

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/30/2026	
NAME OF PROVIDER OR SUPPLIER HILLTOP MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 101 KIRKLAND STREET , UNION, Mississippi, 39365			
(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	
M0000	Initial Comments The State Agency (SA) conducted three (3) Complaint Investigations (CI MS#2797423, CI MS # 2804922 and CI MS #2962788) at the facility on 3/30/26. The SA determined the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm related to the complaint CI MS #2962788 for accidents and cited M640. Based on the facility's implementation of corrective actions taken on 3/23/26, prior to survey entrance, this deficient practice was determined to be Past Non-Compliance. The SA found no deficient practice for CI MS#2797423 and CI MS # 2804922. The facility had a census of 55 at the time of the survey and held a license for 60 beds.		M0000				
M0640	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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on interview, record review, and facility policy review the facility failed to provide adequate supervision to prevent a cognitively impaired resident with a history of wandering from exiting the facility unattended for one (1) of three (3) residents reviewed for elopement risk. Resident #1. Findings Included: Record review of facility policy titled, "Missing Patient/Resident", revealed "An elopement occurs when a patient/resident leaves the premises or a safe area without authorization and/or any necessary supervision		M0640	"Past Noncompliance - no plan of correction required"			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0640	Continued from page 1 to do so, placing the patient/resident at risk of harm or injury." Record review of the facility investigation revealed on 3/22/26 at approximately 1:09 PM, a visitor observed Resident #1 standing near the front door. The visitor exited the facility and did not realize the resident followed him outside. At approximately 1:15 PM staff located Resident #1 on the front porch and escorted him back into the facility. The investigation determined Resident #1 was outside unattended for approximately five (5) minutes. Record review of the Admission Record revealed Resident #1 was admitted 7/23/25 and readmitted from geriatric psychiatric hospitalization on 11/26/25 with diagnosis including Dementia with agitation. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/26 revealed a Brief Interview for Mental Status (BIMS) score of three (3), indicating severe cognitive impairment. Interview with Licensed Practical Nurse #1 (LPN) on 3/30/26 at 2:00 PM, revealed that staff alerted her that Resident #1 was missing and she assisted with locating the resident. She stated Resident #1 ambulated in the halls and had not previously attempted to exit the building. Interview with Certified Nursing Assistant #1 (CNA) on 3/30/26 at 2:30 PM, revealed she located Resident #1 outside the front door on the porch and returned him to the facility at approximately 1:15 PM. Interview with the Director of Nursing (DON) on 3/30/26 at 3:00 PM, revealed Resident #1 had a history of wandering. She stated the interdisciplinary team previously determined the resident was not at risk for elopement. She verified that following the incident the resident was reassessed, and a wander guard was applied. The facility implemented corrective actions prior to State Agency entrance including completion of an elopement assessment for Resident #1, application of a wander guard, completion of elopement risk assessments for all residents, auditing of high-risk elopement interventions, staff education on elopement risk and missing resident procedures, updating the elopement binder, checking magnetic door locks, changing door codes on 3/23/26, conducting a Quality Assessment and Performance Improvement (QAPI) meeting with the interdisciplinary team, and conducting elopement drills		M0640				

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M0640	Continued from page 2 on all shifts. Quality monitoring will include the Maintenance Director will conduct Elopement Drills weekly times four (4) weeks, then monthly times two (2) months, the ADM will monitor door locks to ensure visitors, family members and vendors do not have the code by observing five (5) per week during exiting times 4 weeks, then monthly times 2 months. The Interdisciplinary team (IDT) will have a QAPI meeting on 4/8/26 and 5/6/26 to review the monitoring process to ensure compliance is met and substantiated. Based on the implementation of the facility's corrective actions on 3/23/36, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 3/24/26. Validation: The SA validated on 3/30/26, through interview and record review that all corrective actions had been implemented as of 3/23/26, and the facility was in compliance as of 3/24/26, prior to the SA's entrance on 3/30/26.			M0640			