STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #18233 and MS #18261 on 11/8/21 through 11/10/21. The SA unsubstantiated the facility reported MS #18233 related to Quality of Care (QOC)/services not performed per physicians' orders, QOC/falls, and QOC/not groomed. The SA substantiated the facility reported MS #18261 related to an elopement, when the facility failed to provide supervision to prevent Resident #1, who was diagnosed with Alzheimer's Disease and Cognitive Communication Deficit from leaving the facility without supervision on 10/19/21. On 10/19/21, Resident #1 was allowed to exit the facility at approximately 8:25 PM, removing her screen from her window and exiting through the window. When Licensed Practical Nurse (LPN) #1 was passing Resident #1's medications at 8:45 PM, LPN #1 realized the screen was out of the window and the window was open. LPN #1 alerted all staff who then began to search for Resident #1. Registered Nurse (RN) #1, LPN #1, and LPN #2 immediately went outside to the front of the facility, and saw Resident #1 on Proper Street Name #1 at an intersection. LPN #1 and RN #1 was able to escort Resident #1 back to the facility 8:53 PM. RN #1 completed a body audit on Resident #1 and there were no adverse findings noted. Resident #1 was placed on one-one-one supervision and received constant observation until Resident #1 was transported to a local hospital, and then discharged from facility. During the investigation of the complaint, on 11/10/21 the SA identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC)	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2021

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.

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	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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F 000	Continued From page 1 which occurred on 10/19/21 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 Cognitive Communication Deficit. Resident #1 was allowed to leave the facility, unnoticed and unsupervised until LPN #1, LPN #2, and RN #1 found Resident #1 standing at the corner of an intersection approximately 125 feet 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 correction actions on 10/20/21, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 10/22/21, prior to the SA's entrance on 11/8/21. The SA notified the facility's Director of Nurses (DON) of the PNC IJ and SQC on 11/10/21 at 10:56 AM. At the time of the investigation, the facility has a census of 59, and held a license of 118.	F 000		
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	F 689		12/21/21

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	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 2 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 interviews, observation, record review, facility investigation review and policy review the facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility on 10/19/21 at 8:25 PM. The facility staff did not know that Resident #1 was off the facility grounds until Licensed Practical Nurse (LPN) #1 was going to give Resident #1 medication and Resident #1 was not in her room. This concern was identified for one (1) of four (4) residents reviewed for diagnosis of Alzheimer's Disease (Resident #1). On 10/19/21, Resident #1 was allowed to exit the facility at approximately 8:25 PM, removing her screen from her window and exiting through the window. When LPN #1 was passing Resident #1's medications at 8:45 PM, LPN #1 realized the screen was out of the window and the window was open. LPN #1 alerted all staff who then began to search for Resident #1. Registered Nurse (RN) #1, LPN #1, and LPN #2 immediately went outside to the front of the facility and saw Resident #1 at the intersection of Proper Street Name #1 and Proper Street Name #2. LPN #1 and RN #1 was able to escort Resident #1 back to the facility 8:53 PM. RN #1 completed a body audit on Resident #1 and there were no adverse findings noted. Resident #1 was placed on one-one-one supervision and received constant observation until Resident #1 was transported to a local hospital, and then discharged from the	F 689	Past noncompliance: no plan of correction required.	

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

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F 689	Continued From page 3	F 689		

facility.

During the investigation of the complaint, on 11/10/21 the SA identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which occurred on 10/19/21 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 Cognitive Communication Deficit. Resident #1 was allowed to leave the facility, unnoticed and unsupervised until LPN #1, LPN #2, and RN #1 found Resident #1 standing at the corner of an intersection approximately 125 feet 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 correction actions on 10/19/21, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 10/22/21, prior to the SA's entrance on 11/8/21.
The SA notified the facility's Director of Nurses (DON) of the PNC IJ and SQC on 11/10/21 at 10:56 AM.

Findings include:

Record review of the facility's policy," Wandering/Elopement Risk," updated 11/17, revealed, " ...Elopement occurs when a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 4	F 689		

leaves the premises or a safe area without authorization (i.e. (that is), an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being stuck by a motor vehicle."

