MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46FM	A. BUILDING: _____ B. WING _____	C 11/24/2020

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COLUMBIA REHABILITATION AND HEALTHCARE CEI	1506 NORTH MAIN STREET COLUMBIA, MS 39429

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M 000	Initial Comments The State Agency (SA) conducted the Complaint Investigations (CI), CI #16776 and CI # 17074, on 11/23/2020 through 11/24/2020. CI #17074 was not substantiated regarding Resident # not being taken to Doctors appointments and quality of care. CI #16776 was substantiated related to an elopement, when the facility failed to provide adequate staff supervision to prevent Resident #1's elopement. On, 04/13/2020, Resident #1 was last seen by facility staff at 5:53 AM. Resident #1 eloped from the facility on 04/13/2020 from approximately 5:53 AM when he was last seen, till 7:50 AM. Resident #1 was missing, unsupervised and away from the facility for an undetermined amount of time. The last staff person to see him in the facility was a dietary staff at 5:53 AM. The facility staff was not aware of Resident #1's absence until he was discovered across the street, walking down the road by staff coming to work at 7:50 AM. Resident #1 was returned to the facility at 7:50 AM by two Certified Nurses Assistants (CNAs). Resident #1 was assessed for any signs and symptoms of injury and pain. His wander bracelet was intact and working when he was returned to the facility. The nurse's notes dated 4/13/20 at 18:12 and 7:27 AM documented "staff member witnessed resident walking down the street. Resident was soaked wet and shaking." During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 11/23/2020, which occurred on 04/13/2020 and existed at: 45.21.8, M 640, Accidents, Level IV.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/21

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M 000	Continued From page 1 The facility's failure to provide adequate supervision to prevent an elopement of Resident #1 who was an elopement and wander risk and allowed the resident to be away from the facility, unnoticed and unsupervised until an employee coming to work observed Resident #1 wandering in the street. This situation placed Resident #1 and other residents with wandering behavior and at risk of elopement and could likely cause serious injury, harm, impairment or death. Based on the facility's implementation of corrective actions on 04/13/2020, the SA determined the IJ and Substandard Quality of Care (SQC) to be Past Non-Compliance (PNC) and the IJ was removed as of 04/14/20, prior to the SA's first entrance on 11/23/2020. The SA notified the facility's Administrator of the PNC IJ and SQC on 11/23/2020 at 2:40 PM. At the time of the survey, the facility had a census of 87, and held a license of 108 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: Level 4 Based on staff interviews, record review, facility investigation review, and policy review, the facility failed to provide adequate staff supervision to prevent Resident #1's elopement from the facility	M 640	Dr. Lucius Lampton 111 Magnolia St. Magnolia, MS 39652	1/5/21

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M 640	Continued From page 2 on 4/13/20 after 5:53 AM. The facility staff were unaware Resident #1 was out of the facility until he was seen by Certified Nursing Assistant (CNA) #1 and CNA #2 coming into the building. This concern was identified for one (1) of four (4) residents reviewed for wandering behavior and risk for elopement. The State Agency (SA) conducted Complaint Investigation, CI #16776, from 11/23/2020 through 11/24/2020 and substantiated CI #16776 related to an elopement due to the facility's failure to provide adequate supervision to prevent Resident #1's elopement from the facility on 4/13/20 from approximately 5:53 AM until 7:50 AM. Resident #1 was missing, unsupervised and away from the facility for approximately two (2) hours. The facility staff was not aware of Resident #1's absence until he was discovered walking down the road by staff coming to work at 7:50 AM. Resident #1 was returned to the facility at 7:50 AM by Certified Nurse Assistant (CNA) #1 and CNA #2. Resident #1 was assessed for any signs and symptoms of injury and pain by Licensed Practical Nurse #1 with no injury identified. The CNAs found the resident soaking wet and shaking. The facility's immediate investigation concluded Resident #1 exited the facility through a side door when the door did not lock after a staff exited the door. Resident #1 was immediately placed on one on one (1:1) supervision. During the 11/23/20 survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) existed at 45.21.8, M 640, Accidents, due to facility's failure to provide adequate supervision to prevent an elopement for Resident #1. This situation caused the likelihood for serious injury, harm, impairment, or death for	M 640	Tony Hamrick- LNHA,RN	

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Resident #1 and other residents with wandering behaviors and at risk of elopement. The SA notified the facility's Administrator of the PNC IJ and SQC on 11/23/2020 at 2:40 PM.

