STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255095	A. BUILDING _____ B. WING _____	C 04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

(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 CI MS #15810, CI MS #15851 & CI MS #15852 The State Agency (SA) conducted a complaint survey, for CI MS #15810, #15851, and #15852, at the facility from 4/22/19 to 4/23/19. The SA was not able to substantiate CI MS #15810 related to Quality of Care or CI MS #15852 related to Injury of Unkown Origin. During the survey the SA substantiated CI MS #15851 related to Resident #4 exiting the building unsupervised on 4/13/19, and determined the facility was not incompliance with the requirements of participation for Medicare and Medicaid, and cited the deficiency F689 related to CI MS #15851. The census at time of entrance was 109, and the facility had a license for 120 beds.	F 000		
F 689 SS=D	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: Based on observation, interview, record review, policy/procedure review and document review, the facility failed to ensure the South Lobby Exit Door was functioning correctly, on 4/13/19 at 3:46 PM, therefore Resident #4 was able to exit through the door after a staff member had put the code in to allow a visitor to exit. After the visitor	F 689	BY SUBMITTING THE ENCLOSED MATERIALS, WE ARE NOT ADMITTING THE TRUTH OR ACCURACY OF ANY SPECIFIC FINDINGS OR ALLEGATIONS. WE RESERVE THE RIGHT TO CONTEST THE FINDINGS OR ALLEGATIONS AS PART OF ANY	6/26/19

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

Electronically Signed | 06/13/2019

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F 689	Continued From page 1 exited Resident #4, who was assessed by the facility as an elopement risk and wore a wanderguard bracelet, was able to exit through the door without the alarm sounding, without staff awareness and unsupervised. The security system on the south lobby entrance/exit door did not function properly, therefore allowing Resident #4 to exit from the building. The elopement prevention system failed to prevent the occurrence of elopement. Resident #4 was one of one (1 of 1) residents in the facility assessed at risk for elopement. Findings include: Review of the facility's policy titled, "Elopement/Wandering-Security System, with the latest revision date of 01/17, revealed: Policy: To provide a safety system to ensure wandering residents do not wander out of the facility or in unsafe areas. To implement protective measures to help guard against a resident wandering from the facility. Residents who are mentally impaired to the point of being unable to determine when they are at risk for harm by wandering out of the facility should be placed on the Resident Security System to ensure safety. Procedure: Transmitters must be tested on at least a daily basis. Follow policy and procedure below for checking security systems. Door Checks: Will be done at least weekly by the Administrator or designee, and documented on Weekly Inspection Checklist. Bracelet Checks: Nursing is responsible to check placement of residents' bracelet every shift and record on MAR (Medication Administration Record). The transmitter function will be checked at least daily and recorded on the MAR. Review of the Intake Information, dated 4/17/19,	F 689	PROCEEDINGS AND SUBMIT THESE RESPONCES PURSUANT TO OUR REGULATORY OBLIGATION. * Upon returning to the facility, Resident #4 was assessed by the Licensed nurse at 3:57 pm on April 13, 2019. There were no adverse findings. The Maintenance Director checked proper functionality of the exit doors on April 13, 2019. All doors functioned properly, except the south unit entrance / exit door. On April 13, 2019, the Director of Nursing initiated continuous monitoring of the south lobby entrance / exit door, which ended on April 15, 2019, after repairs were made to the door. On April 13, 2019, at 5:40 pm, the Maintenance Director and the Director of Nursing check Resident #4's wander system transmitter, for placement and functionality. Resident #4's wander system transmitter was in place and working properly. As an added precaution, Resident #4's wander system transmitter was replaced on April 13, 2019, at 5:45 pm. On April 15, 2019,the electronics vendor replaced the existing wandering resident security system on the south and north entrance / exit doors. On April 15, 2019, the electronics vendor's installer trained the Maintenance Director on the functions and programing of the new wandering residents system. Beginning April 15,	