On 11/8/21 at 3:00 PM, an interview with Director of Nursing (DON) revealed Resident #1 exited the facility on 10/19/21, which was five (5) days after the facility admitted her on 10/14/21. The DON stated that upon admission, the resident was assessed for wandering and was determined to be at risk for wandering. She was also assessed for elopement and was not deemed to be an elopement risk because she had not been "exit-seeking". She further stated that Resident #1 had never exhibited any behaviors or attempted to exit any of the facility doors. The DON stated the facility's investigation revealed Resident #1 was located at approximately at 8:53 PM, standing near a ditch, in the front of the building on Proper Street Name #1 approximately 125 feet from the facility's front entrance. The DON stated Resident #1 exited through the window in her room and was seen by the pharmacy delivery person at 8:25 PM. LPN #1 called a "Code Purple" with assistance of LPN #2 and RN #1, they immediately went outside. The female nurses calmed Resident #1 down and brought her back to the facility at 8:53 PM. RN #1 performed a head-to-toe assessment and found no scratches and/or bruises. RN #2 notified the DON who notified the Administrator, the Medical Director, the State Agency, the Maintenance Supervisor, and the Responsible Representative. RN #1 immediately placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 5	F 689		

resident on 1:1 observation, complete check on all residents that they were all accounted (which they were), in-services began (review elopement policy and reminding all staff to always monitor residents), and began conducting in-services, and no employee was allowed to work unless they attended the in-services. On 10/20/21, the DON reviewed new resident/wander binder that is located centrally at Unit A and Unit B nurses' stations.

Record review of a "Timeline for (Resident #1)" completed by the DON dated 10/20/21, revealed, "writer received a call from Registered Nurse (RN) #1 on 10/19/21 at approximately 8:53 PM, stating, "that Resident #1 had gotten out of the facility by removing the screen from her window and was found down from the facility toward the red light. This occurred at approximately 8:45 PM, writer instructed RN #1 to initiate an in-service on elopement and always monitoring the residents where-abouts. Assessment of all residents were done for elopement. When writer received the call, Resident #1 was already in facility. Writer placed resident on 1:1 constant observation, full head to toe assessment was done, family was notified (10/19/21). Medical Director was notified on 10/19/21 at 8:56 PM, state that he would get patient a bed at senior care for Geri-psych eval. Administrator was notified on 10/19/21 at 9:04 PM of patient out of facility. Maintenance Supervisor was notified on 10/19/21 at approximately 9:15 PM of patient getting out of facility (oof) and need to check all windows. Spoke with Medical Director again at approximately 9:30 PM on 10/19/21, order given to send patient to local hospital emergency room for evaluation. Patient departed facility at approximately 10:00 PM per Ambulance in route

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 6	F 689		

to local hospital emergency room. Quality Assurance (QA) initiated on 10/20/21 in-service continued."

On 11/8/21 at 3:20 PM, in an interview with LPN #2 revealed, when he was aware Resident #1 had eloped, he immediately got into his vehicle and started driving toward the end of driveway of the facility. The resident appeared next to him, and she became agitated. Resident #1 was resisting his assistance, at that time LPN #1 and RN #1 were present and they were able to calm Resident #1. RN #1 and LPN #1 brought Resident #1 back to the facility.

On 11/8/21 at 3:45 PM, in an interview with RN #1, she stated when she was made aware Resident #1 had eloped, both LPN #1 and herself immediately went outside of facility. They noticed Resident #1 was on Proper Street Name #1 and Proper Street Name #2 intersection, and they were able to calm Resident #1 and bring her back to the facility. Upon bringing her to the facility, they immediately performed a head-to-toe body audit and found no signs of bruising and/or scratches noted on her body. The DON was notified of the elopement.

On 11/8/21 at 4:30 PM, the SA walked throughout the facility and observed no residents 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 evening care. SA observed call lights being answered and there were no foul odors. Signs were noted on both sides of the front door reminding staff not to allow residents to exit the doors unattended.

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	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 7	F 689		

On 11/8/21 at 8:30 PM, the SA drove to the intersection at Proper Street Name #1 and Proper Street Name #2 for 30 minutes and observed seven (7) cars pass through the intersection at intervals.

On 11/9/21 at 10:00 AM, an interview with the Maintenance Director revealed following the elopement incident, he checked all windows at the facility and placed a window stopper in each window so the windows can be opened only 6 inches. He further stated, in the event of a fire, the windows can be fully raised, but will make a loud noise when raised fully.