Based on the facility's implementation of corrective actions on 04/13/2020, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 04/14/20, prior to the SA's first entrance on 11/23/2020.

Findings include:

Review of the facility's policy, "Wander Management, Monitoring System & Resident Elopement Protocol," dated 1/17/18, revealed, it is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible.

A Wandering Risk Evaluation for Resident #1 was completed on 2/14/20 and was assessed to be forgetful and disoriented times three (3), ambulates independently and has a history of wandering. The facility initially admitted Resident #1 on 6/22/2018, approximately 2 years prior to the elopement. Resident #1's diagnosis included Alzheimer's Diseases, Altered Mental Status, Dementia with Behavior Disturbance, Psychotic Disorder with Delusions and Major Depressive Disorder. Resident #1's most recent Quarterly Minimum Data Set (MDS), dated 02/23/2020, revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated severe cognitive impairment and could not be assessed.

Review of his Quarterly Minimum Data Set (MDS), dated 2/23 /20, revealed the resident requires one (1) person assistance with transfers

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and with Activities of Daily Living (ADLs) (to include bathing, eating, and dressing). Resident #1 walks in the room and in the hall independently. Resident #1's Care Plan, was created and initiated 6/28/2018, identified Resident #1 at risk for elopement related to wandering and confusion. He was care planned for staff to place a wandering device on resident as applicable, check placement every shift, check function daily, place my demographic sheet and picture in the elopement notebook, redirect resident away from doorways and engage me in diversional activities, and wander bracelet related to wandering and exit seeking behavior. Nurse to check placement and function every shift including skin check under bracelet right wrist. The checking of placement was validated on 11/23/20 on the Medication Administration Record (MAR) by the State Agency (SA).

A tour with the Maintenance Director on 11/23/20, at 7:30 AM, revealed all facility doors were locked and were functioning properly. Observation revealed a keypad on the door Resident #1 was believed to exit through on 11/23/20. The Maintenance Director confirmed an additional keypad was added to this door after the investigation of the elopement of Resident #1.

During a phone interview with the Administrator on 11/23/20 at 2:40 PM, the Administrator confirmed on 4/13/20 at 5:53 AM, Dietary Aide (DA) # 1 reported the last known visual of Resident #1, where he was observed sitting in a chair across from the front Nurses' Station. At 7:50 AM, CNA #1 and CNA #2 stepped outside of the facility into the front parking lot and observed Resident #1 across the road, adjacent from the facility. At 7:50 AM, CNA #1 and CNA #2 were witnessed by Dietary Manager (DM), escorting

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Resident #1 back into the facility. The wander bracelet was attached to the Resident # 1's right wrist. The facility's front door alarm sounded as Resident #1 entered the facility noting it was working properly. The investigation revealed the facility only had one (1) available exit door, the side door, with the ability to enter and exit without supervision by use of a keypad. Investigation surmised an unknown employee input the facility code into the keypad and exited the facility without the door fully closing thus allowing Resident #1 to exit unobserved. The Administrator confirmed he initiated an investigation immediately and a head count of the other residents was conducted.

In an interview with CNA #1 on 11/24/20 at 4:36 PM, she confirmed she and CNA #2 went across the street from the facility to assist Resident #1 back into the facility. CNA #1 stated she found Resident #1 at approximately 7:50 AM.

Attempted to call CNA #2 on the phone on 11/24/20 at 9:41 AM and 11:02 AM but was unable to reach.

Attempted to call Medical Director on the phone on 11/24/20 at 3:04 PM and a message was left but was unable to reach.