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F 689	Continued From page 2 revealed the facility reported an incident that occurred on 4/13/19. The report revealed Resident #4 was admitted to the facility on 8/22/19. On 4/13/19 at 3:47 PM, Resident #4 exited the facility through the south unit lobby entrance/exit door. At 3:46 PM, Employee #1 had entered the code to the south unit lobby door entrance/exit door to allow Visitor #1 out of the facility, and then Resident #4 approached the door, put his hand on the door and pressed on the door until it opened, and then exited the through the door. Resident #4 was wearing a wanderguard bracelet, which did not alarm at the time of his exiting through the door. At 3:48 PM, Licensed Practical Nurse (LPN) #1 goes and enters a code on the south unit lobby entrance/exit door in response to an alarm. LPN #1 looks out the door and returns to her unit. Resident #4 was seen by Visitor #2 and his wife. At 3:50 PM, Visitor #2 rung the door bell, while his wife walked with Resident #4, and when Certified Nursing Assistant (CNA) #1 answered the doorbell, Visitor #2 reported a resident was outside and his wife was walking with the resident. At 3:50 PM, CNA #1 runs down the hall calling for LPN #2 to be sure it was Resident #4 outside, and then at 3:51 PM, CNA #1 goes out the door, and runs to where Resident #4 and Visitor #2's wife were located. Review of the facility's Follow Up Investigation, dated April 15, 2019, and signed by the Administrator (ADM), revealed on 4/13/19 at 3:46 PM, Employee #1 entered the code to the south unit lobby door entrance/exit door to allow visitor #1 out of the facility. Resident #1 approaches the south unit lobby entrance/exit door at 3:47 PM, places his hand on the door and presseson the door, the door opened and Resident #4 walked	F 689	2019, the Maintenance Director trained the Registered Nurses, the Licensed Practical Nurses and the Certified Nurses Aides on the operations of the new wandering residents system. No employee was allowed to work until she or he received this training. The training of the staff was completed on April 17, 2019. Beginning on April 13, 2019, and ending on April 17,2019, the Staff Development Licensed Practical Nurse and / or the Administrator in-serviced all staff on facility policies for Elopement / Wander General Policy, Elopement. The Wandering Security System, Elopement / Wandering Residents at Risk, Wandering Residents Drill, Abuse and Neglect, the Elder Justice Act, Investigation and Reporting and Abuse / Crime Reporting. Beginning on April 22, 2019, the Maintenance Director conducts weekly test of the wandering resident security system on the entrance / exit doors. The results of these test are recorded on the "weekly inspection checklist". On April 13, 2019, at 10:00 pm, an Emergency Quality Assurance and Improvement Committee Meeting was held with the Medical Director via telephone. Included in this meeting were the Administrator, the Director of Nursing, the Quality Improvement Nurse, the Maintenance Director and the Infection Control Preventalist. **	

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F 689	Continued From page 3 out the door. At 3:48 PM, Licensed Practical Nurse (LPN) #1 goes and enters a code on the south unit lobby entrance/exit door in response to an alarm. LPN #1 looks out the door and returns to her unit. CNA #1 in response to the doorbell, goes to the south unit lobby entrance/exit door at 3:50 PM to answer the door. CNA #1 is by Visitor #2, "one of ya'lls residents is walking up the road. My wife is walking with him." CNA #1 ran down the hall calling for LPN #2 and made sure it was Resident #4 that was outside. At 3:51 PM, CNA #1 ran to the door and went out the door. CNA #1goes on foot, approximately 1/4 mile from the facility, to where Resident #4 and Visitor #2's wife were located. Resident #4 is returned to the facility at 3:57 PM in a wheelchair by the facility staff. LPN #2 notified the ADM of the incident at 3:52 PM. LPN #2 reported Resident #4's wanderguard bracelet did not alarm on the return via the south unit lobby door. LPN #2 evaluated Resident #4, and not injuries were noted. Vital signs were stable. Resident #4's Physician, Responsible Person (RP), and the Mississippi State Department of Health were all notified of the incident on 4/13/19, and the Mississippi State Attorney Generals Office was notified on 4/14/19. Further review of the Follow Up Investigation revealed: 1. All doors were checked 4/15/19, and all were functioning properly except the south lobby entrance/exit door. 2. Staff was assigned to continuously monitor entry and exit of the south lobby door. 3. Resident #4's wanderguard system was checked for placement and function, no problems noted. 4. Resident #4's wander system was replaced with a new one anyway. 5. In-Services initiated to staff: Elopement/Wandering General Policy, Elopement/Wandering Security System, Elopement/Wandering Residents at Risk,	F 689	Two Residents, at risk for wandering, have the potential to be affected by this practice. *** On April 15, 2019, the electronics vendor replaced the existing wandering resident security system on the south and north entrance / exit doors. On April 15, 2019, the electronics vendor's installer trained the Maintenance Director on the functions and programing of the new wandering residents system. Beginning April 15, 2019, the Maintenance Director trained the Registered Nurses, the Licensed Practical Nurses and the Certified Nurses Aides on the operations of the new wandering residents system. No employee was allowed to work until she or he received this training. The training of the staff was completed on April 17, 2019. On April 15, 2019, the Registered Nurse Case Manager completed an audit of elopement risk assessments for completeness and accuracy for all active residents. This audit revealed the elopement risk assessments were all complete and accurate. **** The wander system transmitters will be checked each shift for placement and daily for functionality, by the Medications Nurse that is assigned to the Resident at risk for wandering. This information is recorded on the "medication administration record".	