On 11/9/21 at 10:30 AM SA observed the Maintenance Director opening the windows at facility which only opened 6 inches. The SA observed 12 exterior doors at the facility and all were locked.

On 11/9/21 at 11:00 AM, in an interview with DON, she stated when a resident is missing, the facility calls a "Code Purple". She also stated the facility performed Code Purple drills quarterly, with the last two drills being conducted on 4/30/21 and 9/29/21. The "Code Purple" drills are located in the "Logbook Documentation". The DON confirmed Resident #1 was wearing a long sleeve shirt, pants (regular clothes not sleepers) and shoes. She also stated the weather outside on 10/19/21 was warm that night. The SA verified the weather report was correct at https://www.timeanddate.com.

On 11/9/21 at 12:40 PM in an interview with LPN #1, she revealed on 10/19/21 at approximately 7:00 PM, she saw Resident #1 sitting in a chair in her room and there was no indication of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 8	F 689		

behavior issues and the resident was calm. LPN #1 stated at approximately 8:20 PM, Resident #1 was noted to be in her room. At 8:45 PM, LPN #1 stated she entered Resident #1's room and she was not in the room. After searching the room, she observed Resident #1's window was open with there was no screen. She immediately called a "Code Purple" in facility, then LPN #2, RN #1, and herself ran out of the facility to search outside. They saw Resident #1 immediately on Proper Street Name #1 ambulating to Proper Street Name #2. They were able to calm the resident and bring her back to the facility. LPN #1 stated she and RN #1 performed a head-to-toe assessment and saw no bruising and/or scratches on Resident #1.

On 11/10/21 at 9:56 AM, in a telephone interview with the previous Administrator who was the Administrator at the time of the event revealed the resident had a psychotic episode and staff acted well and there was no harm to the resident.

On 11/10/21 at 4:45 PM, in an interview with the facility Security Guard revealed he saw and watched the resident outside for about 10 minutes on 10/19/21 around 8:30 PM but did not realize she was a resident at the facility, until staff ran outside in search of the resident.

Record review of Quality Assurance (QA) sign-in sheet revealed department heads and the Medical Director were in attendance for the Quality Assurance and Performance Improvement (QAPI) meeting on 10/21/21 at 4:00 PM.

Record review of "Logbook Documentation ... Emergency Preparedness Drills: Conduct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 9	F 689		

elopement drill (Missing Resident Drill)" which is also known as "Code Purple" drills dated 4/30/21 revealed an elopement drill was conducted by Maintenance Director #2. Record review of "Logbook Documentation ... Emergency Preparedness Drills: Conduct elopement drill (Missing Resident Drill)" dated 9/29/21 revealed an elopement drill was conducted by Maintenance Director #1.

Record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 10/14/21, with diagnoses including Alzheimer's Disease, Essential Hypertension, Unsteadiness on Feet, and Cognitive Communication Deficit.

Record review of Resident #1's "Baseline Care Plan 2" (page 8 of 10) dated 10/14/21 revealed, "C. Social Services ...3. Behavioral Concerns wandering, and psychosis related to Alzheimer's" revealed a baseline care plan was initiated when Resident #1 was admitted and there was a concern for wandering.

Record review of Resident #1's "(NSG)Wandering Risk Screen" with an effective date of 10/15/21, completed by the Minimum Data Set (MDS) Coordinator revealed Resident #1 received a score of "5" which indicates "Category: Moderate Risk for Wandering". The "(NSG) Wandering Risk Screen" was completed as "A. Orientation ...3. Forgetful/short attention span ... C. Recent Experiences ...3. Admission in the last month, D. Mobility ... (2) Independent (no assist) ... E. Diagnoses ...2. Alzheimer's disease F. Medications ...2. Taking antidepressants ..."

Record review of Resident #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

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F 689	Continued From page 10	F 689		

"COMS-Elopement Evaluation-V 2.1" dated 10/14/21, completed by the DON revealed, "Score N/A" which meant resident was not at risk for elopement.

Record review of Resident #1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/20/21 indicated a Brief Interview for Mental Status (BIMS) summary score of 06, which indicated Resident #1 had severe cognitive impairment.