On 11/24/20 the Dietary Manager (DM) confirmed she wrote a statement on 4/13/20 that stated she observed Resident #1 across the street from the facility and two (2) CNAs ran across the street to get him. She confirmed it was about 7:50 AM. The DM also confirmed she wrote a statement for Dietary Aide #1 stating she had walked past Resident #1 at 5:53 AM.

Record review of Nurses' Notes dated 4/13/20,

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M 640	Continued From page 6 at 7:27 AM, Licensed Practical Nurse (LPN) #1 documented that a staff member witnessed Resident #1 walking down the street, soaked/wet and shaking. LPN #1 documented on 4/13/20 at 18:12 PM in the Nurses Notes that Resident #1 was walking down street, wet, shivering, and cold. LPN #1 documented the morning nurse changed Resident #1 and assessed him. In an interview with the Director of Nurses (DON) on 11/24/20 at 9:40 AM, the DON explained there was a camera in the hall that pointed at the door Resident #1 exited, but it was not recording at the time of the incident. The DON stated residents' needs are evaluated on Admission, Quarterly, and upon change in condition and the plan of care is modified as needed. Review of a written statement revealed CNA #5 wrote on 4/13/20 at 11:00 AM, "as soon as I got off my break, I went to "B" wing to search for Resident #1 and he was wandering around. That was around 3:30-4 AM when I saw him last." A review of a statement from LPN #2 on 4/13/20, revealed that the alarm (wander guard alarm) went off and the Hospitality Aide turned it off as Resident #1 came back into the building. The documented weather temperature for the city on 4/13/20 was 49 degrees fahrenheit. The approximate distance from the facility to where the resident was discovered was 155 feet from the side door near laundry. The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions prior to the State Agency (SA) entrance on 11/23/20.	M 640		

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M 640	Continued From page 7 In response to the Past Non-compliance IJ and SQC cited at 2:40 PM on 11/23/20, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility to remove the IJ. Brief Summary of Events: On 11/23/20 at 2:40 PM State Agency (SA) notified facility Administrator of Immediate Jeopardy (IJ) existed at past noncompliance and substandard quality of care. On 4/13/20 at 5:53 AM Dietary Aide (DA) #1 reported the last known visual of the Resident # 1, where he was observed sitting in a chair across from the front Nurses' Station. At 7:50 AM Certified Nursing Assistant #1 (CNA) and CNA #2 stepped outside of the facility into the front parking lot and observed Resident # 1 across the road, adjacent from the facility. At 7:50 AM CNA #1 and CNA #2 were witnessed by Dietary Manager (DM) #1, escorting Resident #1 back into the facility. The wander bracelet was attached to the Resident # 1's right wrist. The facility's front door alarm sounded as Resident #1 entered the facility noting it was working properly. The investigation revealed the facility only had one (1) available exit door, the side door, with the ability to enter and exit without supervision by use of a keypad. Investigation surmised an unknown employee input the facility code into the keypad and exited the facility without the door fully closing thus allowing Resident #1 to exit unobserved. The facility's camera was unable to capture the exit of Resident #1 due to failure to record and inability to play back events leading to Resident #1 exit. Corrective Actions: 1. On 4/13/20 Resident #1 was assisted back into	M 640		

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the facility at 7:50 AM by CNA #1 and CNA #2. Resident # 1 was assessed by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) # 1 with no injuries found. The facility has no legal representative for Resident #1. The facility initiated an investigation.

2. On 4/13/20 at 7:55 AM RN # 1 completed a head count on all Residents to ensure everyone was accounted for with no issues identified.

3. On 4/13/20 between 7:50 AM and 7:55 AM the Maintenance Director completed a 100 percent audit on all doors and windows in the facility. All windows were locked with security devices in place. All doors were functioning properly. All locked doors were unlocked and reset to assure they were working properly. Doors with alarms (magnet and elopement alarms using wander bracelet) were active and reset to assure proper function.

4. On 4/13/20 at 8:00 AM LPN # 2 completed an audit with the order listings of current wander bracelets to assure they were in place. LPN # 2 reviewed the Medication Administration Record (MAR) for documentation on functioning with current expiration dates. All care plans and Kardex/ task were reviewed and were current and up to date.