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F 689	Continued From page 4 Wandering Resident Drill, Abuse & Neglect, Elder Justice Act, Investigating and Reporting, Abuse/Crime Reporting and 24 hour monitoring of south unit lobby entrance/exit door, on Saturday, April 13, 2019 by Staff Development Licensed Practical Nurse. 6. Quality Assurance meeting called on 4/13/19 at 10 PM. 7. Case Management completed an audit of elopement risk assessments on 4/15/19 to ensure they were accurate and complete for all active residents. Audit revealed they were all complete and accurate. 8. All bracelets will continue to be checked every shift for placement and daily for function. Maintenance will continue to check entrance/exit doors functioning weekly. Any issues identified will be brought to the Administrator, who will refer them to the Quality Assessment and Assurance Committee. 9. Resident #4 was placed on hourly checks on 4/13/19. At 2:30 PM on 4/23/19, the Administrator displayed on the screen a copy of the video, which clearly revealed Resident #4 exit the south lobby exit door without staff, on 4/13/19 at 3:46 PM. Three (3) minutes later the video revealed a Certified Nursing Assistant (CNA) speaking to a man at the door, who was reporting that a resident was outside. The video revealed the CNA rushing out the door to get the resident four (4) minutes after he was seen exiting the door. The Administrator related that the man told them that his wife stayed with Resident #4, watching him and walking with him until he was retrieved by facility staff, two-tenth of a mile from the exit door. The video revealed Resident #4 back in the facility at 3:57 PM, eleven (11) minutes after his exit.	F 689	Beginning on April 13, 2019, and ending on April 17,2019, the Staff Development Licensed Practical Nurse and / or the Administrator in-serviced all staff on facility policies for Elopement / Wander General Policy, Elopement. The Wandering Security System, Elopement / Wandering Residents at Risk, Wandering Residents Drill, Abuse and Neglect, the Elder Justice Act, Investigation and Reporting and Abuse / Crime Reporting. Beginning on April 14, 2019, a Code "W" (elopement) Drill will be held daily on each shift for one week, then twice per month for two months and then monthly, thereafter. These drills will be recorded on the "wandering resident drill statement" form. Beginning on April 22, 2019, the Maintenance Director conducts weekly test of the wandering resident security system on the entrance / exist doors. The results of these test are recorded on the "weekly inspection checklist". The Administrator will bring the findings to the Quality Assurance and Improvement Committee, quarterly for three quarters. Additional training and / or disciplinary action will be considered as warranted. The committee consist of the Administrator, the Director of Nursing, the Medical Director, the Maintenance Director, the Registered Nurse Case Manager, the Infection Control Preventionist and a Certified Nurses Aide.	

