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	255150	A. BUILDING _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MENDENH	**925 WEST MANGUM AVENUE MENDENHALL, MS 39114**

(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 The State Agency (SA) conducted a Complaint Investigation, CI MS #18517, on 2/15/22 through 2/18/22. The SA substantiated CI MS #18517 related to an elopement, when the facility failed to provide adequate staff supervision to prevent Resident #1, a severely cognitively impaired resident, from leaving the facility without supervision. On 2/7/22, Resident #1 was last seen by facility staff at approximately 6:48 PM. Licensed Practical Nurse (LPN) #1 was notified at 7:24 PM by the Director of Nurses at the hospital, one hundred (100) yards from the facility, that Resident #1 was at the hospital unattended. The facility Director of Nurses (DON) and staff Certified Nursing Assistant (CNA) went to the hospital and escorted Resident #1 to the hospital emergency department for assessment. The hospital emergency department found no injury. Resident #1 was escorted back to the facility and assessed by the facility DON with no noted injuries. The resident reported he had exited out of the window in his room and had walked to the hospital. The facility staff had discovered the window in the room of Resident #1 was still open following the report from the hospital's Director of Nurses. Resident #1 had been residing at the facility for six (6) days and had been evaluated and identified as negative for elopement risk. The resident was immediately placed on one on one observation upon return to the facility. The resident had initially scored three (3) on his admission Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) score, indicating Resident #1 was severely cognitively impaired. Resident #1 was receiving minimal one	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 person assistance for ambulation (walking) at the time of the elopement. The facility Maintenance Technician installed devices in all windows to prevent the windows from opening more than six (6) inches. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which occurred on 2/7/22 and existed at 42 CFR(s): 483.25 (d)(1)(2)- Free of Accidents, Hazards/ Supervision/Device (F689) - Scope/Severity "J" due to the facility's failure to provide adequate supervision to prevent an elopement for Resident #1. The SA notified the facility's Administrator of the Past Noncompliance IJ and SQC on 2/17/2022 at 11:55 AM and provided the Administrator with the IJ template. The facility's failure to provide adequate supervision to prevent an elopement for Resident #1 allowed the resident to be away from the facility, unnoticed and unsupervised until the Director of Nurses of the hospital next door to the facility notified the facility Resident #1 was wandering in the hospital lobby. This situation placed Resident #1 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death. Based on the facility's implementation of corrective actions on 2/7/22, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 2/8/22, prior to the SA's entrance on 2/15/22. At the time of the survey, the facility was licensed for 60 beds and had a census of 54.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices	F 689		3/10/22

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F 689	Continued From page 2 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, facility investigation review and facility policy review, the facility failed to provide adequate supervision to prevent the elopement of Resident #1 on 2/07/22. The facility was not aware Resident #1 had exited the facility until the Director of Nurses at the hospital next door, approximately one hundred (100) yards away, notified the facility. This concern was identified for one (1) of four (4) sampled residents. The State Agency (SA) conducted a Complaint Survey for CI MS #18517 on 2/15/22 through 2/18/22 and substantiated CI MS #18517 related to an elopement, when the facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility. On 2/07/22 at approximately 6:48 PM Resident #1 was missing, unsupervised and away from the facility for approximately thirty-six (36) minutes. The facility staff were not aware Resident #1 had exited the facility until the Director of Nurses at the hospital telephoned on 2/07/22 at 7:24 PM. Resident #1 was escorted for assessment at the hospital emergency department by facility staff prior to returning to the facility with staff, where he was immediately placed on one-on-one supervision.	F 689	Past noncompliance: no plan of correction required.	

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On 2/07/22 and 2/08/22, the facility Maintenance Technician installed devices in all facility windows to prevent the windows from opening more than six (6) inches.

Based on the facility's implementation of corrective actions on 2/07/22 through 2/08/22, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed as of 2/08/22.

The SA notified the facility's administrator of the Past Non-compliance (PNC) Immediate Jeopardy (IJ) on 2/17/22 at 11:55 AM.

Findings Include:

Record review of the facility policy titled "ELOPEMENTS", dated January 2012, revealed "POLICY STATEMENT: This facility will make every effort to protect the safety of all residents in the facility ..."

