STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

(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 Survey for Complaint Investigations (CI) MS#18317, CI MS # 18520 and CI MS#18525 on 2/18/22 through 2/25/22. The SA substantiated CI MS #18520 related to an elopement due to the facility's failure to provide adequate supervision to prevent Resident #1's elopement from the facility on 2/11/22 at approximately 12:30 PM. Resident #1 was missing, unsupervised and away from the facility for approximately 23 minutes. The facility staff was not aware of Resident #1's absence until he was discovered in the ditch by a local tire shop owner, who notified the local Police Department. The Police Department then notified the local ambulance service to transport the resident to the local emergency room to be assessed for injuries. The local ambulance paramedic called the nursing home facility, asking if they have any residents missing from the facility. The nursing home staff did not know the whereabouts of Resident #1 at that time. The local Police Department took a picture of Resident #1 and took it to the staff at the nursing home facility in which Resident #1 was identified. The local Police Department informed the nursing home staff that Resident #1 was taken to the local emergency room to be assessed for injuries. Resident #1 was later returned to the facility by the local ambulance company. The facility's immediate investigation revealed Resident #1 stated he was standing in the entrance hallway and noticed that the Screener was screening a visitor and the receptionist had her head down reading something. Resident #1 stated he looked at the door and the green light was on, and he went out the door. Resident #1 told the	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2022

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F 000	Continued From page 1	F 000		

paramedics and the local police that he was running away from the nursing home and he was not going back. Resident #1 was dressed in a light jacket with a t-shirt, blue jeans, socks, and shoes. Resident #1 was placed on one on one (1:1) supervision.

During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 2/23/22, which occurred on 2/11/22 and existed at 42 CFR(s): 483.25(d)(1)(2)-Free of Accidents, Hazards/Supervision/Devices (F689). Based on the facility's implementation of corrective actions on 2/11/22, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed 2/12/22 prior to the SA's entrance on 2/18/22. During the survey, the facility submitted the final report for an investigation related to verbal abuse. The SA investigated CI MS# 18525 related to verbal abuse and cited F600 at a scope and severity of "D".

The facility's failure to provide adequate staff supervision for Resident #1, who had a history of elopement risk and current display of wandering behaviors, placed this resident and all other residents who exhibit wandering behaviors at risk with a likelihood for serious injury, harm, impairment or death.

The SA notified the facility's Administrator of the PNC IJ and SQC on 2/23/22 at 3:40 PM and presented the IJ Template.

CI MS#18317 was not substantiated.

At the time of the survey, the facility had a census of 107, and held a license of 145 beds.

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F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review the facility failed to ensure residents were protected from verbal abuse for one (1) of three (3) residents reviewed for abuse. Resident #3. Findings include: Record review of the facility's policy "Abuse, Neglect, Exploitation, and Misappropriation" revealed a revision date of 11/28/2017 and the policy stated, " ...It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse ... Employees of the center are charged with a continuing obligation to treat residents, so they are free from abuse ... No employee may at any time commit an act of physical, psychological, or emotional abuse ..." The policy defined "verbal abuse may be	F 600	1. Corrective action was accomplished for the resident found to be affected by the deficient practice by: a. The Housekeeping Supervisor was suspended on 02/14/2022 pending investigation. b. Resident #3 was assessed by licensed nurse and was monitored for mental and emotional distress. 2. The facility identified other residents who had the potential to be affected by the deficient practice by the Social Worker conducting a quality review of residents within the care area. The Social Worker interviewed residents with BIMs score 13 and above to ensure residents were free from abuse. No issues were identified. 3. Measures put in place to ensure the	4/14/22