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F 689	Continued From page 5 At 3:30 PM on 4/23/19, an interview and observations with the Maintenance Director (E1) revealed he stated that he checks all five (5) exit doors every Monday; documented as evidence. He stated that, on 4/13/19, all exit doors functioned properly except the south lobby exit door, so the Director of Nurses (DON) assigned staff to monitor the door. E1 stated that he and the DON tested Resident #4's wanderguard, and it was functioning properly. However, they did replace it with a new one "just in case". E1 stated that they conducted an emergency Quality Assurance meeting to determine if they were covering everything, and he started wandering resident drills for all staff the next day. It was noted that there were signs on the inside and inside of all exit doors, warning people to not let residents out the door. He stated that the alarm company replaced all wandering security systems on both the south and north entrances, and that he trained staff regarding the system. He referred to a memo from the equipment company. The system ensures that these doors lock when a resident with a wanderguard is near the door, and the door will not open even if the code is activated, and if someone is holding the door open, the mag lock will not lock the door, but an alarm will sound. All exit doors were observed and tested with E1, at 3:30 PM on 4/23/19. At least three (3) staff were observed checking to see why the alarm sounded within ten (10) seconds at each door. Review of the facility's In-Service records revealed the following: 4/13/19 In-Service regarding observaton of south lobby entrance door. Staff must have door in their sight at all times. Staff must get relief to go on break and leave at end of shift. 4/14/19 thru 4/20/19	F 689		

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F 689	Continued From page 6 In-serviced on Code W (Missing Resident). 4/15/19 In-serviced on operation of new patient wandering system, and operation of tester for the transmitters. Review of Resident #4's Care Plan, dated 9/3/18, revealed the Problem/Need for a security bracelet due to attempts to leave the facility without staff's knowledge. Resident ambulates freely through the facility. Approaches included: Check function of security bracelet per facility protocol; Redirect as needed; Check for proper placement of security bracelet every shift-wandering. On 4/15/19, visual checks every hour was added. Review of Resident #4's Psychiatric Evaluation, dated 10/30/18, at the (Name of Behavior Facility), revealed Resident #4 had previously resided at a group home prior to admission to the behavior facility. Resident #4 demonstrated episodes of confusion, delusional ideations, and being out of touch with reality. Resident #4 reported he had eloped from the group home. Resident #4's admitting diagnoses included Schizophrenia and Obesity. Review of Resident #4's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/21/19, revealed a BIMS score of 5, which indicated severe cognitive impairment. No behaviors were identified. Resident #4 was able to transfer and walk independently. Required supervision/set up assistance with dressing, eating, toileting and personal hygiene. His balance was steady, and there were no Range of Motion (ROM) limitations. Resident #4 did not require any mobility assistive devices. Resident #4 did not have any speech, hearing, or visual impairments.	F 689		

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F 689	Continued From page 7 Review of Resident #4's Physician's Orders revealed an order, dated 8/22/18, for proper placement check of a security bracelet every shift for wandering. Further review, revealed an order, dated 4/13/19, to check the function of wandering bracelet daily. Record review revealed documentation Resident #4's wanderguard was checked by staff every shift for placement, and daily for function, and the entrance/exit doors were checked weekly prior to the incident on 4/13/19. Review of the facility's Incident Log, from 1/23/19 to 4/22/19, revealed Resident #4 had no incidents of elopement/attempts to exit the building unsupervised. Review of an email, dated 4/16/19, from (Name of Medical Equipment Company) stated on Monday, 4/15/19 at 8:30 AM, a patient wandering was installed on the north and south entrance doors, which are single doors. These doors lock when a resident is at the door and a code will not release the mag lock. If someone is holding the door open, the mag lock cannot lock the door, but the door will alarm. Review of the facility's One On One Supervision sheets, dated from 3 PM to 11 PM shift on 4/13/19 thru 3 PM to 11 PM shift on 4/15/19, revealed staff signatures to verify they were assigned to monitor the south lobby entrance/exit door. All staff had been in serviced on unsafe wandering and elopement. On 4/23/19 at 2:00 PM and 2:20 PM,	F 689		

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F 689	Continued From page 8 observations revealed Resident #4 had a wanderguard in place, and he would not communicate with the surveyor. Interview with the Director of Nursing (DON), on 4/23/19 at 8:00 AM, revealed a form with evidence that on 4/15/19, licensed nurses had re-evaluated all one hundred seven (107) other residents in the facility. This form confirmed that there was no other resident in the facility with exit seeking behavior. Record review revealed Resident #4, date of birth 1/3/1954, was admitted by the facility, on 8/22/18, with diagnoses including Parkinson's Disease, Gastric Disorder, Schizophrenia, Anxiety, Mood Disorder and Wandering Behavior. Medications included Risperdal daily, benztropine twice a day, oxcarbazepine twice a day and trazodone daily. The Administrator submitted proof of training, copies of procedures and corrective action plans. She stated that the man and his wife were her "guardian angels" because they caught Resident #4 so quickly, and protected him from possible harm.	F 689		