Record review of the facility policy titled "Safety and Supervision of Residents", dated July 2017, revealed "Our facility strives to make the environment as free from accidents are facility-wide priorities ...Individualized, Resident-Centered Approach to Safety ...3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices ..."

Record review of the facility policy titled "Wandering and Elopements", dated June 2021, revealed "...Resident supervision is a core component of the systems approach to safety ..."

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Record review of the 'Facility Investigation" prepared by the facility Director of Nurses (DON), dated 2/07/22, revealed the last staff observation of Resident #1 prior to the elopement was at 6:48 PM on 2/07/22; the facility received a telephone call from the hospital Director of Nurses at approximately 7:24 PM on 2/07/22 who notified her that a resident was at the hospital and had told the hospital DON that he had left the facility through a window. The 'Facility Investigation" revealed staff 'made rounds' and determined all residents were accounted for except Resident #1, who's room window blinds and window were up. The investigation revealed that the DON, Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1 had taken the facility van to the hospital, located Resident #1 in the lobby, escorted him to the hospital Emergency Department for assessment where he was noted to have no injuries. The report revealed Resident #1 was returned to the facility at 9:25 PM by the DON, LPN #1 and CNA #1 and was assessed by facility nurses and interviewed by the Administrator and DON. Resident #1's Care Plan was updated and the resident was reassessed for elopement risk. The report recorded that Resident #1 was transferred to a different room, a 'Wander Guard' bracelet was placed on the resident and the staff began one-on-one observation. The Resident Representative (RR) was notified on 2/08/22 at 11:12 AM. The report included that an appointment had been made for Resident #1 for a psychological assessment. The "Facility Investigation" stated the facility Quality Assessment and Performance Improvement (QAPI) committee held a meeting on on 2/08/22, attended by the facility Medical Director during which the facility policies related to elopement were reviewed.

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F 689	Continued From page 5 On 2/15/22 at 7:24 PM, observation revealed the facility was situated on a street with the only neighboring building being the local hospital. SA counted eight (8) vehicles traveling the street in front of the facility during a five (5) minute period from 7:18 PM through 7:23 PM. There was a water drainage ravine approximately ten to twelve (10-12) feet deep which ran between the facility and the hospital next door with a very large culvert running under the street between the buildings. The parking lot was well lit with eight (8) outdoor streetlights and lights over the doors. The facility had a clear, clean, well-maintained sidewalk which ran along the front of the building between the building and parking lot. The parking lot was a flat, well-maintained macadam and free of holes or tripping hazards. The hospital was located approximately one hundred (100) yards up a slight incline from the facility with a well-lit parking lot and a well-maintained sidewalk along the front of the facility. On 2/15/22 at 7:40 PM, observation and an interview with Resident #1 revealed the resident was resting on his bed, watching television with a Certified Nurse's Aide sitting at the bedside. The resident was alert and oriented to self and his surroundings and able to communicate well verbally. He stated he remembered walking to the hospital during the night but could not recall which night. He stated he remembered feeling fearful and left through the window but could not remember what he had been frightened about. He stated he went to the hospital and recalled going to the hospital emergency department. He stated he had not been injured during the elopement.	F 689		

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On 2/15/22 at 8:08 PM, SA conducted an interview with the facility Administrator, who stated Licensed Practical Nurse (LPN) #1 answered a telephone call from the Director of Nurses (DON) at the hospital 100 yards from the facility, during which the hospital DON reported a facility resident was at the hospital unaccompanied. The Administrator reported the facility staff were not aware Resident #1 had exited the facility until the Director of Nurses at the hospital telephoned. The administrator stated the facility 'Elopement Procedure' was initiated immediately. She stated the staff notified her immediately and she notified the facility Maintenance Technician. She stated she and the Maintenance Technician immediately reported to the facility, and arrived at 8:31 PM. She stated the facility DON was already at the facility at the time of the incident. The Administrator stated she was not aware that the windows opened completely prior to Resident #1's elopement. She stated immediately following her arrival at the facility on the night of the elopement (2/07/22) she instructed the facility Maintenance Technician "to install window stops on all of the windows, every single one". She said the Maintenance Technician began the process on the night of 2/07/22 and completed the process on 2/08/22. The Administrator stated that all residents were evaluated for elopement risk upon admission. She said Resident #1 had been evaluated as "not at risk for elopement". She reported the facility was licensed for 60 beds and had a census of 54 residents. The Administrator confirmed she attended the QAPI committee meeting on 2/8/22.

