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	255158	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF HATTIESBURG	10 MEDICAL BOULEVARD HATTIESBURG, MS 39401

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F 000	INITIAL COMMENTS CI MS #14952 A complaint survey, MS#14952 was initiated on 1/14/18, but was aborted due to an influenza outbreak. Survey continued on 2/5/18 and concluded on 2/6/18. During the survey, the facility was found not to be in compliance with the Requirements for Medicare and Medicaid participation and the survey was substantiated for elopement and a deficiency was cited at F689. The census at the time of survey was 148 and the facility was licensed for 152 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: CI MS #14952 Based on observation, interview, record review, policy/procedure review and document review, the facility failed to ensure supervision to help prevent accidents for Resident #1, one (1) of five (5) residents at risk for elopement. On 12/31/17, Resident #1 left the facility without the knowledge of the facility staff. Resident #1 wore a wanderguard which did not activate after a nurse	F 689	Disclaimer: Bedford Care Center of Hattiesburg, LLC acknowledges receipt of Statement of Deficiency and proposes this plan of correction to the extent that the summary of the findings is factually correct and in order to maintain compliance with applicable rules and regulations. Please accept this plan of correction as our allegation of compliance. Bedford Care	3/13/18

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

Electronically Signed | 03/12/2018

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F 689	Continued From page 1 unlocked an exit/entry door using a remote phone system. Resident #1 held the exit/entry door open for the ambulance crew, then walked out the door unsupervised. Findings include: Review of the facility's "Elopements" policy statement, with an effective date of January 2012, revealed: "This facility will make every effort to protect the safety of all residents in the facility. Nursing personnel must report and investigate all reports of missing persons." Review of a facility handout procedure for "A Systems Approach to Resident Safety", described elopement as an occurrence when a resident leaves the premises without authorization and/or necessary supervision to do so. While alarms can help to monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision. Review of an incident report and facility investigation, dated 12/31/18, revealed Resident #1 left the facility unattended on 12/31/18 at approximately 12:08 AM, as a result of the locking mechanism on South #6 door failing to properly lock. Resident #1 was located within 30 minutes of departure and sent to the Emergency Room for evaluation of a knot on his head, and returned without new orders. Facility determined Resident #1 had no injury and placed him on enhanced supervision, disabled the remote phone system to unlock the exit door, and educated staff to use only the key pad entry system. The entry/exit sites were monitored for properly locking. Resident #1's statement was	F 689	Center of Hattiesburg, LLC response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. F689 Resident #1 was found on December 31, 2017 at approximately 12:40am and returned to the facility on December 31, 2017 at 12:46am. He was sent to the emergency room on December 31, 2017 at 1:05am for evaluation and returned with no new orders. All residents at risk for elopement have the potential to be affected by this practice. The facility disabled the remote phone system to unlock all the entry and exit doors on December 31, 2017. The Staff Development Nurse conducted an in-service on January 2, 2018 and continues to in-service all current as well as newly hired staff prior to working in the facility on proper entry and exit door locking procedures. Effective on December 31, 2017 daily entrance and exit is revised to be accessible through the front lobby entrance of the facility between the hours of 8:00am until 5:00pm with staff supervision at the main entrance and exit door 7 days per week. Daily entrance and exit after 5:00pm until 8:00am is now and will continue to be North Nurses Station Door #2. Staff is and will continue to provide entry and exit access while assuring properly locking	