5. On 4/13/20 at 8:15 AM the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) initiated in-services on Abuse, Neglect, Vulnerable Adult Act, Resident Rights, Wander Policy with Supervision, Following Care Plan, Kardex, reporting changes of conditions including behavior, and Elopement. 10 RNs, 21 LPNs, 36 CNAs, eight (8) Dietary, eight (8)Housekeeping, four (4) Hospitality Aides, one (1) Business office

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M 640	Continued From page 9 Manager, one (1) Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until completion of in-service. 6. On 4/13/20 at 9:54 AM State Agency (SA) was notified. The facility investigation was completed on 04/13/20. 7. On 4/13/20 at 10:00 AM a new keypad on the side door was replaced by the Maintenance Director. 8. On 4/13/20 at 9:30 AM a wander guard bracelet drill was initiated and concluded on 4/23/20 with Ten RNs, 21 LPNs, 36 CNAs, eight (8)Dietary, eight (8) Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1)Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until completion of in-service. 9. On 4/13/20 at 10:45 AM a technician from the wander system checked all Access Control System doors and determined that all doors locked securely and that all codes worked correctly. 10. On 4/13/20 at 3:00 PM an AD-Hoc Quality	M 640		

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Assurance (QA) meeting was conducted by the facility Administrator that included the following participants: DON, ADON (also the Infection Control Preventionist), Director of Therapy, Medical Records, Director of Social Services, Business Office Manager, Maintenance Director, Housekeeping Manager, RN #1 (also Nurse Supervisor), Medical Director, Minimum Data Set (MDS) Coordinator, Dietary Manager, Human Resources, and the Treatment Nurse.

The facility's corrective actions were initiated on 4/13/20. All activities to remove the IJ was initiated on 4/13/20 and completed on 4/13/20. The facility alleges the IJ was removed on 4/14/20.

The SA validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observations, facility record review and interviews.

1. The SA validated by the facility's investigation and interviews that on 4/13/20 Resident #1 was assisted back into the facility at 7:50 AM by CNA #1 and CNA #2. Resident # 1 was assessed by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) # 1 with no injuries found. The facility has no legal representative for Resident #1 and the facility initiated an investigation.

2. The SA validated by review of the facility's investigation on 4/13/20 at 7:55 AM RN # 1 completed a head count on all Residents to ensure everyone was accounted for with no issues identified.

3. The SA validated through interviews and facility investigation on 4/13/20 between 7:50 AM and

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M 640	Continued From page 11 7:55 AM the Maintenance Director completed a 100 percent audit on all doors and windows in the facility. All windows were locked with security devices in place. All doors were functioning properly. All locked doors were unlocked and reset to assure they were working properly. Doors with alarms (magnet and elopement alarms using wander bracelet) were active and reset to assure proper function. 4. The SA validated the facility's investigation revealed on 4/13/20 at 8:00 AM LPN # 2 completed an audit with the order listings of current wander bracelets to assure they were in place. LPN # 2 reviewed the Medication Administration Record (MAR) for documentation on functioning with current expiration dates. All care plans and Kardex/ task were reviewed and were current and up to date. 5. The SA validated by interviews and facility investigation that on 4/13/20 at 8:15 AM the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) initiated in-services on Abuse, Neglect, Vulnerable Adult Act, Resident Rights, Wander Policy with Supervision, Following Care Plan, Kardex, reporting changes of conditions including behavior, and Elopement. 10 RNs, 21 LPNs, 36 CNAs, eight (8) Dietary, eight (8) Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1) Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until they completed the in-service.	M 640		