On 2/15/22 at 8:20 PM, observation revealed the room from which Resident #1 eloped was on the front of the facility facing the street. The bottom

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windowsill was two (2) feet above the floor and there was a room air conditioner/heater unit in the window. There was a window blind on the window. The window looked out onto the sidewalk which ran alongside and against the facility outside wall. The sidewalk led to perpendicular sidewalk which ran across the front of the facility between the building and the parking lot. The facility was surrounded by flat lawn which slanted downward toward and into the drainage ravine between the facility and the hospital. The window would open five (5) inches.

On 2/15/22 at 8:50 PM, an interview with CNA #1 revealed he was working the PM shift on 2/07/22 and was present at the time of the elopement. He confirmed the elopement procedure was immediately initiated upon notification of the location of Resident #1. He stated he "rode in the (facility) van with the nurse to get the resident". He stated upon arrival at the hospital he and LPN #1 and the DON entered the lobby of the hospital and saw Resident #1 sitting in a chair, calmly talking with an orderly. He said Resident #1 was wearing shoes, pants, two shirts and a baseball cap. CNA #1 stated he accompanied LPN #1 and the DON to drive Resident #1 "around to the emergency room" at the same hospital where the resident was assessed by emergency department staff. CNA #1 confirmed Resident #1 had no apparent injuries and voiced no complaints at the time. CNA #1 said he accompanied LPN #1, the DON and the resident back to the facility where the resident had a monitoring bracelet applied, another assessment by facility nurses, and was placed on one-on-one supervision. CNA #1 confirmed Resident #1 remained on one-on-one supervision and all windows in the facility were fitted with devices to prevent them from opening

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more than six (6) inches.

On 2/16/22 at 10:00 AM, an interview with the facility DON revealed that she was at the facility on 2/07/22 when she received notification that a resident had been located unattended at the hospital next door. She confirmed that the facility elopement procedure was immediately initiated. She stated, "Right away we identified it was (Resident #1) because the window blind was still up and the window was still open and he was not in his room". She stated that at approximately 7:25 PM, LPN #1 drove the facility van and she and CNA #1 were in accompaniment as they drove to the hospital next door, approximately one hundred (100) yards away. The DON confirmed that when she entered the hospital lobby Resident #1 was calmly sitting in a chair talking with a hospital orderly and LPN #2, without voiced complaint or apparent injury. She said Resident #1 had been dressed in shoes, pants, two shirts and a baseball cap. She stated LPN #2 went back to the facility and she (the DON), LPN #1 and CNA #1 took Resident #1 in the facility van around the building to the entrance of the emergency department where Resident #1 was assessed by the hospital emergency department staff with no negative findings reported. The DON stated she, LPN #1 and CNA #1 then transported Resident #1 back to the facility in the facility van where he was assessed by facility nurses, a 'Wander Guard' bracelet was applied to the resident, and he was placed on one-on-one supervision. She confirmed Resident #1 remained on one-on-one supervision. She stated an elopement evaluation was completed for Resident #1 upon return to the facility and he was evaluated as "high risk for elopement" and the facility immediately began to implement

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"elopement precautions" for Resident #1. She reported that the staff attempted notification of the Resident Representative (RR) without success and the Social Worker (SW) notified the RR on 2/08/22 at 11:12 AM.

On 2/16/22 at 2:00 PM, observation and interview with the facility Maintenance Supervisor revealed he had participated in application of 'window stop', which were devises to prevent the windows from opening more than six (6) inches were applied to all windows in the building. He confirmed the completion of the installment of the devices was achieved on 2/08/22. Observation revealed all windows in the facility were equipped with 'window stops' and the windows opened no more than six (6) inches.

