being allowed to work.

On 6/9/21 at 11:35 AM, Maintenance Staff #1 was interviewed regarding the elopement of Resident #1 on 5/31/21. He explained that he had just reported to work that morning and was working out back when he heard Resident #1 could not be located. He stated his instinct was to get in his truck and start driving to look for her. He said he saw her standing at the corner of a major intersection, so he immediately called RN #2. He further stated that he parked his car and just watched the Resident because he was afraid if he approached her, it would scare her. He said that the Resident was not attempting to cross the road, she was just standing there, so he watched her and waited for RN #2 to come and get Resident #1 and take her back to the facility. Maintenance Staff #1 stated that he had never seen Resident #1 wandering around the building or standing at doors attempting to get out. He said that the only time he had ever seen her do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

anything away from her hall was when she played BINGO. Maintenance Staff #1 confirmed that he had been required to attend an in-service about elopement and had taken part in an elopement drill right after Resident #1 eloped.

On 6/9/21 at 11:50 AM, in an interview with RN #2, Staff Development Coordinator, she said that she was working on the 7-3 shift the morning of 5/31/21 when Resident #1 eloped. She stated that when the CNAs were passing out the breakfast trays, a CNA told her Resident #1 was not in her room. They looked across the hall in the room of Resident #1's friend to see if she was in there, but she was not. RN #2 stated that she walked over to Unit A and asked LPN #1 if she had seen Resident #1. RN #2 said that when LPN #1 said that she had not seen the resident, she activated Dr. Wander, and everyone stopped what they were doing and began to search the rooms for Resident #1. She stated that she and LPN #1 went outside and began to search the grounds. Maintenance Staff #1 got in his truck and within a few minutes, he called her stating that he had located Resident #1. She said that she got into her car and went to the corner where the Resident had been located and assisted Resident #1 into her car and returned to the facility. RN #2 further said that Resident #1 stated that she had been for a walk and did not resist her effort to walk with her to her car and drive back to the facility. RN #2 stated that she did not ever recall seeing Resident #1 anywhere except in her room, across the hall in her friend's room or at the nursing station. Since the elopement, RN #2 stated that all employees had been in-serviced on elopement, supervision, and the importance of identifying anyone attempting to exit the building prior to opening the door and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

allowing them to exit. RN #2 said that employees were required to attend the in-services and elopement drills prior to being allowed to report to work.

On 6/9/2021 at 12:15 PM, the Administrator provided the SA with a copy of the QAPI sign-in sheet, copies of the elopement drills and in-services that were held on were held in the six (6) months preceding Resident #1's elopement and copies of the elopement drills and in-services on supervision and elopement that were conducted post the 5/31/2021 elopement. The Administrator also provided copies to the SA of a staffing grid for review, the facility's Missing Resident/Elopement Policy, and the facility's investigation notes that were completed after the elopement.

On 6/9/2021 at 1:45 PM, SA attempted to call Dietary Aide #1, but was unable to reach.

On 6/10/21 at 11:15 AM, in an interview with the DON, she stated that the facility did not have a separate policy on observation. She stated that they do not have documentation of the times prior to the elopement that the nursing staff had visual contact of Resident #1 on the morning prior to her elopement. She stated that unless residents have been identified as an elopement risk, the staff are not required to document times of visualization.

Record review of the QAPI sign-in sheet revealed that all department heads and the Medical Director were in attendance for the QAPI meeting held on 5/31/2021 at 4:00 PM.

Record review of Resident #1's Face Sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

revealed that Resident #1 was admitted on 10/19/2020. Resident #1's medical diagnoses included Dementia with behavioral Disturbance, Major Depression, Alzheimer's Disease, and Hypertension.

Record review of Resident #1's Admission Risk of Elopement Evaluation completed on 10/19/2020, revealed that the Resident #1 was not at risk for elopement and Resident #1 was not care planned for wandering behavior.

Review of Resident #1's most recent Quarterly Minimum Data Set (MDS), dated 4/18/2021, revealed a Brief Interview for Mental Status (BIMS) score of five (5), which indicated severe cognitive impairment. Section E of the Quarterly MDS revealed that Resident #1 had an absence of wandering behavior.

