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F 000	INITIAL COMMENTS The State Agency (SA) conducted three complaint investigations (CI MS #17819, CI MS #17826, CI MS #17827) from 6/7/21 through 6/10/21. As a result of the complaint investigations, the facility is not in compliance. CI MS #17826 was substaniated with deficiences cited related to elopement, when the facility failed to provide adequate staff supervision to prevent Resident #3's elopement from the facility on 5/22/21. Resident #3 was last seen on 5/22/21 at 8:00 PM, by Certified Nursing Assistant (CNA) #1. Resident #3 was found at 10:06 PM. Resident #3 was gone for 92 minutes CNA #1 and CNA #2 found Resident #3 unsupervised in a parked vehicle in a driveway trying to crank it. The vehicle was located on a street behind the facility. They assisted Resident #3 out of the vehicle and back to the facility. Licensed Practical Nurse (LPN) #4 assessed Resident #3 for any signs and symptoms of injury and pain. Resident#3 was found to have a small red area on her back. The facility investigation revealed Resident #3 exited the facility through an exit door on the 600 Hall. Resident #3 was identified as a wanderer during admission screening on 2/21/21. CI MS #17819 and CI MS #17827 were unsubstaniated related to Abuse. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 6/8/21, which occurred on 5/22/21 and existed at 42 CFR(s): 483.25(d)(1)(2)-Free of Accident Hazard/Supervision/Devices. The facility's failure to provide adequate supervision to prevent an elopement for Resident #3, who was an elopement and wander risk,	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2021

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F 000	Continued From page 1 allowed the resident to leave the facility, unnoticed and unsupervised until CNA #1 and #2 found Resident #3 one street over from the facility in a parked vehicle trying to crank it. The keys were not in the vehicle. The situation placed Resident #3 and other residents with wandering behavior and at risk of elopement at risk to likely cause serious injury, harm, impairment, or death. Based on the facility's implementation of corrective actions on 05/22/21 through 05/23/21, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 5/24/21, prior to the SA's first entrance on 6/7/21 at 4:45 PM. At the time of the survey, the facility had a census of 90 and held a license for 110 beds.	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 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 the complaint investigation (CI MS #17826) from 6/7/21 through 6/10/21 and substantiated CI MS #17826 related to elopement, when the facility failed to provide adequate staff supervision to prevent Resident #3's elopement from the facility on 5/22/21. Resident #3 was last seen at 8:00 PM and found	F 689	Past noncompliance: no plan of correction required.	6/24/21

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at 10:06 PM. Resident #3 was missing unsupervised and away from the facility for approximately ninety-two minutes. The facility was not aware of Resident #3's absence until they made rounds and the resident was not in the building. Certified Nurse Assistant (CNA) #1 and CNA #2 went to look for Resident #3 and found her in a parked car. Resident was trying to crank car. Resident #3 was found one street over behind the facility. Resident #3 was returned to the facility by CNA #1 and CNA #2 Resident #3 was assessed by LPN #2 for any signs and symptoms of injury and pain. Resident #3 was found to have a small, reddened area on her back. The facility's immediate investigation revealed Resident #3 exited through the exit door on the 600 Hall when the door opened after being pressed down on 10 seconds. Resident #3 was immediately placed on one on one (1:1) supervision after she was returned to the facility at 10:06 PM.

During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 6/8/21 which occurred on 5/22/21 and existed at: CFR(s): 483.25 (d)(1)(2)- Free of Accident Hazards/Supervision/Devices (F689) Scope and Severity - "J".

The facility's failure to provide adequate supervision to prevent an elopement for Resident #3 who was an elopement and wander risk, allowed the resident to leave the facility, unnoticed and unsupervised until CNA #1 and CNA #2 found the resident sitting in a parked vehicle in a nearby neighborhood, trying to start the vehicle. This situation caused the likelihood for serious injury, harm impairment or death for Resident #3 and other residents with wandering

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behaviors and at risk of elopement.

The SA notified the facility's Administrator of the PNC IJ and SQC on 6/8/21 at 4:45PM.

Based on the facility's implementation of corrective actions on 5/22/21, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 5/24/21, prior to the SA's first entrance on 6/7/21.

Based on staff interviews, record review, facility investigation review and facility policy review, the facility failed to provide adequate staff supervision to prevent Resident #3's elopement from the facility on 5/22/21 after 8:30 PM. The facility staff did not know Resident #3 was off the facility grounds until they could not locate her in the facility at 8:30 PM. CNA #1 and CNA #2 found Resident #3 in a parked car on a nearby street. This concern was identified for one (1) of eight (8) residents reviewed for wandering behavior and risk for elopement.