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F 600	Continued From page 3 considered a form of mental abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance regardless of age ability to comprehend or disability ..." Record review of the Admission Record revealed Resident #3 was admitted to the facility on 7/23/21 with diagnoses that included End Stage Renal Disease, Type 2 Diabetes and Major Depressive Disorder. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/22 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. On 02/23/2022 at 5:00 PM, during an interview with the Director of Nursing (DON), she explained on 02/14/2022 Resident #3 came to the Assistant Director of Nursing (ADON) and asked her to come look at his room because his room was dirty and he wanted her to see it. She explained the ADON went to his room and observed the dirty room and removed his trash. The ADON then asked for the Housekeeping Supervisor to go look at the room. She explained the Housekeeping Supervisor then came to her and told her during the time she was looking at Resident #3's room, the resident started cursing her. She explained to the Housekeeper Supervisor that Resident #3 had outburst and cursing, not to engage, walk away, and notify herself or the charge nurse. The Housekeeping Supervisor told her she didn't say anything to the resident because she didn't want to get in trouble or lose her job. She explained she told the Housekeeping Supervisor she would talk to	F 600	deficient practice does not recur: a. Current facility staff educated by the Director of Clinical Services (DON) and Executive Director(ED) regarding policies and procedures for Abuse and Neglect with emphasis on verbal abuse on 02/25/20222. b. New employees will be educated on Abuse and Neglect at the time of hire. 4. The facility plans to monitor its performance to make sure that solutions are sustained by: a. Quality monitoring will be conducted beginning on 03/21/2022 by the DON, ED, and Social Service Director(SSD) to ensure residents are free from Abuse and Neglect. Monitoring will be conducted through resident interviews and observations. b. Quality Monitoring will be conducted with 10 residents twice weekly for 4 weeks the weekly for 3 months. c. The findings of these quality monitoring's will be reported to the Quality Assurance/Performance Improvement Committee monthly for 3 months with the first review on 04/12/2022. d. Quality Monitoring schedule will be modified based on reported findings and QAPI Committee review.	

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Resident #3. After the incident, Resident #3 then came to her office and told her what the Housekeeping Supervisor said and so did Certified Nurse Aide (CNA) #1. She explained she was not aware the Housekeeping Supervisor had engaged with Resident #3 until Resident #3 told her. He explained to her the Housekeeping Supervisor was yelling, calling him names, and cursing him while she was walking away. The DON explained CNA #1 witnessed the Housekeeping Supervisor cursing at the resident and engaging in an altercation. The Housekeeping Supervisor was suspended during the investigation and then terminated. The Housekeeping Supervisor never returned to the facility after leaving on 02/14/2022.

At 10:25 AM on 02/24/2022, during an interview with Social Services Director, she explained the incident with Resident #3 and the Housekeeping Supervisor happened on 02/14/22 after she had left for the day. She explained the next morning on 02/15/2022, the DON told her about the incident and the Housekeeping Supervisor had been put on suspension. She explained she went to talk to Resident #3 about the incident and he reported to her that he asked the Housekeeping Supervisor to clean his room and she told him I am not cleaning your room there is nothing wrong with it. The Housekeeping Supervisor said something to Resident #3 about his momma. The Social Services Director reported Resident #3 and Housekeeping Supervisor knew each other, and she felt the argument was more personal. She explained Resident #3 told her that both him and the Housekeeping Supervisor exchanged words about each other's momma's and Housekeeping Supervisor was still fusing and cursing at him as she walked down the hall. A

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staff member heard them yelling and cursing each other and reported the altercation to the DON.

On 02/24/2022 at 11:30 AM, during an observation and interview, Resident #3 was sitting in therapy interacting with therapy staff. Resident #3 explained he asked the Housekeeping Supervisor to clean his room and she said, "F*** that room, don't give a d**n if the room got cleaned." Resident #3 explained the Housekeeping Supervisor called him names and his mommy a "B***h".

At 1:50 PM on 02/24/2022, during a phone interview with Housekeeping Supervisor, she explained she was the Housekeeping Account Manager for the facility. The regular housekeeper left early on 02/14/22 but she notified the housekeeper she needs to clean her rooms before she left. She reported around 4:20 PM she was at the time clock ready to clock out and Resident #3 came to her and said, "your lazy b**ches and whores need to clean my room." She explained the resident just kept talking to her and said the ADON had been taking out his garbage and she told him if he keeps talking to her like that then maybe the ADON will have to keep cleaning his room. She reported she started to walk away from the resident, but he continued to talk and yell at her. Resident #3 called my mom a "crackhead" and said, "I could be your daddy." I did get upset and don't remember what all I did say to him, but I did call him a "crackhead m*****f***er" and told him he should know my mom because he smoked crack with her. She explained she did call him names and engaged in conversation that escalated. She explained she received training on resident's rights and abuse

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and was aware the definition of abuse.