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F 689	Continued From page 2 attempting to return home and that he missed his sister. Review of the facility's timeline investigation for 12/31/18, as per South Exterior Door Camera, revealed at 12:05 AM a CNA entered the door and CNA pulls the door shut behind her to verify sealed properly. At 12:11 AM the ambulance arrives and Resident #1 is observed holding the door and talking to the ambulance staff. At 12:13 AM Resident #1 closes the door and turns right to walk down the sidewalk. The South Anterior Hallway Camera revealed Resident #1 peeking out the doorway to his room several times between 12:04 AM to 12:07 AM. This camera shows the resident at 12:08 AM leaving the facility after holding the door open for the ambulance crew. At 12:17 AM the timeline documents staff looking for Resident #1 and the elopement procedure activated, with multiple staff looking for the resident. LPN #2 called the facility at 12:41 AM to report Resident #1 in her custody and he was back in the facility at 12:46 AM, per the timeline. Review of Resident #1's medical record revealed the most current assessment for elopement risk, dated 12/24/17. Physician's orders included the use of a wanderguard on 12/26/17. Physician's orders also included to visualize the resident every hour for presence. Resident #1 required supervision, but was fairly light care except for bathing and dressing. His BIMS score was 03, indicating severe impairment on 1/9/17. His care plan with a date of 8/21/17, revealed a risk for elopement related to resident ambulatory an looks like a visitor and will follow visitors out of the door. The care plan dated 12/27/17, identified at risk for elopement for 10 or greater on the	F 689	and securing the door. The Administrator checked all doors for proper operation and locking from December 31, 2017 until January 3, 2018. The Administrator in-serviced the maintenance department on January 3, 2018 for daily door checks and then in-serviced the Maintenance Director on January 8, 2018 upon his return from vacation. The facility replaced the entrance and exit doors on February 7, 2018. The Maintenance Director, Maintenance Staff or the Administrator is and will continue to complete daily door operation inspections to assure proper operation of the doors. The findings will be reported monthly to the Quality Assurance Committee by the Director of Maintenance. This will be integrated into the quality assurance system.	

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elopement evaluation, watches doors for opportunity to go out. He is ambulatory. The goal was that the resident will not exit the building, and interventions were those ordered by the physician, placing a picture in the elopement books, and to check the wanderguard for placement every shift.

Review of the Interdisciplinary Progress Note, documented by LPN #1, dated 1/1/18 at 2:47, revealed Resident #1 was discovered missing 12/31/18 at 12:20 PM. Resident was last seen approximately 12:00 MN sitting on his. North station staff recalled seeing someone fitting his description hold the door open for an ambulance crew and then walking toward the local hospital. The police and Administrator were notified and LPN #2 found Resident #1 at approximately 12:40 AM and returned to the facility. Resident assessed with two (2) lumps on the right side of the head and the resident said he'd fell in the ditch. No other injuries noted. Sent to local ER for evaluation and returned at 5:15 AM with no new orders. Resident had wandergard on his ankle but did not alarm upon exit or re-entry to the building.

Interview with the Director of Nursing (DON), on 2/5/18 at 10:35 AM, revealed that she had placed the Wanderguard bracelet on Resident #1's ankle on 12/24/17, and it was functional. The DON stated that Resident #1 had been missed within five (5) minutes and located in less than 30 minutes, on 12/31/17, with no evidence of harm. The DON stated that LPN #1 had informed her that the resident had been assessed and monitoring put in place to observe resident closely. Further interview, on 2/5/18 at 11:21 AM, revealed Resident #1's History and Physical,

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dated 2/8/17, revealed a lipoma on the same location of the current "knot on the head".

Review of a signed statement from LPN #3, dated 12/31/18, revealed that she had observed the ambulance crew arriving at the facility and saw someone holding the door for them, wearing plaid pants and a hoodie, and then closed the door and walked down the sidewalk. LPN #3 documented that she thought it was a family member and when staff came from the other unit looking for Resident #1, with a description of what he was wearing, is when she realized that was the person holding the door open and they all began to search for him.

The Administrator related on 2/5/18 at 10:40 AM, that "he's sharper than the BIMs score shows", about Resident #1's mentality. The Administrator said that Resident #1 crossed the parking lot, going toward (a discount department store) to see his sister. He stated that when he called the sister she told him Resident #1 used to walk there all the time and walk around with her. The Administrator explained there is a video that shows Resident #1 holding the door open for people to enter. He said LPN #2 saw him on a monitor, but she thought he was a visitor. The Administrator stated he saw Resident #1, when he played the video, walk out the door.