MSDH - Health Facilities Licensure and Certification

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M 000	Initial Comments The State Agency (SA) conducted a complaint survey for CI MS #15810, #15851, and #15852 from 4/22/19 to 4/23/19. The SA was unable to substantiate CI MS #15810 and #15852. During the survey the SA substantiated CI MS #15851, and determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M640 related to CI MS #15851. The census at the time of entrance was 109, and the facility was certified for 120 beds.	M 000		
M 640	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 Statute is not met as evidenced by: Based on observation, interview, record review, policy/procedure review and document review, the facility failed to ensure the South Lobby Exit Door was functioning correctly, on 4/13/19 at 3:46 PM, therefore Resident #4 was able to exit through the door after a staff member had put the code in to allow a visitor to exit. After the visitor exited Resident #4, who was assessed by the facility as an elopement risk and wore a wanderguard bracelet, was able to exit through the door without the alarm sounding, without staff awareness and unsupervised. The security system on the south lobby entrance/exit door did not function properly, therefore allowing Resident #4 to exit from the building. The elopement	M 640	BY SUBMITTING THE ENCLOSED MATERIALS, WE ARE NOT ADMITTING THE TRUTH OR ACCURACY OF ANY SPECIFIC FINDINGS OR ALLEGATIONS. WE RESERVE THE RIGHT TO CONTEST THE FINDINGS OR ALLEGATIONS AS PART OF ANY PROCEEDINGS AND SUBMIT THESE RESPONCES PURSUANT TO OUR REGULATORY OBLIGATION. * Upon returning to the facility, Resident #4 was assessed by the Licensed nurse at 3:57 pm on April 13, 2019. There were no	6/26/19

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M 640	Continued From page 1 prevention system failed to prevent the occurrence of elopement. Resident #4 was one of one (1 of 1) residents in the facility assessed at risk for elopement. Findings include: Review of the facility's policy titled, "Elopement/Wandering-Security System, with the latest revision date of 01/17, revealed: Policy: To provide a safety system to ensure wandering residents do not wander out of the facility or in unsafe areas. To implement protective measures to help guard against a resident wandering from the facility. Residents who are mentally impaired to the point of being unable to determine when they are at risk for harm by wandering out of the facility should be placed on the Resident Security System to ensure safety. Procedure: Transmitters must be tested on at least a daily basis. Follow policy and procedure below for checking security systems. Door Checks: Will be done at least weekly by the Administrator or designee, and documented on Weekly Inspection Checklist. Bracelet Checks: Nursing is responsible to check placement of residents' bracelet every shift and record on MAR (Medication Administration Record). The transmitter function will be checked at least daily and recorded on the MAR. Review of the Intake Information, dated 4/17/19, revealed the facility reported an incident that occurred on 4/13/19. The report revealed Resident #4 was admitted to the facility on 8/22/19. On 4/13/19 at 3:47 PM, Resident #4 exited the facility through the south unit lobby entrance/exit door. At 3:46 PM, Employee #1 had entered the code to the south unit lobby door entrance/exit door to allow Visitor #1 out of the facility, and then Resident #4 approached the	M 640	adverse findings. The Maintenance Director checked proper functionality of the exit doors on April 13, 2019. All doors functioned properly, except the south unit entrance / exit door. On April 13, 2019, the Director of Nursing initiated continuous monitoring of the south lobby entrance / exit door, which ended on April 15, 2019, after repairs were made to the door. On April 13, 2019, at 5:40 pm, the Maintenance Director and the Director of Nursing check Resident #4's wander system transmitter, for placement and functionality. Resident #4's wander system transmitter was in place and working properly. As an added precaution, Resident #4's wander system transmitter was replaced on April 13, 2019, at 5:45 pm. On April 15, 2019,the electronics vendor replaced the existing wandering resident security system on the south and north entrance / exit doors. On April 15, 2019, the electronics vendor's installer trained the Maintenance Director on the functions and programing of the new wandering residents system. Beginning April 15, 2019, the Maintenance Director trained the Registered Nurses, the Licensed Practical Nurses and the Certified Nurses Aides on the operations of the new wandering residents system. No employee was allowed to work until she or he received this training. The training of the staff was completed on April 17, 2019.	