On 02/24/2022 at 3:00 PM, during a phone interview with the Regional Housekeeper Supervisor, he explained he received a phone call from the DON on 02/14/2022 and she explained what happened between the Housekeeping Supervisor and Resident #3. The DON told him the Housekeeping Supervisor got into a verbal altercation that became escalated and name calling was done and strong language was exchanged. He reported he then called the Housekeeping Supervisor and she explained to him that her and the resident did get into an argument but when he asked what she said, she reported to him she could not remember what all she did say to him, but she did talk back to the resident and called him a "crackhead." He reported he informed her to make a statement and forward the statement to the DON and him. He explained she did not act professionally when interacting with resident. The Housekeeping Supervisor was terminated but he does not currently have the date.

At 3:35 PM on 02/24/2022, during an interview with CNA #1, she explained on 02/14/22, she does not remember the time, but she was in a resident's room two rooms down from Resident #3's room and heard the Housekeeping Supervisor arguing with Resident #3 and the argument kept going on and on and getting louder in the hall to the point that she stopped what she was doing and looked outside the room. She saw the Housekeeping Supervisor in the hallway walking away from Resident #3, who was outside his room. She reported she heard the Housekeeping Supervisor say, "Clean it your G**d**n self, you don't do nothing anyway" and

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the resident called the Housekeeper's mom a "Crackhead Whore". The supervisor replied, "you should know her because you f****d her." After the Housekeeping Supervisor left, she went to the DON and informed her of the altercation between the Housekeeping Supervisor and Resident #3. She reported she had never heard the Housekeeping Supervisor talk about or act that way to any other residents. She explained no one deserves to be talked to the way the Housekeeping Supervisor talked to Resident #3. She reported she knows to report abuse and it was verbal abuse to Resident #3 from the Housekeeping Supervisor. She explained everyone desires the same respect and has been educated on abuse.

On 02/24/2022 at 3:50 PM, during an interview with the Administrator, revealed she was informed of the altercation between the Housekeeping Supervisor and Resident #3. She reported that Housekeeping Supervisor has been terminated. She explained the facility's housekeeping is contracted out through (Formal Name of Cleaning Services). The housekeeping staff is educated through the contract services for annual training including Abuse/Neglect and the contract staff is also included in trainings on site at the facility. She explained it is unacceptable for staff to speak to any resident in any manner other than with respect and dignity.

At 11:15 AM on 02/25/2022, during an interview with the DON, she reported Abuse in-service/trainings are done with each employee on hire and then quarterly. She explained the Housekeeping Supervisor had received her Abuse training from the contract agency. She explained all staff are trained on Residents'

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F 600	Continued From page 8 Rights and to be free from any kind of abuse. She the Housekeeping Supervisor should not have said anything to the resident and report the incident to the nurse or her. Record review of the facility's "Employee Corrective Action" dated 2/17/22, revealed in the statement from Housekeeping Supervisor, "...according to your statement, and by your own admission, you state... I then called him a crack headed m*****f****r". The record was signed by the Housekeeping Supervisor and the Regional Housekeeping Supervisor. Record review of the statement given by the Housekeeping Supervisor dated 2/14/22, revealed, " ...I honestly don't remember what was said because I was mad ... I tell housekeepers not to engage in conversation with him and to ignore him in which I should've taken my own words/advice ..." Record review of the statement given by CNA #1 dated 2/14/22, revealed she heard the Housekeeping Supervisor say, " ...she told his mama and she said bitch ...you ought to know m*****f****r you a f*****g crackhead too." A record review of Housekeeping Supervisor's "(Formal Name of Cleaning Service) Course History" revealed she completed the course on "Patient-Residents' Rights, Abuse, Neglect, and the Elder Justice Act 2021 on 02/02/2022 with a score of 100% passed and completed other courses including "Professionalism-2022 and Employee Conduct and Work Rules-2022."	F 600		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/21/22