Surveyor #1 documented an observation on 1/14/18, where she arrived at the facility shortly after 12:00 MN and sat in the parking lot to observe traffic in the area of the facility during that time of night. She documented that traffic was light, only a couple of cars on the main street where the facility was located, She went to the door and spoke with a staff member who told her

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that Resident #1 had been located (12/31/17) close to (Retail Store). Surveyor #1 drove to the area and counted three (3) or four (4) cars on the major highway, and none on the frontage road the resident allegedly walked down.

The current surveyor walked and observed with the Administrator, the "suspected" route that the Administrator said he thought Resident #1 took, based on the location of the exit door and the sought-after department store. The distance was "guesstimated" as 0.4 miles with no serious hazards noted except crossing the main street, on which the facility is located, where he was found, almost on the SE corner leading to the major highway, according to the Administrator. Observation of parking lots for Doctor's offices, which would have been empty at night, but well-lighted, a few steps up from one parking lot to the next. There were hand rails for the steps. No serious hazards were observed.

Resident #1 was observed with the wanderguard in place on 2/5/18 at 3:40 PM, and on 2/6/18 at 3:30 PM. Resident #1 was observed on 2/5/18 at 3:40 PM, in the dining room sitting at a table. He was neat, clean and well-dressed. Resident #1 stated "I just found a way to go see my sister." He said he would not ever do it again. There was a wanderguard on his right ankle. On 2/6/18 at 3:30 PM, Resident #1 was again sitting in the dining room with the wanderguard in place. He remembered me from the previous day and smiling, said, "I've been real good-----I told you I wasn't gonna be bad anymore. I like it here". He seemed much more cognitive than his score indicated.

LPN #1 was interviewed by telephone on 2/6/18

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at 1:35 PM She stated that a Certified Nurse Aide (CNA) checked Resident #1's room, did not see him, searched nearby rooms then reported to the LPN. She stated that she paged the elopement code, called the police and the Administrator and they began both the in-house and outside search. She stated LPN #2 found Resident #1 and he told her he was happy to be back. She said he was wearing pajama bottoms, a t-shirt, gray sweats, socks and slip-on sandals. She said his clothing was damp because it was misting rain; that his vital signs were good and he was not cold. LPN #1 stated the resident said he fell, but no injury was noted except the knot on his head, so she sent him to the emergency room to be checked. She said she later found out the knot was an old one, and did not know if he had fallen. She said Resident #1 was back in the facility about 6:00 AM and they watched him closely until change of shift. She stated that she checked and his wanderguard was working.

Interview with the Licensed Social Worker (LSW) on 2/6/18 at 2:00 PM, revealed that the sister had been notified at the time of the elopement, and she called her again. The LSW stated that Resident #1 and the sister are twins, and they are close. She stated that the sister was not upset, she knew it could happen. The sister told the LSW that she had worked nights at this department store for over 20 years and that Resident #1 would walk there at night to see her. She said that her brother is "clever" and would find a way if he could. The LSW said Resident #1 told her when she interviewed him that he will not ever do that again. Documentation of the Social Progress Notes, dated 1/2/18 confirmed the conversation with the sister.

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On 2/6/18 at 11:20 AM, the Administrator and Maintenance Director played the video for 12/30/17-12/21/17, in his office. It showed that at 11:29 PM on 12/30/17, Resident #1 "peeked" out his bedroom door, saw a CNA and went back inside. He did this again at 11:35 PM, again at 11:45 PM, again at 11:54 PM and again on 12/31/17 at 12:04 AM. He saw staff and went back in his room. At 12:05 AM, a CNA was seen going into his room to check on him and at 12:06 AM, Resident #1 peeked out, no one else is around, and walked out of the room. The ambulance arrived at 12:06 AM, bringing a resident to the facility. The men rang the doorbell and the nurse opened the door remotely. Resident #1 was seen to hold the door open, and converse with the ambulance staff. The video showed Resident #1 leaving the doorway at 12:08 AM. A CNA is seen to enter Resident #1's room at 12:16 AM and goes into the room next door. The ambulance crew is seen leaving out the door at 12:17 AM, and a nurse was observed going out behind them. The Administrator stated that at this time, the old system apparently would not sound the alarm if the door was open, but the new one sounds if a resident with a wanderguard is within three (3) feet from an open exit door. The video was fast forwarded to the time the resident returned from the hospital at 6:12 AM. Step by step there was visualization of close monitoring by staff.