Findings include:

The facility's policy," Wandering/Missing Residents", dated 11/2019, revealed it is the policy of this Center to ensure the safety and well-being of each resident within the environment of the Center while meeting their needs and sustaining a quality of life they can enjoy.

On 6/8/21 at 11:35 AM, in an interview with Registered Nurse (RN) #2/ Risk Management stated, we have two (2) residents that wander, Resident #3 and Resident #6. CNA #1 heard the exit door on the 600-Hall alarm go off at 8:00 PM.

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CNA #1 saw Resident #6 at the door. CNA #1 redirected Resident #6 away from the door. CNA #1 noticed 30 minutes later that Resident #3 was not in the building. Resident #3 was found one street behind the facility in a driveway. Resident #3 was missing for over one hour. Staff left in cars looking for Resident #3. CNA #1 and CNA #2 found Resident #3 in a vehicle in a driveway trying to start the vehicle. The police were called.

On 6/8/21 at 1:08 PM, in an interview with the Administrator, stated we had 2 wandering residents that would go to exit doors. Residents #3 and #6 were together often. CNA #1 heard the alarm go off. CNA #1 went to the exit door on the 600 Hall and found Resident #6 at the exit door. CNA #1 redirected Resident #6 back to her room and 20 minutes later she noticed that Resident #3 was missing. Resident #3 was found one street over in a vehicle. Resident #3 was brought back to the facility by CNA #1 and CNA #2. Licensed Practical Nurse (LPN) #2 did a full body audit. Resident #3 was not in distress. She stated it was reported to the SA within two (2) hours.

A review of the facility's investigation report revealed they immediately completed a count of all residents to ensure that all residents were accounted for. The staff checked all doors. The facility investigation revealed Resident #3 exited through the exit door on hall 600, when the alarm went off. The facility does not utilize wander guard. The facility staff began to search for Resident #3 inside and outside the facility at 9:00 PM. At 9:15 PM LPN #2 notified the Director of Nursing (DON) and search continued of the facility grounds. At 10:02 PM, CNA #1 and CNA #2 were searching the neighborhood one street over and directly behind the center when they

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saw the headlights of a vehicle flashing and heard the car alarm sound. The CNAs immediately went to the vehicle and found Resident #3 trying to crank the car. Resident #3 stated she was trying to go to her appointment. The Resident was directed out of the vehicle and back to the facility. One on one was initiated with Resident #3. At 10:30 PM all exterior doors were checked, and codes were changed. The north courtyard gate was secured. At 11:00 PM in-services were done on elopement. wandering screening was done, care plan was updated, and staff interviewed. On 5/23/21 at 9:00 AM, wandering risk assessments were completed and wandering pictures and list updated and placed at each nursing station and ancillary department. At 10:00 AM, stop alarms were added to two (2) exterior doors and new locks placed on courtyard gates.

During an interview with the RN #2/Risk Manager on 6/9/2021 at 11:35 AM, she stated when a resident is identified as a risk for wandering/elopement, the staff follows the interventions on the person-centered Comprehensive Care Plan. She stated the Comprehensive Care Plan is changed and updated as needed. RN#2/ Risk Manager clarified the door alarm sounding was the keypad alarm located to the right of the 600 Hall door.

On 6/9/2021 at 11:44 AM, in an interview and observation, the Director of Operations (DOO) demonstrated the use and function of the stop sign alarms placed on the exterior doors and demonstrated the doors will not open when the push bar across the center of the door is pushed. The Director of Operations stated prior to the elopement, the doors would open after 10

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seconds whenever the push bar of the door was leaned on or pushed on. The SA observed the stop sign alarm located near the top of the doors on both exterior doors of Hall 600. The DOO opened the door on Hall 600 leading to the interior courtyard and activated the alarm which makes a loud noise. The SA noted staff responding to the alarm during the demonstration.