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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) COMPLETE DATE
M 640	Continued From page 12 6. The SA validated by interviews and record review, on 4/13/20 at 9:54 AM State Agency (SA) was notified. The facility investigation was completed on 04/13/20. 7. The SA validated by interview, tour of the facility and record review on 4/13/20 at 10:00 AM a new keypad on the side door was replaced by the Maintenance Director. 8. The SA validated by facility investigation review and interviews, on 4/13/20 at 9:30 AM a wander guard bracelet drill was initiated and concluded on 4/23/20 with 10 RNs, 21 LPNs, 36 CNAs, eight (8) Dietary, eight (8) Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1)Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until completion of the in-service. 9. The SA validated by observation, facility investigation and interviews, on 4/13/20 at 10:45 AM a technician from the wander system checked all Access Control System doors and determined that all doors locked securely and that all codes worked correctly. 10. The SA validated by interviews and record review, on 4/13/20 at 3:00 PM an AD-Hoc Quality Assurance (QA) meeting was conducted by the facility Administrator that included the following participants: DON, ADON (also the Infection Control Preventionist), Director of Therapy, Medical Records, Director of Social Services,	M 640		

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M 640	Continued From page 13 Business Office Manager, Maintenance Director, Housekeeping Manager, RN #1 (also Nurse Supervisor), Medical Director, Minimum Data Set (MDS) Coordinator, Dietary Manager, Human Resources, and the Treatment Nurse. Based on staff interviews, record review, facility investigation review, and policy review, the facility failed to provide adequate staff supervision to prevent Resident #1's elopement from the facility on 4/13/20 after 5:53 AM. The facility staff were unaware Resident #1 was out of the facility until he was seen by Certified Nursing Assistant (CNA) #1 and CNA #2 coming into the building. This concern was identified for one (1) of four (4) residents reviewed for wandering behavior and risk for elopement. The State Agency (SA) conducted Complaint	M 640		

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M 640	Continued From page 14 Investigation, CI #16776, from 11/23/2020 through 11/24/2020 and substantiated CI #16776 related to an elopement due to the facility's failure to provide adequate supervision to prevent Resident #1's elopement from the facility on 4/13/20 from approximately 5:53 AM until 7:50 AM. Resident #1 was missing, unsupervised and away from the facility for approximately two (2) hours. The facility staff was not aware of Resident #1's absence until he was discovered walking down the road by staff coming to work at 7:50 AM. Resident #1 was returned to the facility at 7:50 AM by Certified Nurse Assistant (CNA) #1 and CNA #2. Resident #1 was assessed for any signs and symptoms of injury and pain by Licensed Practical Nurse #1 with no injury identified. The CNAs found the resident soaking wet and shaking. The facility's immediate investigation concluded Resident #1 exited the facility through a side door when the door did not lock after a staff exited the door. Resident #1 was immediately placed on one on one (1:1) supervision. During the 11/23/20 survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) existed at 42 CFR(s): 483.25 (d)(1)(2)- Free of Accidents, Hazards/ Supervision/device (F689) due to facility's failure to provide adequate supervision to prevent an elopement for Resident #1. This situation caused the likelihood for serious injury, harm, impairment, or death for Resident #1 and other residents with wandering behaviors and at risk of elopement. The SA notified the facility's Administrator of the PNC IJ and SQC on 11/23/2020 at 2:40 PM. Based on the facility's implementation of corrective actions on 04/13/2020, the SA	M 640		

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determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 04/14/20, prior to the SA's first entrance on 11/23/2020.

Findings include:

Review of the facility's policy, "Wander Management, Monitoring System & Resident Elopement Protocol," dated 1/17/18, revealed, it is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible.

A Wandering Risk Evaluation for Resident #1 was completed on 2/14/20 and was assessed to be forgetful and disoriented times three (3), ambulates independently and has a history of wandering. The facility initially admitted Resident #1 on 6/22/2018, approximately 2 years prior to the elopement. Resident #1's diagnosis included Alzheimer's Diseases, Altered Mental Status, Dementia with Behavior Disturbance, Psychotic Disorder with Delusions and Major Depressive Disorder. Resident #1's most recent Quarterly Minimum Data Set (MDS), dated 02/23/2020, revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicated severe cognitive impairment and could not be assessed.