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F 689	Continued From page 9 §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 observations, interviews, record review and facility policy review, the facility failed to provide adequate staff supervision to prevent Resident #1's elopement from the facility, on 2/11/22 at approximately 12:30 PM. This concern was identified for one (1) of three (3) residents reviewed for wandering behaviors and at risk for elopement. Resident #1. Resident #1 was identified by the facility as an elopement risk related to his history of attempts to leave the facility unattended, impaired safety awareness, and confusion. Resident #1 was wearing a Wander Guard device and exited the facility from the front entrance door after a default code was entered by the staff. The default door code allowed the door to remain unlocked for a longer period than the regular door code and prevented the Wander Guard device from alarming. Resident #1 was missing, unsupervised and away from the facility for approximately 23 minutes until he was found in a ditch by a local tire shop owner who reported it to the police. The facility staff did not know Resident #1 was off the facility grounds until they were notified by a paramedic with the local ambulance service and a Police Officer brought a photograph of the resident to the facility for identification. The local	F 689	Past noncompliance: no plan of correction required.	

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Police Department informed the nursing home staff that Resident #1 was taken to the local emergency room to be assessed for injuries. Resident #1 was later returned to the facility by the local ambulance company.

The facility failed to provide adequate staff supervision for Resident #1, who was an elopement risk with a current display of wandering behaviors, placed this resident and all other residents who exhibit wandering behaviors at risk with a likelihood for serious injury, harm, impairment or death.

This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) identified on 2/23/22, which occurred on 2/11/22 and existed at 42 CFR(s): 483.25(d)(1)(2)-Free of Accidents, Hazards/Supervision/Devices (F689) Scope and Severity "J".

Based on the facility's implementation of corrective actions on 2/11/22, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed 2/12/22 prior to the SA's entrance on 2/18/22.

The SA notified the facility's Administrator of the PNC IJ and SQC on 2/23/22 at 3:40 PM and presented the IJ Template.

Findings include:

Record review of the facility's policy, "Elopement/Wandering Risk Guideline," revised 8/01/2020 revealed, "Overview: To evaluate and identify patients/residents that are at risk for elopement and develop individualized

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interventions. Process: Patients/Resident's to be evaluated on admission, re-admission, 7 days post admission, quarterly, with a significant change in condition, an elopement event using the risk tool. If a patient/resident is identified as being at risk the staff should complete an Elopement Risk Alert and obtain a photograph. Initiate individualized interventions based on the patient/residents' risk. Document individualized interventions in the resident's care plan and Kardex. If they do a wander monitoring system device check placement of the device every shift and functionality every day. Maintain the elopement risk alerts in an easily accessible location. Complete routine elopement drills monthly and reviewed in Quality Assurance and Performance (QAPI) meetings ..."

Record review of the facility's policy, "Elopement Risk", dated 11/30/2014 revealed, "Policy: It is the policy of The Company that on admission and quarterly, all residents will be assessed for elopement risk. Procedure: An elopement risk assessment will be completed on admission and quarterly by nursing. If the resident is identified as an elopement risk based on the assessment, the care plan will reflect the intervention (i.e., wander guard or code alert) and desired outcomes. Review and or revised care plan following an attempt to leave the facility. Resident identified as at risk for elopement will require nursing to check residents regularly and document on the Safety Checks..."

Record review of the facility's policy, "Missing Patient/Resident, "dated 11/30/2014 revealed, "Overview: Staff will investigate cases of missing residents and possible elopement. An elopement occurs when a resident leaves the premises or a

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state area without authorization and or any necessary supervision to do so, placing the resident at risk for harm or injury ..."

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 10/2/18.

Record review of the Diagnosis Report revealed Resident #1 had diagnoses that included Unspecified Dementia without Behavioral Disturbances and Alzheimer's Disease, unspecified.