On 6/9/2021 at 11:45 AM, the State Agency (SA), Director of Operations, Administrator, Director of Nursing, and Risk Manager left the facility from the 600 Hall exit door into the fenced exterior yard. SA observed three gates in this area which are secured with a screw-type latch. Gate #1 exits into a wet grassy area with no exterior lighting. The Administrator states this area is always wet due to drainage from the washing machine. SA noted puddled water and wet grass from the facility to the exterior fence in this area. Gate #2 is located between Gates #1 and #3 and does not have a sidewalk access. Gate #2 also exits into a grassy, wooded area where there is no direct exterior lighting. The wooded area is dense with tall underbrush and fences from residential homes located on the back of the property which would prevent the resident from entering the neighborhood from this area. Gate #3 has a sidewalk access with a security light directly above the gate. The gate opens onto a paved street (not a through-street) that turns into a parking lot for surrounding medical offices. The paved area continues by a fenced and gated children's park with playground equipment. The gates to the park are pull latch gates and exits onto a residential street which is near where the resident was located. This street can also be accessed by continuing straight through the

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hospital parking lot and onto a residential street that loops back toward the houses behind the facility where the resident was located. The SA observed two vehicles traveling on the roadway during the tour. The ground is even, except for sidewalk curbs which have small inclines. The lighting is adequate with streetlights and motion sensor lights attached to medical/office buildings and the hospital. The resident was located 720 feet from the exit door of the facility inside a vehicle at a residential home.

A record review of the weather on 5/22/2021 between 8:00 PM. and 10:00 PM. revealed the temperature was 73 degrees, 0% precipitation, and winds at 7-8 mph.

On 6/9/2021 at 2:15 PM, the SA conducted a telephone interview with LPN #2. LPN #2 stated she was not sure of the exact time she last saw Resident #3 because she was not assigned to her, but she believed it was approximately 8:15 p.m. LPN #2 stated she heard a door alarm sounding earlier in the shift around 6:00 PM and noted Resident #6 standing at the exit door on 600 Hall that exits to the interior courtyard. LPN #2 stated she looked outside and turned the door alarm off. The LPN stated she did not hear the door alarm go off later in the evening. LPN #2 stated when she was alerted that Resident #3 was missing, she helped search for her. LPN #2 stated she attended an in-service the night of the elopement 5/22/21 on the elopement process and what to do if a resident is missing. LPN stated she saw Resident #3 when she came back to the facilities and did not notice any scratches or injuries. LPN #2 stated resident was placed on one-on-one monitoring.

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In the telephone interview with CNA #1 on 6/9/21 at 5:00 PM, she stated Resident #3 was assigned to her on the night of the elopement CNA #1 stated the last time she saw Resident #3 was before her final rounds before 9:00 PM. CNA stated she heard an alarm sounding at approximately 8:50 PM and saw Resident #6 at the door trying to get out. The CNA stated she was attempting to redirect Resident #6 and did not look outside the door. CNA #1 stated she started doing her rounds and when she got to Resident #3's room, she noted the resident was not in her room and she started looking for her. CNA #1 stated she notified the nurse and they started doing the protocol. The CNA stated she kept looking for Resident #3 and went outside to try to find her. CNA #1 stated she and another staff member walked down the street into the neighborhood behind the facility and noticed a car alarm going off and noted Resident #3 sitting in the car. The CNA stated Resident #3 was wearing gripper socks that were not wet and slightly dirty. The CNA stated Resident #3 did not have any scratches or bruises. CNA stated she received an in-service that night on elopement and wandering and attending an emergency elopement drill a couple of days after the elopement. CNA stated that residents with wandering behaviors are tagged on the charts and if a resident is identified as a wanderer, she tries to lay eyes on them at least every 30 minutes.

In the telephone interview with CNA #2 on 6/9/21 at 4:40 PM, stated she was working on the 500 Hall the night of the elopement. CNA stated she did not hear an alarm sounding, but she saw a staff member through a window walking around outside. CNA #2 went outside and was informed

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that a resident was missing. CNA stated she assisted with searching for the resident inside and outside of the facility. CNA stated she was walking through a neighborhood behind the facility and did not see resident. CNA stated she walked the neighborhood behind the facility next to the hospital and saw some flashing lights that looked like hazard lights from a vehicle. CNA stated she found Resident #3 sitting in a vehicle about a block away from the facility. CNA stated the resident was not wearing shoes and her socks were dirty but were not wet and she did not see any cuts or bruises on Resident #3. CNA stated they had in services on abuse, neglect, and wandering residents before and after the elopement occurred and Code Silver is paged overhead. CNA also stated that pictures of residents identified as wanders are posted behind the nurse's station, in the office, and by all the doors.

On 6/9/21 at 5:40 PM, in an interview with CNA #3 stated she was in-serviced on wandering residents a couple of weeks ago. CNA directed SA to area behind the nurses' station and in the chart room where pictures of wandering residents are displayed. SA observed laminated posters with 9 photos of residents with pictures, names, and room numbers.