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M 640	Continued From page 2 door, put his hand on the door and pressed on the door until it opened, and then exited the through the door. Resident #4 was wearing a wanderguard bracelet, which did not alarm at the time of his exiting through the door. At 3:48 PM, Licensed Practical Nurse (LPN) #1 goes and enters a code on the south unit lobby entrance/exit door in response to an alarm. LPN #1 looks out the door and returns to her unit. Resident #4 was seen by Visitor #2 and his wife. At 3:50 PM, Visitor #2 rung the door bell, while his wife walked with Resident #4, and when Certified Nursing Assistant (CNA) #1 answered the doorbell, Visitor #2 reported a resident was outside and his wife was walking with the resident. At 3:50 PM, CNA #1 runs down the hall calling for LPN #2 to be sure it was Resident #4 outside, and then at 3:51 PM, CNA #1 goes out the door, and runs to where Resident #4 and Visitor #2's wife were located. Review of the facility's Follow Up Investigation, dated April 15, 2019, and signed by the Administrator (ADM), revealed on 4/13/19 at 3:46 PM, Employee #1 entered the code to the south unit lobby door entrance/exit door to allow visitor #1 out of the facility. Resident #1 approaches the south unit lobby entrance/exit door at 3:47 PM, places his hand on the door and presseson the door, the door opened and Resident #4 walked out the door. At 3:48 PM, Licensed Practical Nurse (LPN) #1 goes and enters a code on the south unit lobby entrance/exit door in response to an alarm. LPN #1 looks out the door and returns to her unit. CNA #1 in response to the doorbell, goes to the south unit lobby entrance/exit door at 3:50 PM to answer the door. CNA #1 is by Visitor #2, "one of ya'lls residents is walking up the road. My wife is walking with him." CNA #1 ran down the hall calling for LPN #2 and made sure it was	M 640	Beginning on April 13, 2019, and ending on April 17,2019, the Staff Development Licensed Practical Nurse and / or the Administrator in-serviced all staff on facility policies for Elopement / Wander General Policy, Elopement. The Wandering Security System, Elopement / Wandering Residents at Risk, Wandering Residents Drill, Abuse and Neglect, the Elder Justice Act, Investigation and Reporting and Abuse / Crime Reporting. Beginning on April 22, 2019, the Maintenance Director conducts weekly test of the wandering resident security system on the entrance / exit doors. The results of these test are recorded on the "weekly inspection checklist". On April 13, 2019, at 10:00 pm, an Emergency Quality Assurance and Improvement Committee Meeting was held with the Medical Director via telephone. Included in this meeting were the Administrator, the Director of Nursing, the Quality Improvement Nurse, the Maintenance Director and the Infection Control Preventalist. ** Two Residents, at risk for wandering, have the potential to be affected by this practice. *** On April 15, 2019, the electronics vendor replaced the existing wandering resident security system on the south and north entrance / exit doors. On April 15, 2019, the electronics vendor's installer trained	