Review of the weather report provided by the Administrator obtained during her investigation, stated that the temperature during the time of Resident #1's elopement had been approximately 65 degrees Fahrenheit with no rain noted. The SA verified the report was correct at https://www.timeanddate.com.

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 6/9/2021:

Resident #1's incident was taken to Quality Assurance and Performance Improvement (QAPI) on 5.31.21 at 4:00p.m. The QAPI members in attendance were the Medical Director, Executive Director, Director of Nursing, Social Services Director, Business Office Manager, Unit A Manager, Unit B Manager,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

Certified Dietary Manager, Activity Director, Staffing/Central Supply, Human Resources, Maintenance Director, Registered Nurse, Infection Preventionist/Staff Development, Medical Records, Restorative/Minimum Data Set (MDS) Licensed Practical Nurse (LPN), Treatment Nurse, and the Director of Admissions. The facility took actions to ensure the provision of adequate supervision to meet the resident's needs. This was evident by in-services, re-assessments, elopement drills, wander guard checks, and audit tools.

The Maintenance Assistant located Resident #1 on 5.31.21 at 7:22 a.m. Resident #1 was located at the corner of Chadwick Drive and Robinson Road extension. After locating Resident #1, the Maintenance Assistant remained parked with visual observation of Resident #1 until the Registered Nurse (RN) arrived at 7:26 a.m. and transported Resident #1 back to the facility. Resident #1's assessment was completed immediately upon return to the facility by the Registered Nurse (RN) with no adverse findings.

Resident#1's Care Plan and Pocket Care Guide was updated on 5.31.21 by the Unit Manager to reflect elopement risk and presence of wander guard bracelet. A wander guard bracelet was applied to Resident #1 on 5.31.21 by the Registered Nurse (RN). Resident #1's location was monitored no less than every 15 minutes until assessed by the Physician on 5.31.21 at noon. The assigned nurse, Certified Nursing Assistant (CNA), and/or designee documented every 15-minute visual checks on Resident #1's Resident Location Monitoring Sheet with no significant changes. Resident #1's assigned nurse conducted a visual check of the wander

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

guard bracelet daily on 5.31.21 every hour with documentation of the intervention on the Electronic Medication Administration Record (E-MAR). Resident #1's wander guard bracelet was checked by the assigned nurse every shift for proper placement and functioning with documentation on the E-MAR, daily for each shift. The Maintenance Supervisor initiated testing of the Wander Guard System of the building on 5.31.21 daily for proper functioning for two (2) weeks, then three (3) times a week for one (1) week, then weekly.

The Social Service Director updated on 5.31.21 the Elopement Books and initiated an Elopement Alarm Drill on all shifts with employees. Mandatory Elopement Alarm Drills were conducted weekly by the Social Service Director for four (4) weeks, then monthly for one (1) month, then quarterly.

The Regional Nurse Consultant on 5.31.21 conducted a mandatory in-service with the Executive Director (ED) and Director of Nursing (DON) on HART review and checklist. The Executive Director on 5.31.21 conducted a one on one (1:1) in-service regarding "Validating Identity of Person Prior to Opening the Entrance Door and Allowing an Unknown Person to Exit the Building"; "Abuse and Neglect, Prevention, and Reporting"; "Elopement/Alarm Drill Protocol" with the dietary worker who failed to verify the identity of Resident #1, to prevent an elopement, on 5.31.21. The Staff Development Coordinator (SDC) initiated mandatory in-service on 5.31.21 on: "Validating a Person's Identity Before Opening the Facility's Front Door", "Elopement Alarm Drill Protocol", and "Abuse and Neglect", 6.1.21 in-service on "Resident Daily Observation". No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

staff were allowed to work until in-serviced. The Dietary Manager (DM) initiated on 5.31.21 an in-service on the "Importance of Knowing Residents and Keeping Them Safe".