Record review of Resident #1's Care Plan with a date initiated as 10/14/21, revealed a "Focus" as "Resident is at risk for wandering related to she has diagnosis of Alzheimer's and is ambulatory." "Interventions" include "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book. Identify pattern of wandering, is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? And Intervene as appropriate."

Record review of Resident #1's Progress Note dated 10/19/21 (page 2) signed by LPN #1, revealed, " ...at approximately 2045 I was administering medication to residents and noticed Resident #1 was not in her room. I then looked in bathroom and under both beds, noticed residents room window was up/open. Then alerted charge nurse RN #1 of resident's elopement. Nursing staff (LPN #2 and RN #1) and myself then proceeded to exit the building and upon arriving outside resident was seen standing down the street on the corner." " ...Resident calmed down and began to walk back to facility with me." " ...Resident was escorted back into facility and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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) COMPLETION DATE
F 689	Continued From page 11	F 689		

placed at nurses' station. No visible wounds or scars noted."

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 11/8/21:

11/10/21 1100 a.m.
Corrective Action Plan
1. On 10/19/2021, at approximately 8:45p.m., Resident #1, exited from the facility unassisted through her window. Resident #1 was assessed by Registered Nurse (RN) #1 had no injuries. She was placed on 1:1 constant observation on 10/19/21 at approximately 8:50 p.m. until she departed the facility at 10:15 p.m. 10/19/21. Through Quality Assurance (QA) the facility was able to determine how the resident exited the facility. The facility reviewed the elopement/wander/missing person standard, and in-service staff License Practical Nurse (LPN) #1, LPN #2, Certified Nurse Assistants (CNA) on elopement/wandering and monitoring residents where-abouts, also held a QA meeting 10/20/21 at 10:30a.m. The facility maintenance director inspected all windows and installed window stops to allow windows to lift/open 6 inches. Based on these steps, the facility determined that the immediate jeopardy was removed and represents past non-compliance. This event was reported to the State Agency via the hot line on 10/19/21 at approximately 9:36p.m. An elopement drill was done on 10/21/21 with all staff and no issues identified.

2. On 10/19/21 at approximately 8:45PM LPN #1 alerted RN #1 and LPN #2 of being unable to locate Resident #1 in her room and saw window open. Approximately 8: 50 PM Resident #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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

located outside on facility property approximately 120 feet from the facility entrance. Resident #1 was safely returned to the facility by LPN #1 unharmed and in no distress. At 8: 53 PM on 10/19/21 Director of Nurses (DON) was notified. On 10/19/21 at approximately 8:56 PM Medical Director, Administrator, responsible party and maintenance Supervisor were notified.

3. On 10/19/21 at 8:50 PM Resident #1 was located on the facility property and returned safely to facility. RN #1 performed a head-to-toe physical assessment on Resident #1 and found no scratches, bruises, edematous areas, or any abnormalities on 10/19/21 at approximately 8:55p.m. RN #1 and LPN #1 completed a 100% head count of all residents, and all residents were accounted for.

4. On 10/19/21 at approximately 8:53 PM Resident #1 was placed on 1:1 constant observation until she departed the facility at 10:15 PM in route to local hospital Emergency Room for evaluation. Resident #1 was admitted to the Geri-psych unit. On 10/20/21 all wandering/elopement risk assessments were audited by the DON on all residents with no newly found elopement or wander risks.

5. On 10/20/21 the risk wandering binder was reviewed by the Director of Nurses and returned to unit A and unit B. The facility has one wander/elopement risk resident in facility with care plan updated to check and lay eyes on resident every 2 hours.

6. On 10/20/21 at 10:00 AM Maintenance Director installed window stops to all resident windows. On 10/20/21 10:30 AM the event was

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	255326	A. BUILDING _____ B. WING _____	C 11/10/2021

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F 689	Continued From page 13	F 689		

reviewed and discussed in Quality Assurance Performance Improvement meeting attended by the Administrator via phone, Director of Nursing, Medical records nurse, Medical Director by phone, Minimum Data Set nurse, Maintenance Supervisor, and Social Service. Based on the meeting, it was determined that no changes were warranted to the elopement/wander/missing person standard.