Review of his Quarterly Minimum Data Set (MDS), dated 2/23 /20, revealed the resident requires one (1) person assistance with transfers and with Activities of Daily Living (ADLs) (to include bathing, eating, and dressing). Resident #1 walks in the room and in the hall independently. Resident #1's Care Plan, was created and initiated 6/28/2018, identified Resident #1 at risk for elopement related to wandering and confusion. He was care planned

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for staff to place a wandering device on resident as applicable, check placement every shift, check function daily, place my demographic sheet and picture in the elopement notebook, redirect resident away from doorways and engage me in diversional activities, and wander bracelet related to wandering and exit seeking behavior. Nurse to check placement and function every shift including skin check under bracelet right wrist. The checking of placement was validated on 11/23/20 on the Medication Administration Record (MAR) by the State Agency (SA).

A tour with the Maintenance Director on 11/23/20, at 7:30 AM, revealed all facility doors were locked and were functioning properly. Observation revealed a keypad on the door Resident #1 was believed to exit through on 11/23/20. The Maintenance Director confirmed an additional keypad was added to this door after the investigation of the elopement of Resident #1.

During a phone interview with the Administrator on 11/23/20 at 2:40 PM, the Administrator confirmed on 4/13/20 at 5:53 AM, Dietary Aide (DA) # 1 reported the last known visual of Resident #1, where he was observed sitting in a chair across from the front Nurses' Station. At 7:50 AM, CNA #1 and CNA #2 stepped outside of the facility into the front parking lot and observed Resident #1 across the road, adjacent from the facility. At 7:50 AM, CNA #1 and CNA #2 were witnessed by Dietary Manager (DM), escorting Resident #1 back into the facility. The wander bracelet was attached to the Resident # 1's right wrist. The facility's front door alarm sounded as Resident #1 entered the facility noting it was working properly. The investigation revealed the facility only had one (1) available exit door, the side door, with the ability to enter and exit without

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supervision by use of a keypad. Investigation surmised an unknown employee input the facility code into the keypad and exited the facility without the door fully closing thus allowing Resident #1 to exit unobserved. The Administrator confirmed he initiated an investigation immediately and a head count of the other residents was conducted.

In an interview with CNA #1 on 11/24/20 at 4:36 PM, she confirmed she and CNA #2 went across the street from the facility to assist Resident #1 back into the facility. CNA #1 stated she found Resident #1 at approximately 7:50 AM.

Attempted to call CNA #2 on the phone on 11/24/20 at 9:41 AM and 11:02 AM but was unable to reach.

Attempted to call Medical Director on the phone on 11/24/20 at 3:04 PM and a message was left but was unable to reach.

On 11/24/20 the Dietary Manager (DM) confirmed she wrote a statement on 4/13/20 that stated she observed Resident #1 across the street from the facility and two (2) CNAs ran across the street to get him. She confirmed it was about 7:50 AM. The DM also confirmed she wrote a statement for Dietary Aide #1 stating she had walked past Resident #1 at 5:53 AM.

Record review of Nurses' Notes dated 4/13/20, at 7:27 AM, Licensed Practical Nurse (LPN) #1 documented that a staff member witnessed Resident #1 walking down the street, soaked/wet and shaking.
LPN #1 documented on 4/13/20 at 18:12 PM in the Nurses Notes that Resident #1 was walking down street, wet, shivering, and cold. LPN #1

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M 640	Continued From page 18 documented the morning nurse changed Resident #1 and assessed him. In an interview with the Director of Nurses (DON) on 11/24/20 at 9:40 AM, the DON explained there was a camera in the hall that pointed at the door Resident #1 exited, but it was not recording at the time of the incident. The DON stated residents' needs are evaluated on Admission, Quarterly, and upon change in condition and the plan of care is modified as needed. Review of a written statement revealed CNA #5 wrote on 4/13/20 at 11:00 AM, "as soon as I got off my break, I went to "B" wing to search for Resident #1 and he was wandering around. That was around 3:30-4 AM when I saw him last." A review of a statement from LPN #2 on 4/13/20, revealed that the alarm (wander guard alarm) went off and the Hospitality Aide turned it off as Resident #1 came back into the building. The documented weather temperature for the city on 4/13/20 was 49 degrees fahrenheit. The approximate distance from the facility to where the resident was discovered was 155 feet from the side door near laundry. The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions prior to the State Agency (SA) entrance on 11/23/20. In response to the Past Non-compliance IJ and SQC cited at 2:40 PM on 11/23/20, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility to remove the IJ.	M 640		