On 2/16/22 at 2:35 PM an interview with LPN #1 revealed she was working the 7:00 PM shift at the facility on 2/07/22 when she received notification that a resident had been located unattended at the hospital next door. She confirmed that the facility elopement procedure was immediately initiated. She stated staff identified Resident #1's window blind was still up and the window was still open and he was not in his room. She stated that at approximately 7:25 PM, she drove the facility van and she and CNA #1 and the DON drove to the hospital next door, approximately one hundred (100) yards away. LPN #1 confirmed that when she entered the hospital lobby Resident #1 was calmly sitting in a chair talking with a hospital orderly and LPN #2, without voiced complaint or apparent injury. She said Resident #1 had been dressed in shoes, pants, two shirts and a baseball cap. She stated LPN #2 went back to the facility and she, the DON and CNA #1 took Resident #1 in the facility van around the building

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to the entrance of the emergency department where Resident #1 was assessed by the hospital emergency department staff with no negative findings reported. LPN #1 stated she, the DON and CNA #1 then transported Resident #1 back to the facility in the facility van where he was assessed by facility nurses, a 'Wander Guard' bracelet was applied to the resident, and he was placed on one-on-one supervision. She confirmed Resident #1 remained on one-on-one supervision. She stated an elopement evaluation was completed for Resident #1 upon return to the facility and he was evaluated as "high risk for elopement" and the facility immediately began to implement "elopement precautions" for Resident #1.

On 2/16/22 at 3:09 PM, a telephone interview with LPN #2 revealed she was working the PM shift on 2/07/22 and was present at the time of the elopement. She confirmed elopement procedure was immediately initiated upon notification of the location of Resident #1. She stated she "ran outside and looked around and then ran to the hospital to be with him (Resident #1)". He stated upon arrival at the hospital she entered the lobby of the hospital and saw Resident #1 sitting in a chair, calmly talking with an orderly; she said Resident #1 had been wearing shoes, pants, two shirts and a baseball cap. LPN #2 confirmed Resident #1 had no apparent injuries and voiced no complaints at the time. LPN #2 confirmed CNA #1, LPN #1 and the DON brought the resident back to the facility where the resident had a monitoring bracelet applied, was assessed by facility nurses, and was placed on one-on-one supervision. LPN #2 confirmed all windows in the facility were fitted with devices to prevent them from opening more than six (6) inches.

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On 2/16/22 at 4:11 PM, a telephone interview with the Resident Representative (RR) for Resident #1 revealed she had been contacted of the elopement by the facility. She stated she was surprised Resident #1 had exited the facility out of the window because he had never shown any similar behavior before. She stated the elopement had concerned her, but she was planning to be admitted to the same facility on 2/25/22 and share a room with Resident #1. She stated she felt assured that with one-on-one supervision he would be safe at the facility.

On 2/17/2022 at 11:55 AM, the State Agency (SA) notified the Administrator that the facility failed to provide supervision for Resident #1, who left the facility unnoticed and unsupervised on 2/7/2022 at approximately 6:48 PM and was located at the local hospital which was approximately 36 minutes later. This was cited as an Immediate Jeopardy (IJ) Past Noncompliance (PNC). The IJ Template was provided to the Administrator.

Record review of the Admission Record revealed Resident #1 was admitted by the facility on 2/01/22 with diagnoses that included Chronic Atrial Fibrillation, Pressure Ulcer of Sacral Region and Hypertension.

Record review of the Admission BIMS (Brief Interview for Mental Status) Evaluation-V2.1 dated 2/2/22 revealed Resident #1's BIMS score was 3.0 which indicates severe cognitive impact.

Record review of the 'Elopement Evaluation' dated 2/01/22 for Resident #1 revealed he was evaluated as 'Negative' for risk of elopement.

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Corrective Action Plan

On 2/17/2022 at 11:55 AM the State Agency (SA) notified the Administrator that the facility failed to provide supervision for Resident #1, who left the facility unnoticed and unsupervised on 2/7/2022 at approximately 6:48 PM and was located at the local hospital which was approximately 36 minutes from the last observation of a staff member. This was sited as an Immediate Jeopardy (IJ) Past Noncompliance (PNC). The IJ Template was provided to the Administrator.

On 2/7/2022 at 7:24 PM, Bedford Care Center of Mendenhall, (BCCM) received a phone call from the local hospital informing them that a Resident from BCCM was at the hospital.

1. Activation of the Elopement procedure was initiated immediately by the Director of Nurses (DON), which involves 2 staff members exiting the facility to inspect surrounding grounds and all other staff to begin room by room search for the missing resident. The DON discovered that Resident #1 had exited the facility through his room window. All other Residents were accounted for and verified by the DON at 7:40 PM.