Record review of a quarterly Minimum Data Set (MDS) dated 1/27/22, Section C- Cognitive Patterns revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating Resident #1 had severe cognitive impairment. Section D- Mood revealed item H. Moving or speaking so slowly that other people could have noticed, or the opposite-being so fidgety or restless that you have been moving around more than usual. This section was marked with "1" which indicates symptoms were present and the symptom frequency was on 2-6 days.

Record of the Resident #1's "Elopement Risk Evaluation" with an effective date of 12/29/21 revealed, " ...resident is determined to be AT RISK for elopement 1. yes ..."

Record review of the facility's "Timeline" with the "Date of Event" of 2/11/22, revealed "Date 2/11/22 Time 1215 (12:15 PM) Event Resident at the nurses station. Stated to staff that his sister was going to pick him up today and take him out for a while. Time 1230 (12:30 PM) Event Resident

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noted near the front lobby when transportation driver brought another resident back in from the van. Time 1253 (12:53 PM) Event Facility contacted by (Proper Name of local ambulance service) and notified that resident was noted outside of facility. No apparent injuries. Resident transported to ER for evaluation per (Proper Name of local ambulance service) protocol. Time 1255 (12:15 PM) Event (Proper Name of local police department) notified and at facility. 100% resident head count initiated. All other residents accounted for. Time 1255 (12:55 PM) Event MD Notified. Door alarm function checked per Maintenance Director. Time 1315 (1:15 PM) Event Transmitter placement and function verified by nursing staff. Time 1332 (1:32 PM) Event Social Services attempted to contact RP (Responsible Party). Time 1430 (2:30 PM) Reported to (State Agency) Reportable Incident Hotline Time 1530 (3:30 PM) Event IDT (Interdisciplinary Team) meeting held r/t (related to) incident, staff education initiated. Time 1600 (4:00 PM) Event Resident placed on one-on-one observation. 24/7 door monitoring initiated. Time 1638 (4:38 PM) AG (Attorney General) notified. Time 1643 (4:43 PM) Event Resident returned to facility. No injuries, no c/o pain. Resident able to verbalize and physically confirm area of exit from facility. New wangerguard placed to right ankle."

Record review of a handwritten "Witness Statement" dated 2/11/22, revealed "Name of Witness" as Certified Nursing Assistant (CNA) #2. "At about 12:30 me and (Proper Name of another Resident) was coming back from a doctor's appt. (appointment) When we came in the door (Resident #1) was standing by the table in the front lobby ..."

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On 2/18/22 at 1:20 PM through 1:25 PM, observation revealed there were an average of nine (9) cars counted traveling on the street in front of the facility every minute during a five (5) minute observation (approximately 45 cars). Observation of the area surrounding the facility revealed the street was approximately twenty-five (25) yards from the front door of the facility. There was a covered entry area approximately ten-foot square with a standard size sidewalk past the entry way. Past the sidewalk there was an intact macadam parking lot with parking spaces lining the sidewalk along the front of the building. Past the lined parking spaces was the circular driveway with two entrances. There was a drainage ditch which ran around the facility which was approximately ten to twelve feet deep and ran under the street through a culvert at the east corner of the property. There were no sidewalks, walking or bike lanes along the street in front of the facility. There was a paved area which measured six (6) feet wide between the edge of the street and a rumble strip in the street.

On 2/18/22 at 2:50 PM, observation of the area in which Resident #1 was located 0.4 tenths of a mile from the facility in a ditch in front of the tire shop revealed there were an average of forty-seven (47) cars counted traveling on Highway 98 during a six (6) minute observation. The ditch was approximately three (3) feet deep with a smooth sloping surface.

On 2/18/22 at 4:15 PM, a telephone interview with the Resident Representative (RR) for Resident #1 revealed the facility notified her of Resident #'1s elopement. She stated she was concerned about it, but not surprised by it. She stated her father had voiced a desire to "leave the facility"and "to

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get out of there" since admission. She stated he had been identified as an elopement risk since admission but had not exited the building alone prior to this incident. She stated she was concerned about how he could have exited if he had been wearing a 'Wander Guard' bracelet.