Interview with the Administrator on 2/6/18 at 11:30 AM, related that he was at the facility within about 10 minutes of being notified of Resident #1 missing. He said he sent staff out looking and they found him within less than half an hour after he left. He said he called the security company to check all exit doors, and all were operating well.

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On 2/5/18 at 1:45 PM, an interview and tour of the facility was conducted with the Maintenance Supervisor. There were records of doors being checked mornings and evenings daily. He stated that before the elopement, all doors could be activated by phone, but that method had been taken out. He stated that since the elopement, you can't get in door #6. He stated staff use door #3 before 5:00 AM, which requires two (2) key pads and after 5:00 PM., visitors use door #2. He stated that a staff member is assigned to sit at the nursing station to let them into the building, and other hours visitors use the front door, which is observed by the receptionist. He said before the elopement they used a wanderguard to check exit doors, but did not record it, but now it is recorded. He stated that there are now two (2) different wanderguard systems; a new system was purchased for all doors except those kept locked for emergency exit only, the old system is in the rehab area, and a code system must now be used to get into the Rehab area.

At 2:10 PM, on 2/5/18, door #6 (where Resident #1 left the building) was observed with the Maintenance Supervisor. There was a sign on the door advising emergency use only, the door was locked and the doorbell removed from outside. Door #5 was locked; Maintenance Supervisor said he checks it daily but no one uses it now. At 2:20 PM, on 2/5/18, a code was used to go into rehab area and door #7 was locked, not used now except in an emergency per the Maintenance Supervisor. The panic bar would not open, and was told that feature was disengaged, but would work in the event of a fire. Door #10 and door #11 were identified as emergency only,

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found locked and no longer used, per the Maintenance Supervisor. At 2:30 PM on 2/5/18, at door #12, rounds continued with the Maintenance Supervisor. A housekeeper was observed coming in the door. She stated that she used the keypad to get in. The Maintenance Supervisor stated that this door is now used only by staff, with keypads inside and out. Door #9 in Rehab led into a gated gazebo area. Therapist use this entrance with a keypad. Door #4 leads into the parking area, used by staff with a key pad. Door #3 is double doors leading into the north hallway. The Maintenance Supervisor stated they are getting a 4 foot door with skylights here. He stated that Door #2 is now used by the ambulance crew and families after 5:00 PM. This door was locked, a key pad noted, and he stated that the double doors will be replaced with a four (4) foot door with skylights. At 2:40 PM, door #1 was locked and labeled for emergency use only. There was only a keypad inside. Door #21 was the front entrance with no key pads. The Maintenance Supervisor stated that the door is kept locked except from 8:00 AM to 5:00 PM, with constantly observation by staff. All doors tested and locked, wanderguards activated at doors and no concerns were noted.

At 3:15 PM, on 2/5/18, Staff #5 stated that she watches the front door 8:00 AM - 5:00 PM, and if she needs a break, she gets other staff to watch the door. She said it is observed every minute until 5:00 PM, when it is locked.

RN #2 submitted proof of training, copies of procedures and copies of an orientation checklist which included codes for events such as tornado, elopement, bomb threat and cardiac arrest. She said she advised staff to put it behind their badge.

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When asked about the code for tornado at 3:45 PM on 2/5/18, Staff #6 pulled the code out and gave the correct response.

On 2/6/18, a tour at 8:50 AM found all residents in the sample wearing wanderguards, staff queried knew the location of each of them and door #6 and #7 were locked. At 3:00 PM on 2/6/18, the DON wheeled Resident #2 near the exit door and an alarm sounded.

Record review revealed R#1, date of birth 2/9/60, was admitted to the facility on 8/18/17, with diagnoses which included Hypertension, Diabetes Mellitus, Intellectual Disability, Osteoarthritis, and Anemia.

Review of Resident #1's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/25/17, and again on 11/19/18, revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognitive status. Review of an assessment documented 1/4/18, revealed Resident #1 scored 7 on his BIMS, which indicated moderate cognitive impairment.