2. LPN #1 exited the facility at 7:25 PM and ran to the hospital and remained with Resident #1 until the DON arrived at approximately 7:46 PM. Upon arrival LPN #1 noted Resident #1 to be fully dressed with coat and hat. The DON and LPN #2 drove the van to the hospital at 7:45 PM and took Resident #1 to the Emergency Room (ER) for evaluation.

3. The Administrator was notified at 7:29 PM

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	255150	A. BUILDING _____ B. WING _____	C 02/18/2022

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and at this time it was noted to be 46 degrees outside with no wind or rain present. The Administrator contacted the Maintenance staff at 7:35 PM to report to the facility for inspection of the windows. The Medical Director was notified at 10:15 PM. Multiple attempts were made to notify the Responsible Party, but were not successful until 10:00 AM on 2/8/2022 due to her phone malfunction.

4. Upon arriving at the facility at 8:31 PM, Maintenance #1 inspected the windows and applied a safety stop to Resident #1's window to prevent opening more than 6 inches.

5. The ER Physician conducted an evaluation of Resident #1 at approximately 8:21 PM, with no injuries noted. The DON and staff returned to the facility with Resident #1 at 9:25 PM.

6. The Administrator and DON conducted an interview with Resident #1 at 9:28 PM. Resident #1 was moved to room 202A at 10:09 PM and placed on 1:1 staff observation which continues until re-evaluation on 2/25/2022.

7. The Administrator applied a safety stop to the window in room 202A at 10:09 PM. The DON applied a Wander Guard Bracelet to Resident #1 at 10:10 PM.

8. Staff education was initiated by the Administrator at 10:15 PM to include Wander Guard System, Wandering and Elopement Policy, Exit Seeking Procedures, Abuse, Neglect and Reporting. Staff interviews were initiated by Administrator at 8:45 PM to determine if any Exit Seeking behavior had occurred with Resident #1 prior to his exiting the facility unsupervised. No

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exit seeking behavior had been witnessed by facility staff.

9. The Administrator notified the SA and Attorney Generals Office at approximately 10:00 PM on 2/7/2022.

10. On the morning of 2/8/2022 at 8:00 AM, the Quality Assessment and Assurance Committee (QAA) to include the Medical Director met and reviewed the policies related to Wandering and Elopements, Abuse, Neglect and Reporting and the Exit Seeking Procedures and recommended to add Resident Rights to the education. No revisions to the policies were recommended. The QAA Committee recommended installing Safety Stops to all windows in the facility. All staff was educated on these policy and procedures prior to working.

11. Maintenance staff #1 and #2, completed installation of Safety Stops to all windows in the facility at approximately 2:00 PM on 2/8/2022.

12. Elopement Evaluations were completed by the DON, Resident Care Coordinator and Staff Development Nurse beginning at approximately 10:00 AM 2/8/2022 for all Residents and the Plan of Care updated accordingly for Resident #1 and Resident #2. The Elopement Binder was revised to include Resident #1 and Resident #2 as at risk for elopement at this time as well.

13. The QAA Committee met at 1:30 pm on 2/8/2022 to review the intervention progress and implemented a weekly window inspection to be completed by Maintenance #2 and to be documented on the Window Safety Stop Maintenance Log for 4 weeks and monthly there

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after. Any concerns found would be reported to the QAA committee for recommendations. The Window Safety Stop Maintenance Log will be submitted at least quarterly for the Medical Director and QAA Committee's suggestions or recommendations for sustaining compliance.

VALIDATION

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 interview.

1. SA validated through record review and interviews with the Administrator, DON, LPN #1 and LPN #2 and CNA #1 the activation of the Elopement procedure was initiated immediately by the Director of Nurses (DON), which involves 2 staff members exiting the facility to inspect surrounding grounds and all other staff to begin room by room search for the missing resident. The DON discovered that Resident #1 had exited the facility through his room window. All other Residents were accounted for and verified by the DON at 7:40 PM.

2. SA validated through record review and interviews with the Administrator, DON, LPN #1 and LPN #2 that LPN #1 exited the facility at 7:25 PM and ran to the hospital and remained with Resident #1 until the DON arrived at approximately 7:46 PM. Upon arrival LPN #1 noted Resident #1 to be fully dressed with coat and hat. The DON and LPN #2 drove the van to the hospital at 7:45 PM and took Resident #1 to the Emergency Room (ER) for evaluation.