On 5.31.21, the Unit Managers and Director of Nursing (DON) conducted a 100% head count location audit to ensure all residents were accounted for with no adverse findings. The Director of Nursing and/or designee initiated HART Team audits of Clinical Notes and the 24 hour reports to ensure that any residents that exhibit any wander risk behaviors were properly assessed with the appropriate interventions put in place to minimize any potential risk. This was audited five (5) days a week beginning 5.31.21 for two (2) weeks, then three (3) days a week for two (2) weeks, then weekly. On 5.31.21, 100% audit on residents' elopement assessment were completed by Unit A and Unit B Managers with no adverse findings. The Dietary Manager (DM) toured the facility on 5.31.21 with the dietary staff introducing them to ambulatory residents and resident's mobile via wheelchair capable of wheeling themselves who prefer to eat in their rooms. A screener was scheduled from 5:30am - 6:30am daily in the front lobby. The duties included validating a person's identity before opening the facility's front door. A Dr. Wander Post Test was initiated on 5.31.21 by Social Services Director and/or Executive Director to ensure verbalization and observation of Elopement Alarm Drill Protocol. The Executive Director initiated audits of employees for verbalization and/or observation of Elopement Alarm Drill Protocol daily for one (1) week, then once a week for four (4) weeks, then monthly for one (1) month, then quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

The State Agency (SA) validated the facility's corrective action on 6/10/21:

The SA validated through record review and interviews that the facility discussed Resident #1's incident of elopement from the facility at an emergency Quality Assurance and Performance Improvement (QAPI) meeting on 5/31/2021. The actions taken to ensure the provision of adequate supervision to meet Resident #1's needs were verified was evidenced by verification of the in-services, re-assessments, elopement drills, wander guard checks, and audit tools.

The SA verified that Maintenance Staff #1 had located Resident #1 and parked at the vicinity with visual observation of Resident #1 until RN #2 arrived at 7:26 AM and transported Resident #1 back to the facility. Resident #1's assessment was completed immediately upon return to the facility by RN #2 and no adverse findings were identified.

The SA verified that Resident #1's Care Plan and Pocket Care Guide was updated on 5/31/2021 to reflect elopement risk and presence of wander guard bracelet. The SA verified that the wander guard bracelet was applied to Resident #1's wrist and that Resident #1's location was monitored no less than every 15 minutes until assessed by the Physician on 5/31/2021 at noon through review of documentation. The SA also validated through Resident #1's Electronic Medical Record (EMAR) that the hourly visual checks, shift checks for function and placement, and documentation was completed for Resident #1's wander guard. Record review revealed the Maintenance Supervisor had initiated the two (2) week daily testing of the Wander Guard System of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

building for functioning on 5/31/2021. Through interview on 6/9/2021, the Maintenance Supervisor verified that after the two (2) weeks, he was scheduled to check functioning three (3) times a week for one (1) week, and then weekly.

The SA validated that the Social Services Director had updated the Elopement Books and initiated an Elopement Drill on all shifts with employees. The Maintenance Supervisor was assisting with these drills, and he was able to verify that the facility had conducted the drills as planned.

The SA validated through interviews and sign-in sheets that on 5/31/2021, the Regional Nurse Consultant conducted a mandatory in-service with the Administrator and DON on Health Assessment Review Team (HART) review and checklist, the Administrator conducted one on one (1:1) in-services with the Dietary Aide, and the Staff Development Coordinator (SDC) initiated mandatory in-services beginning on 5/31/21 as planned. The SA validated that the in-services had been conducted as documented by review of sign-in sheets and with interviews with six (6) CNA's, seven (7) LPN's, one ()1 RN, three (3) Housekeeping Staff, one (1) Maintenance Staff, one (1) Receptionist, one (1) Medical Records Staff, and one (1) Dietary Staff.

SA validated through record review and staff interviews the Unit Managers conducted a 100% head count location on all residents, audits of the Clinical Notes and 24 -hour reports were being conducted, 100% audit on residents' elopement assessment were completed, the dietary staff toured the facility, there was a screener scheduled from 5:30 AM - 6:30 AM in the front lobby, and confirmation of Elopement Alarm Drill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	**1900 CHADWICK DRIVE JACKSON, MS 39204**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 Protocol was being conducted as planned.	F 689		