On 6/9/21 at 5:45 PM, SA observed Resident #3 sitting in a bedside chair in her room. Resident was noted to be dressed in pants and a shirt and well groomed. Resident #3's meal tray was in front of her on an overbed table. Resident #3 noted to be smiling and friendly and invited SA to sit and visit. The resident was able to recall her name but could not give the date or time as she stated her meal tray was her breakfast. The SA

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attempted to interview the resident; however, she was unable to recall or give any details related to the elopement.

A record of the Resident #3 Face Sheet revealed resident was admitted 2/21/2021 with a diagnosis of Alzheimer's Disease.

A record review of Resident #3 Wandering Risk Observation dated 2/22/21 revealed resident was admitted as a wanderer on admission.

A record review of Resident #3's Admission Minimum Data Set (MDS) with an Assessment Record Date (ARD of 3/06/21, Section C revealed a Brief Interview for Mental Status (BIMS) score of six (06), indicating severely impaired cognitive status and section I revealed a diagnosis of Alzheimer's.

A record review of the Comprehensive Care Plan dated 2/21/21, revealed Resident #3 is at risk for attempting to leave the facility without supervision related to periods of confusion due to Dementia.

A record review of the nurse's progress notes dated 3/17/21, revealed Resident #3 was wandering throughout the night in other residents' rooms. Nurses Progress Note dated 4/7/21 at 6:09 PM revealed resident was walking the length of the 100, 200, and 600 halls. Nurse Progress Notes dated 4/16/21 at 7:45 PM, revealed Resident #3 was walking down the 100 and 600 halls and required constant redirection by staff. A record review of nurses' progress notes dated 4/23/21 at 6:57PM revealed Resident #3 was wandering the halls.

Record review revealed an Elopement Drill was

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held on 6/8/21 at 5:47 PM.

The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/ Corrective Actions, prior to the SA entrance on 6/7/21.

In response to the Past Non-compliance IJ and SQC cited at 4:45 PM on 6/7/21, the facility submitted a summary of the event, including an IJ Removal Plan and Correction Actions, taken by the facility to remove the IJ.

Brief Summary of Events: On 6/8/21 at 4:45 PM, SA notified facility Administrator of Immediate Jeopardy (IJ) existed at Past Noncompliance and Substandard Quality of Care. On 5/22/21 Resident #3 was missing and could not be located on the facility grounds. Staff immediately began to look for Resident #3. Resident #3 was found in a nearby neighborhood in a park vehicle trying to start it. CNA #1 and CNA #2 found resident and returned the resident to the facility.

Corrective Action Plan/Removal Plan

1. On May 22, 2021, at approximately 8:30 p.m. , Resident #3 exited the center while unsupervised. The unsupervised Resident leaving the facility represented an Immediate Jeopardy. The Resident was assessed and had no injuries and was placed on one-on-one supervision upon returning to the center. Through root cause analysis, the facility determined how the Resident was able to leave unsupervised. The facility reviewed their wandering/missing resident policy, educated staff on the wandering/missing resident policy, and held a quality assurance meeting. In addition to the existing wandering/missing

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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
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resident policy, the facility also removed the delayed egress from three exit doors, including the door the Resident #3 exited through. (Please note that every exit door unlocks in the event that the fire monitoring system alarms.) Based on the steps the facility initiated and completed, the facility contends that the Immediate Jeopardy was removed and represents past noncompliance. This event was reported to Licensure and Certification/Mississippi State Department of Health via phone on May 22, 2021, at 11:11 p.m.

2. On May 22, 2021, at 9:15 p.m., Registered Nurse (RN) #2, was notified that Resident #3 could not be accounted for. At 9:25 p.m., on May 22, 2021, Administrator, Director of Operations, and Nurse Consultant were notified. At 9:27 p.m., on May 22, 2021, Local Police were notified and in route to center. At 9:30 p.m, on May 22, 2021, Medical Director notified that Resident #3 had exited center and police were in route. At 9:32 p.m., on May 22, 2021, Responsible Party notified. At 10:02p.m., on May 22, 2021, Resident was located 720 feet from the center and safely returned to the center.

3. On May 22, 2021, at 10:02 p.m. Resident #3 was located and returned to center. Once Resident #3 was back inside center, Licensed Practical Nurse #3, completed head to toe body audit, noting small red area to lower back which was attributed to a recent fall and not a result of the elopement. Licensed Practical Nurse #4, completed head count of all Residents and all were accounted for. On May 22, 2021, at 10:15 p.m., Maintenance Director performed checks on all exterior doors and windows. His findings determined all doors were locked and alarms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. BUILDING _____ B. WING _____	C 06/10/2021

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were functioning properly. Windows were all shut, and door keypad codes were changed. At 10:30 p.m., on May 22, 2021, one-on-one observation began with Resident #3.