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M 640	Continued From page 19 Brief Summary of Events: On 11/23/20 at 2:40 PM State Agency (SA) notified facility Administrator of Immediate Jeopardy (IJ) existed at past noncompliance and substandard quality of care. On 4/13/20 at 5:53 AM Dietary Aide (DA) #1 reported the last known visual of the Resident # 1, where he was observed sitting in a chair across from the front Nurses' Station. At 7:50 AM Certified Nursing Assistant #1 (CNA) and CNA #2 stepped outside of the facility into the front parking lot and observed Resident # 1 across the road, adjacent from the facility. At 7:50 AM CNA #1 and CNA #2 were witnessed by Dietary Manager (DM) #1, escorting Resident #1 back into the facility. The wander bracelet was attached to the Resident # 1's right wrist. The facility's front door alarm sounded as Resident #1 entered the facility noting it was working properly. The investigation revealed the facility only had one (1) available exit door, the side door, with the ability to enter and exit without supervision by use of a keypad. Investigation surmised an unknown employee input the facility code into the keypad and exited the facility without the door fully closing thus allowing Resident #1 to exit unobserved. The facility's camera was unable to capture the exit of Resident #1 due to failure to record and inability to play back events leading to Resident #1 exit. Corrective Actions: 1. On 4/13/20 Resident #1 was assisted back into the facility at 7:50 AM by CNA #1 and CNA #2. Resident # 1 was assessed by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) # 1 with no injuries found. The facility has no legal representative for Resident #1. The facility initiated an investigation.	M 640		

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M 640	Continued From page 20 2. On 4/13/20 at 7:55 AM RN # 1 completed a head count on all Residents to ensure everyone was accounted for with no issues identified. 3. On 4/13/20 between 7:50 AM and 7:55 AM the Maintenance Director completed a 100 percent audit on all doors and windows in the facility. All windows were locked with security devices in place. All doors were functioning properly. All locked doors were unlocked and reset to assure they were working properly. Doors with alarms (magnet and elopement alarms using wander bracelet) were active and reset to assure proper function. 4. On 4/13/20 at 8:00 AM LPN # 2 completed an audit with the order listings of current wander bracelets to assure they were in place. LPN # 2 reviewed the Medication Administration Record (MAR) for documentation on functioning with current expiration dates. All care plans and Kardex/ task were reviewed and were current and up to date. 5. On 4/13/20 at 8:15 AM the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) initiated in-services on Abuse, Neglect, Vulnerable Adult Act, Resident Rights, Wander Policy with Supervision, Following Care Plan, Kardex, reporting changes of conditions including behavior, and Elopement. 10 RNs, 21 LPNs, 36 CNAs, eight (8) Dietary, eight (8)Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1) Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff	M 640		

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M 640	Continued From page 21 was allowed to work until completion of in-service. 6. On 4/13/20 at 9:54 AM State Agency (SA) was notified. The facility investigation was completed on 04/13/20. 7. On 4/13/20 at 10:00 AM a new keypad on the side door was replaced by the Maintenance Director. 8. On 4/13/20 at 9:30 AM a wander guard bracelet drill was initiated and concluded on 4/23/20 with Ten RNs, 21 LPNs, 36 CNAs, eight (8)Dietary, eight (8) Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1)Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until completion of in-service. 9. On 4/13/20 at 10:45 AM a technician from the wander system checked all Access Control System doors and determined that all doors locked securely and that all codes worked correctly. 10. On 4/13/20 at 3:00 PM an AD-Hoc Quality Assurance (QA) meeting was conducted by the facility Administrator that included the following participants: DON, ADON (also the Infection Control Preventionist), Director of Therapy, Medical Records, Director of Social Services, Business Office Manager, Maintenance Director, Housekeeping Manager, RN #1 (also Nurse	M 640		