3. SA validated through record review and

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interview with the Administrator that the Administrator was notified at 7:29 PM and at this time it was noted to be 46 degrees outside with no wind or rain present. The Administrator contacted the Maintenance staff at 7:35 PM to report to the facility for inspection of the windows. The Medical Director was notified at 10:15 PM. Multiple attempts were made to notify the Responsible Party but were not successful until 10:00 AM on 2/8/2022 due to her phone malfunction.

4. SA validated through observation, record review of the 'Facility Investigation' and interview with the Maintenance Supervisor, Administrator, DON that upon arriving at the facility at 8:31 PM, Maintenance #1 inspected the windows and applied a safety stop to Resident #1's window to prevent opening more than 6 inches.

5. SA validated through record review and interview with LPN #1, CNA #1 and the DON that the ER Physician conducted an evaluation of Resident #1 at approximately 8:21 PM, with no injuries noted. The DON and staff returned to the facility with Resident #1 at 9:25 PM.

6. SA validated through record review of the 'Facility Investigation" that the Administrator and DON conducted an interview with Resident #1 at 9:28 PM. Resident #1 was moved to room 202A at 10:09 PM and placed on 1:1 staff observation which continues until re-evaluation on 2/25/2022.

7. SA validated through interview with the Maintenance Supervisor and the DON that the Administrator applied a safety stop to the window in room 202A at 10:09 PM. The DON applied a Wander Guard Bracelet to Resident #1 at 10:10

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PM.

8. SA validated through record review of the "In-Service Training Record" with attached sign-in sheets with 'In-service topic' stated "Elopement-Wandering", and interview with the Administrator that staff education was initiated by the Administrator at 10:15 PM to include Wander Guard System, Wandering and Elopement Policy, Exit Seeking Procedures, Abuse, Neglect and Reporting. Staff interviews were initiated by Administrator at 8:45 PM to determine if any Exit Seeking behavior had occurred with Resident #1 prior to his exiting the facility unsupervised. No exit seeking behavior had been witnessed by facility staff.

9. SA validated through record review of the confirmation of receipt of report from the SA dated 2/07/22 and interview with the Administrator that the Administrator notified the SA and Attorney Generals Office at approximately 10:00 PM on 2/7/2022.

10. SA validated through review of the QAPI meeting summary and interview with the Administrator that on the morning of 2/8/2022 at 8:00 AM, the Quality Assessment and Assurance Committee (QAA) to include the Medical Director met and reviewed the policies related to Wandering and Elopements, Abuse, Neglect and Reporting and the Exit Seeking Procedures and recommended to add Resident Rights to the education. No revisions to the policies were recommended. The QAA Committee recommended installing Safety Stops to all windows in the facility. All staff was educated on these policy and procedures prior to working.

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11. SA validated through interview with the Maintenance Supervisor and the Administrator and record review of the 'Facility Investigation' and observation that maintenance staff #1 and #2, completed installation of Safety Stops to all windows in the facility at approximately 2:00 PM on 2/8/2022.

12. SA validated through record review of the 'Elopement Binder' and 'Elopement Evaluations' for all current residents and interview with the DON that Elopement Evaluations were completed by the DON, Resident Care Coordinator and Staff Development Nurse beginning at approximately 10:00 AM 2/8/2022 for all Residents and the Plan of Care updated accordingly for Resident #1 and Resident #2. The Elopement Binder was revised to include Resident #1 and Resident #2 as at risk for elopement at this time as well.

13. SA validated through record review of the QAA committee summary that the QAA Committee met at 1:30 PM on 2/8/2022 to review the intervention progress and implemented a weekly window inspection to be completed by Maintenance #2 and to be documented on the Window Safety Stop Maintenance Log for 4 weeks and monthly there after. Any concerns found would be reported to the QAA committee for recommendations. The Window Safety Stop Maintenance Log will be submitted at least quarterly for the Medical Director and QAA Committee's suggestions or recommendations for sustaining compliance.

Based on all the steps taken by the facility and have been successfully completed, the facility alleges the Immediate Jeopardy was removed as of 2/8/2022 and this represents a Past

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