4. At 11:00 p.m., on May 22, 2021, wander risk observation was completed, care plan updated, and laboratory tests [urinalysis (UA), complete blood count (CBC), and complete metabolic panel (CMP)] ordered and completed. On May 23, 2021, at 9:00a.m., wandering risk observations completed on all Residents, with no newly identified resident wandering risk. Resident wandering risk list located at nurse's stations and each ancillary department were updated.

5. On May 24, 2021, at 9:00 a.m., several foot rounds, around the center, were made to determine Resident's path. At 10:00 a.m., on May 24, 2021, Maintenance Director and Regional Maintenance Director completed removal of egress from three (3) exterior doors, exit stopper alarms were added to two (2) exterior doors, and new latches were added to the North courtyard gates. On May 24, 2021, at 11;00 a.m., the incident was taken to a quality assurance performance improvement at an ad hoc meeting, attended by, Administrator, Risk Manager, Infection Preventionist, Medical Director via phone, Director of Nursing, Director of Dietary Services, Social Services, Director of Admissions, Maintenance Director, Assistant Director of Nursing, minimum data set nurses (MDS)Registered Nurse (RN) #3, and minimum data set nurses (MDS) Registered Nurse (RN) #4, Director of Life Enrichment, and Certified Nursing Assistant. No further action needed. No changes made to policy.

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6. On May 22, 2021, in-servicing began, on Wandering/Missing Resident, Prevention of Abuse and Neglect, and door alarms policies, and included 11 certified nursing assistants, 5 licensed practical nurses, 1 hospitality aide, 1 dietary, 1 housekeeping, and 1 plant operations manager. On May 23, 2021, in-servicing included, 7 certified nursing assistants, 2 license practical nurses, 2 registered nurses, 7 dietary staff, 3 housekeeping, 2 from laundry, 1 life enrichment, and 1 screener. May 24, 2021, in-services included, 17 certified nursing assistants, 7 license practical nurses, 7 registered nurses, 8 patient care assistants, 5 dietary staff, 5 housekeeping, 2 from laundry, 4 life enrichment, 3 plant operations, 7 administrative, 1 scheduler, and 3 therapists. As of May 24, 2021, no one worked until this in-service had been completed.

Based on the steps the facility initiated and completed for this event, the facility alleges that the Immediate Jeopardy was removed as of May 24, 2021 and represents past noncompliance since all measures were completed prior to complaint survey entrance.

The facility corrective actions were initiated on 5/22/21. All activities to remove the IJ was initiated on 5/22/21 and completed on 5/24/21. The facility alleges the IJ was removed on 5/24/21.

The SA validated on 5/10/21, the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observations, facility records review and staff interviews.

1. The SA validated by the facility's investigation

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and interviews that on 5/22/21 Resident #3 was directed back into the facility by CNA #1 and CNA #2, from a parked vehicle in the nearby neighborhood. Resident #3 was assessed by LPN #2 and was found to have a small, reddened area on her back. Resident #3 was placed on one-on one. The facility removed the egress from the exit doors. The facility initiated an investigation.

2. The SA validated the facility's investigation on 5/22/21 through record review of the investigation report, police report and interview with the DON, Administrator, and Risk Management.

3. The SA validated by staff interviews and record reviews that a body audit for Resident #3, and head count sheets were completed for 5/22/21. Logbooks of the alarm checks and one on one-time logs for Resident #3 were verified.

4. The SA validated by reviewing all residents Wandering Observation Assessments were completed on 5/23/21. Resident #3's labs were drawn on 5/22/21 AT 11:00 PM.

5. The SA validated the facility's investigation through observations of two (2) potential pathways Resident #3 may have used to exit the facility. The SA validated through staff interview and record review the Quality Assurance Performance Improvement (QAPI) was held on 5/24/21 at 11:00 AM. SA reviewed sign in sheets for the QAPI meeting. DON and RN #2/ Risk Management confirmed they attended QAPI meeting.

6. The SA validated on 5/9/21 through 5/10/21 that staff was in-serviced on elopement, by staff interviews, and record reviews. The SA reviewed in-service sign sheets and interviewed LPN #1, LPN #2, LPN #3, CNA #1, CNA #2, CNA #3, CNA #4, CNA #5, CNA #6, Housekeeping #1, and Central Supply Coordinator #1.