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M 640	Continued From page 3 Resident #4 that was outside. At 3:51 PM, CNA #1 ran to the door and went out the door. CNA #1goes on foot, approximately 1/4 mile from the facility, to where Resident #4 and Visitor #2's wife were located. Resident #4 is returned to the facility at 3:57 PM in a wheelchair by the facility staff. LPN #2 notified the ADM of the incident at 3:52 PM. LPN #2 reported Resident #4's wanderguard bracelet did not alarm on the return via the south unit lobby door. LPN #2 evaluated Resident #4, and not injuries were noted. Vital signs were stable. Resident #4's Physician, Responsible Person (RP), and the Mississippi State Department of Health were all notified of the incident on 4/13/19, and the Mississippi State Attorney Generals Office was notified on 4/14/19. Further review of the Follow Up Investigation revealed: 1. All doors were checked 4/15/19, and all were functioning properly except the south lobby entrance/exit door. 2. Staff was assigned to continuously monitor entry and exit of the south lobby door. 3. Resident #4's wanderguard system was checked for placement and function, no problems noted. 4. Resident #4's wander system was replaced with a new one anyway. 5. In-Services initiated to staff: Elopement/Wandering General Policy, Elopement/Wandering Security System, Elopement/Wandering Residents at Risk, Wandering Resident Drill, Abuse & Neglect, Elder Justice Act, Investigating and Reporting, Abuse/Crime Reporting and 24 hour monitoring of south unit lobby entrance/exit door, on Saturday, April 13, 2019 by Staff Development Licensed Practical Nurse. 6. Quality Assurance meeting called on 4/13/19 at 10 PM. 7. Case Management completed an audit of elopement risk assessments on 4/15/19 to ensure they were accurate and complete for all active residents. Audit revealed they were all complete and	M 640	the Maintenance Director on the functions and programing of the new wandering residents system. Beginning April 15, 2019, the Maintenance Director trained the Registered Nurses, the Licensed Practical Nurses and the Certified Nurses Aides on the operations of the new wandering residents system. No employee was allowed to work until she or he received this training. The training of the staff was completed on April 17, 2019. On April 15, 2019, the Registered Nurse Case Manager completed an audit of elopement risk assessments for completeness and accuracy for all active residents. This audit revealed the elopement risk assessments were all complete and accurate. **** The wander system transmitters will be checked each shift for placement and daily for functionality, by the Medications Nurse that is assigned to the Resident at risk for wandering. This information is recorded on the "medication administration record". Beginning on April 13, 2019, and ending on April 17,2019, the Staff Development Licensed Practical Nurse and / or the Administrator in-serviced all staff on facility policies for Elopement / Wander General Policy, Elopement. The Wandering Security System, Elopement / Wandering Residents at Risk, Wandering Residents Drill, Abuse and Neglect, the Elder Justice Act, Investigation and Reporting and Abuse / Crime Reporting.	

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M 640	Continued From page 4 accurate. 8. All bracelets will continue to be checked every shift for placement and daily for function. Maintenance will continue to check entrance/exit doors functioning weekly. Any issues identified will be brought to the Administrator, who will refer them to the Quality Assessment and Assurance Committee. 9. Resident #4 was placed on hourly checks on 4/13/19. At 2:30 PM on 4/23/19, the Administrator displayed on the screen a copy of the video, which clearly revealed Resident #4 exit the south lobby exit door without staff, on 4/13/19 at 3:46 PM. Three (3) minutes later the video revealed a Certified Nursing Assistant (CNA) speaking to a man at the door, who was reporting that a resident was outside. The video revealed the CNA rushing out the door to get the resident four (4) minutes after he was seen exiting the door. The Administrator related that the man told them that his wife stayed with Resident #4, watching him and walking with him until he was retrieved by facility staff, two-tenth of a mile from the exit door. The video revealed Resident #4 back in the facility at 3:57 PM, eleven (11) minutes after his exit. At 3:30 PM on 4/23/19, an interview and observations with the Maintenance Director (E1) revealed he stated that he checks all five (5) exit doors every Monday; documented as evidence. He stated that, on 4/13/19, all exit doors functioned properly except the south lobby exit door, so the Director of Nurses (DON) assigned staff to monitor the door. E1 stated that he and the DON tested Resident #4's wanderguard, and it was functioning properly. However, they did replace it with a new one "just in case". E1 stated that they conducted an emergency Quality	M 640	Beginning on April 14, 2019, a Code "W" (elopement) Drill will be held daily on each shift for one week, then twice per month for two months and then monthly, thereafter. These drills will be recorded on the "wandering resident drill statement" form. Beginning on April 22, 2019, the Maintenance Director conducts weekly test of the wandering resident security system on the entrance / exist doors. The results of these test are recorded on the "weekly inspection checklist". The Administrator will bring the findings to the Quality Assurance and Improvement Committee, quarterly for three quarters. Additional training and / or disciplinary action will be considered as warranted. The committee consist of the Administrator, the Director of Nursing, the Medical Director, the Maintenance Director, the Registered Nurse Case Manager, the Infection Control Preventionist and a Certified Nurses Aide.	