7. On 10/19/21 following the incident, an in-service began on the facility standard for elopement/wandering/missing person and monitoring patients where-abouts at all times, present was 1 RN, 2 LPN, and 5 CNA. On 10/20/21 in-service continued, approximately 13 LPN's, 3 RN's, 14 CNA, 4 dietary, 4 housekeeping, 4 therapy, 3 maintenance and 1 social worker attended. On 10/21/21 in-service continued, 3 LPN's, 8 CNA's, 2 laundry and 3 dietary staff attended. No staff was allowed to work until in-services were completed.

Based on the steps initiated by the facility for this event, the facility alleges that the Immediate Jeopardy was removed as of 10/22/21 and represents past non-compliance since all measures were completed prior to complaint survey entrance.

VALIDATION

The SA validated through record review and interviews that the facility discussed Resident #1 incident of elopement from the facility an emergency QA and Performance Improvement (QAPI) meeting on 10/20/21. The actions taken

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F 689	Continued From page 14	F 689		

to ensure the provision of adequate supervision to meet Resident #1 needs were verified with evidenced by verification of the in-services, re-assessments, elopement drills, and audit tools.

The SA validated through record review and interview on 10/19/2021, at approximately 8:45p.m., Resident #1, exited from the facility unassisted through her window. Resident #1 was assessed by Registered Nurse (RN) #1 had no injuries. She was placed on 1:1 constant observation on 10/19/21 at approximately 8:50 p.m. until she departed the facility at 10:15 p.m. 10/19/21. Through Quality Assurance (QA) the facility was able to determine how the resident exited the facility. The facility reviewed the elopement/wander/missing person standard, and in-service staff License Practical Nurse (LPN) #1, LPN #2, Certified Nurse Assistants (CNA) on elopement/wandering and monitoring residents where-abouts, also held a QA meeting 10/20/21 at 10:30a.m. The facility maintenance director inspected all windows and installed window stops to allow windows to lift/open 6 inches. Based on these steps, the facility determined that the immediate jeopardy was removed and represents past non-compliance. This event was reported to the State Agency via the hot line on 10/19/21 at approximately 9:36 p.m.

The SA validated through record review and interview that on 10/19/21 at 8:50 PM Resident #1 was located on the facility property and returned safely to facility. RN #1 performed a head-to-toe physical assessment on Resident #1 and found no scratches, bruises, edematous areas, or any abnormalities on 10/19/21 at approximately 8:55p.m. RN #1 and LPN #1 completed a 100% head count of all residents,

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F 689	Continued From page 15	F 689		

and all residents were accounted for.

The SA validated through record review and interview on 10/19/21 at approximately 8:53 PM Resident #1 was placed on 1:1 constant observation until she departed the facility at 10:15 PM in route to local hospital Emergency Room for evaluation. Resident #1 was admitted to the Geri-psych unit. On 10/20/21 all wandering/elopement risk assessments were audited by the DON on all residents with no newly found elopement or wander risks.

The SA validated through record review and interview on 10/20/21 the risk wandering binder was reviewed by the Director of Nurses and returned to unit A and unit B. The facility has one wander/elopement risk resident in facility with care plan updated to check and lay eyes on resident every 2 hours.

The SA validated through record review and interview on 10/20/21 at 10:00 AM Maintenance Director installed window stops to all resident windows. On 10/20/21 10:30 AM the event was reviewed and discussed in Quality Assurance Performance Improvement meeting attended by the Administrator via phone, Director of Nursing, Medical records nurse, Medical Director by phone, Minimum Data Set nurse, Maintenance Supervisor, and Social Service. Based on the meeting, it was determined that no changes were warranted to the elopement/wander/missing person standard.

The SA validated through record review and on 10/19/21 following the incident, an in-service always began on the facility standard for elopement/wandering/missing person and

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F 689	Continued From page 16 monitoring patients where-abouts, present was 1 RN, 2 LPN, and 5 CNA. On 10/20/21 in-service continued, approximately 13 LPN's, 3 RN's, 14 CNA, 4 dietaries, 4 housekeeping, 4 therapy, 3 maintenance and 1 social worker attended. On 10/21/21 in-service continued, 3 LPN's, 8 CNA's, 2 laundry and 3 dietary staff attended. No staff was allowed to work until in-services were completed.	F 689		