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M 640	Continued From page 22 Supervisor), Medical Director, Minimum Data Set (MDS) Coordinator, Dietary Manager, Human Resources, and the Treatment Nurse. The facility's corrective actions were initiated on 4/13/20. All activities to remove the IJ was initiated on 4/13/20 and completed on 4/13/20. The facility alleges the IJ was removed on 4/14/20. The SA validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observations, facility record review and interviews. 1. The SA validated by the facility's investigation and interviews that on 4/13/20 Resident #1 was assisted back into the facility at 7:50 AM by CNA #1 and CNA #2. Resident # 1 was assessed by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) # 1 with no injuries found. The facility has no legal representative for Resident #1 and the facility initiated an investigation. 2. The SA validated by review of the facility's investigation on 4/13/20 at 7:55 AM RN # 1 completed a head count on all Residents to ensure everyone was accounted for with no issues identified. 3. The SA validated through interviews and facility investigation on 4/13/20 between 7:50 AM and 7:55 AM the Maintenance Director completed a 100 percent audit on all doors and windows in the facility. All windows were locked with security devices in place. All doors were functioning properly. All locked doors were unlocked and reset to assure they were working properly. Doors with alarms (magnet and elopement alarms using	M 640		

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wander bracelet) were active and reset to assure proper function.

4. The SA validated the facility's investigation revealed on 4/13/20 at 8:00 AM LPN # 2 completed an audit with the order listings of current wander bracelets to assure they were in place. LPN # 2 reviewed the Medication Administration Record (MAR) for documentation on functioning with current expiration dates. All care plans and Kardex/ task were reviewed and were current and up to date.

5. The SA validated by interviews and facility investigation that on 4/13/20 at 8:15 AM the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) initiated in-services on Abuse, Neglect, Vulnerable Adult Act, Resident Rights, Wander Policy with Supervision, Following Care Plan, Kardex, reporting changes of conditions including behavior, and Elopement. 10 RNs, 21 LPNs, 36 CNAs, eight (8) Dietary, eight (8) Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1) Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until they completed the in-service.

6. The SA validated by interviews and record review, on 4/13/20 at 9:54 AM State Agency (SA) was notified. The facility investigation was completed on 04/13/20.

7. The SA validated by interview, tour of the facility and record review on 4/13/20 at 10:00 AM

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COLUMBIA REHABILITATION AND HEALTHCARE CEI	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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) COMPLETE DATE
M 640	Continued From page 24 a new keypad on the side door was replaced by the Maintenance Director. 8. The SA validated by facility investigation review and interviews, on 4/13/20 at 9:30 AM a wander guard bracelet drill was initiated and concluded on 4/23/20 with 10 RNs, 21 LPNs, 36 CNAs, eight (8) Dietary, eight (8) Housekeeping, four (4) Hospitality Aides, one (1) Business office Manager, one (1)Human Resources, one (1) Administrator Assistant, one (1) Social Service Director, two (2) Activity, two (2) Maintenance, four (4) therapy, one (1) Nurse Practitioner, one (1) Medical Director, one (1) Director of Business Development, one (1) Administrator and eight (8) Respiratory Therapist were in serviced. No staff was allowed to work until completion of the in-service. 9. The SA validated by observation, facility investigation and interviews, on 4/13/20 at 10:45 AM a technician from the wander system checked all Access Control System doors and determined that all doors locked securely and that all codes worked correctly. 10. The SA validated by interviews and record review, on 4/13/20 at 3:00 PM an AD-Hoc Quality Assurance (QA) meeting was conducted by the facility Administrator that included the following participants: DON, ADON (also the Infection Control Preventionist), Director of Therapy, Medical Records, Director of Social Services, Business Office Manager, Maintenance Director, Housekeeping Manager, RN #1 (also Nurse Supervisor), Medical Director, Minimum Data Set (MDS) Coordinator, Dietary Manager, Human Resources, and the Treatment Nurse.	M 640		