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M 640	Continued From page 5 Assurance meeting to determine if they were covering everything, and he started wandering resident drills for all staff the next day. It was noted that there were signs on the inside and inside of all exit doors, warning people to not let residents out the door. He stated that the alarm company replaced all wandering security systems on both the south and north entrances, and that he trained staff regarding the system. He referred to a memo from the equipment company. The system ensures that these doors lock when a resident with a wanderguard is near the door, and the door will not open even if the code is activated, and if someone is holding the door open, the mag lock will not lock the door, but an alarm will sound. All exit doors were observed and tested with E1, at 3:30 PM on 4/23/19. At least three (3) staff were observed checking to see why the alarm sounded within ten (10) seconds at each door. Review of the facility's In-Service records revealed the following: 4/13/19 In-Service regarding observaton of south lobby entrance door. Staff must have door in their sight at all times. Staff must get relief to go on break and leave at end of shift. 4/14/19 thru 4/20/19 In-serviced on Code W (Missing Resident). 4/15/19 In-serviced on operation of new patient wandering system, and operation of tester for the transmitters. Review of Resident #4's Care Plan, dated 9/3/18, revealed the Problem/Need for a security bracelet due to attempts to leave the facility without staff's knowledge. Resident ambulates freely through the facility. Approaches included: Check function of security bracelet per facility protocol; Redirect as needed; Check for proper placement of security bracelet every shift-wandering. On	M 640		

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M 640	Continued From page 6 4/15/19, visual checks every hour was added. Review of Resident #4's Psychiatric Evaluation, dated 10/30/18, at the (Name of Behavior Facility), revealed Resident #4 had previously resided at a group home prior to admission to the behavior facility. Resident #4 demonstrated episodes of confusion, delusional ideations, and being out of touch with reality. Resident #4 reported he had eloped from the group home. Resident #4's admitting diagnoses included Schizophrenia and Obesity. Review of Resident #4's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/21/19, revealed a BIMS score of 5, which indicated severe cognitive impairment. No behaviors were identified. Resident #4 was able to transfer and walk independently. Required supervision/set up assistance with dressing, eating, toileting and personal hygiene. His balance was steady, and there were no Range of Motion (ROM) limitations. Resident #4 did not require any mobility assistive devices. Resident #4 did not have any speech, hearing, or visual impairments. Review of Resident #4's Physician's Orders revealed an order, dated 8/22/18, for proper placement check of a security bracelet every shift for wandering. Further review, revealed an order, dated 4/13/19, to check the function of wandering bracelet daily. Record review revealed documentation Resident #4's wanderguard was checked by staff every shift for placement, and daily for function, and the entrance/exit doors were checked weekly. Review of the facility's Incident Log, from 1/23/19	M 640		

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M 640	Continued From page 7 to 4/22/19, revealed Resident #4 had no incidents of elopement/attempts to exit the building unsupervised. Review of an email, dated 4/16/19, from (Name of Medical Equipment Company) stated on Monday, 4/15/19 at 8:30 AM, a patient wandering was installed on the north and south entrance doors, which are single doors. These doors lock when a resident is at the door and a code will not release the mag lock. If someone is holding the door open, the mag lock cannot lock the door, but the door will alarm. Review of the facility's One On One Supervision sheets, dated from 3 PM to 11 PM shift on 4/13/19 thru 3 PM to 11 PM shift on 4/15/19, revealed staff signatures to verify they were assigned to monitor the south lobby entrance/exit door. All staff had been in serviced on unsafe wandering and elopement. On 4/23/19 at 2:00 PM and 2:20 PM, observations revealed Resident #4 had a wanderguard in place, and he would not communicate with the surveyor. Interview with the Director of Nursing (DON), on 4/23/19 at 8:00 AM, revealed a form with evidence that on 4/15/19, licensed nurses had re-evaluated all one hundred seven (107) other residents in the facility. This form confirmed that there was no other resident in the facility with exit seeking behavior. Record review revealed Resident #4, date of birth 1/3/1954, was admitted by the facility, on 8/22/18, with diagnoses including Parkinson's Disease, Gastric Disorder, Schizophrenia, Anxiety, Mood	M 640		

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M 640	Continued From page 8 Disorder and Wandering Behavior. Medications included Risperdal daily, benztropine twice a day, oxcarbazepine twice a day and trazodone daily. The Administrator submitted proof of training, copies of procedures and corrective action plans. She stated that the man and his wife were her "guardian angels" because they caught Resident #4 so quickly, and protected him from possible harm.	M 640		