STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Survey Agency (SSA) conducted a Focus Infection Control/ COVID-19 Survey, along with Complaint Investigation, CI #16776, from 11/23/2020 through 11/24/2020. The SSA substantiated CI #16776 as evidenced by the facility failed to provide adequate staff supervision to prevent Resident #1's elopement on 4/13/20. The SSA also conducted CI #17074 regarding failure to ensure residents were assisted to physician appointments and failure to provide personal care assistance. CI #17074 was not substantiated. No deficient practice was identified related to the Focus Infection Control/ COVID-19 Survey.

Review of Facility Reported Incident (FRI) from 4/13/20 revealed, Resident #1 was identified for wandering on 6/28/18 after admission on 6/22/18 and he was independently ambulatory. On 4/13/20, Resident #1 was last seen at 5:53 AM by Dietary Aide #1. Approximately 2 hours later, Certified Nursing Assistants (CNA) #1 and CNA #2 found Resident #1 outside, across the street, cold and shivering, unsupervised and wandering down the street. They assisted Resident # 1 inside. The resident was wearing a wander guard and the alarm sounded when staff returned him to the building. Licensed Practical Nurse (LPN) # 1 assessed Resident #1 for any signs and symptoms of injury and pain and findings were negative for injury. The resident was cold and shivering. The facility's 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 until his transfer to a behavior unit two months later on 6/14/2020.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 000	Continued From page 1 Resident #1's most recent Quarterly Minimum Data Set (MDS) prior to the elopement, dated 2/23/2020, revealed a Brief Interview for Mental Status (BIMS) score was 99, which indicated severe cognitive impairment and could not be assessed. During the survey on 11/23/20, the State Survey Agency (SSA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) at 42 CFR(s): 483:25(d)(1)(3)-Free of Accident Hazard/Supervision/Devices due to the facility's failure on 4/13/2020 to supervise a resident with severe cognitive impairment and identified as having a behavior of wandering from exiting the building unsupervised. This incident caused the likelihood of serious injury, harm, impairment or death for Resident #1 and other residents with wandering behaviors. The SSA notified the facility's Administrator of the IJ and SQC on 11/23/2020 at 2:40 PM Based on evidence provided by the facility and upon SSA review, the facility's implementation of corrective actions on 4/13/2020 and completion on 4/14/2020 prior to SSA entrance showed the immediacy was removed on 4/14/2020 and the IJ was considered as Past Non-Compliance (PNC) by the SSA. At the time of the 11/24/2020 survey, the facility had a census of 87 and held a license of 108 beds.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		1/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 2 §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 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 4/13/2020 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 4/13/2020 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	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 3	F 689		

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 11/23/2020 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 4/13/2020, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 4/14/2020, 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 2/14/2020 and was assessed to be forgetful and disoriented times three (3),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 4	F 689		

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 2/23/2020, 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 /2020, 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 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 11/23/2020 on the Medication Administration Record (MAR) by the State Agency (SA).

A tour with the Maintenance Director on 11/23/2020, at 7:30 AM, revealed all facility doors were locked and were functioning properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 5	F 689		

Observation revealed a keypad on the door Resident #1 was believed to exit through on 11/23/2020. 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 11/23/2020 at 2:40 PM, the Administrator confirmed on 4/13/2020 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 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 11/24/2020 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 6	F 689		

Attempted to call CNA #2 on the phone on 11/24/2020 at 9:41 AM and 11:02 AM but was unable to reach.

Attempted to call Medical Director on the phone on 11/24/2020 at 3:04 PM and a message was left but was unable to reach.

On 11/24/2020 the Dietary Manager (DM) confirmed she wrote a statement on 4/13/2020 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 4/13/2020, 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 4/13/2020 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 11/24/2020 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 4/13/2020 at 11:00 AM, "as soon as I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 7	F 689		

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 4/13/2020, 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 4/13/2020 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 11/23/2020.

In response to the Past Non-compliance IJ and SQC cited at 2:40 PM on 11/23/2020, 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 11/23/2020 at 2:40 PM State Agency (SA) notified facility Administrator of Immediate Jeopardy (IJ) existed at past noncompliance and substandard quality of care. On 4/13/2020 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 8	F 689		

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 4/13/2020 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.

2. On 4/13/2020 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 4/13/2020 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 9	F 689		

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

4. On 4/13/2020 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 4/13/2020 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 completion of in-service.

6. On 4/13/2020 at 9:54 AM State Agency (SA) was notified. The facility investigation was completed on 4/13/2020.

7. On 4/13/2020 at 10:00 AM a new keypad on the side door was replaced by the Maintenance Director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 10	F 689		

8. On 4/13/2020 at 9:30 AM a wander guard bracelet drill was initiated and concluded on 4/23/2020 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 4/13/2020 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 4/13/2020 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.

The facility's corrective actions were initiated on 4/13/2020. All activities to remove the IJ was initiated on 4/13/2020 and completed on 4/13/2020. The facility alleges the IJ was removed on 4/14/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 11	F 689		

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 4/13/2020 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 4/13/2020 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 4/13/2020 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. The SA validated the facility's investigation revealed on 4/13/2020 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 12	F 689		

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 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 689	Continued From page 13	F 689		

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.