During an interview on 2/23/22 at 09:00 AM, with the Maintenance Director revealed staff must input a door code which allows the door to open to enter the building. The Maintenance Director confirmed that staff used an override code, which prevented the door alarm from sounding when a resident wearing a Wander Guard device approached the door and allowed the door to remain unlocked for a longer period. The Maintenance Director identified the override code as being the incorrect code for staff to use to open the door. The staff should have used the regular code, which would have caused the door to immediately lock when the door closed. It would also sound an alarm when a resident with a Wander Guard device approached the door. The Maintenance Director said he does not know how the staff got the override code and he was not aware that all the staff was using the override code instead of the regular code until the elopement occurred and it was discovered during the investigation. The old override code was permanently disabled and the new override code is only known to himself and the Administrator.

During an interview on 2/23/22 at 9:15 AM with the Director of Nursing (DON), she stated she was notified by the local ambulance service that a resident was found in the ditch and was taken to the emergency room to be assessed. The DON stated that a local Police Officer came to the facility with a picture of the resident asking if this

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resident lived at this facility and she confirmed that he did. The local Police Officer advised her that the resident was taken to the emergency room via ambulance to be assessed for injuries and Resident #1 had been found at the corner of the street. The DON stated that the facility immediately completed a head count and all doors and windows were checked. The DON immediately started an investigation and received statements from all the staff. During the investigation, the DON learned that the Screener and the Receptionist said the resident was standing by the front entrance at 12:30 PM. The investigation determined Resident #1 left through the front entrance door because staff and visitors were coming in and out of the door. The DON confirmed after investigating and getting statements from the staff, the facility realized the staff were using the wrong code to enter and exit the building. This caused the door alarm not to sound when Resident #1 approached the door.

During an interview on 2/23/22 at 9:30 AM, with the local Police Officer revealed the Police Department received a call from a local business owner stating that an elderly man had fallen in the ditch and had been there for a long time. The local business owner stated that the man could not get up out of the ditch. A police officer came to the scene and took pictures of the resident. The officer notified the local ambulance service to assess the resident and he was transported to the local emergency room (ER) to be assessed for injuries per ambulance protocol.

During an interview on 2/23/22 at 10:00 AM, with a local Business Owner, he stated that he saw Resident #1 sitting in the ditch and he had been sitting there for a long time. He was unsure how

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long the resident had been there, but it didn't look like he could get up without assistance, so he called the local Police Department and they responded quickly.

During an interview with the Paramedic on 2/23/22 at 11:00 AM, she confirmed that she received a call from the local Police Department stating that an elderly male was found in the ditch next to a local business. The Paramedic said she arrived at the scene and noticed Resident #1 sitting in the ditch and that she remembered seeing Resident #1 about 20 or 30 minutes ago walking around in the parking lot at the nursing home. She had thought the resident was a visitor that was visiting someone at the nursing home. The resident was wearing a light jacket with a T-shirt, blue jeans, and socks and shoes. He was walking on the heel of the shoes, wearing them as slides. The Paramedic asked the resident where he was going and he replied that he was running away from the nursing home and he was not going back. The Paramedic assessed Resident #1 and did not see any bruising or signs of broken bones, so he was transported to the emergency room for a wellness exam. The Paramedic stated that they called the nursing home facility and asked if there was a resident missing and the nursing home did not know if there were any residents missing at that time. The local Police Officer took a picture of Resident #1 and went to the nursing home.

During an interview on 2/23/22 at 11:30 AM, with the Social Services Director (SSD), she confirmed Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) on his last Minimum Data Set (MDS) assessment, which indicated severe cognitive impairment. The SSD

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conducted a BIMS when Resident #1 returned to the facility after the elopement and he scored a 7 which still indicated severe cognitive impairment. The SSD said Resident # 1's BIMS score fluctuates. The SSD said Resident #1 wanders all over the building, but he has never tried to exit the facility or had made statements of wanting to leave. The SSD stated that Resident #1 was upset because his daughter had not come to see him for several weeks.

An interview on 2/23/22 at 11:45 AM, with the Speech Therapist (ST) revealed the DON asked her to conduct a Brief Cognitive Assessment Tool (BCAT) on Resident #1 when he came back to the facility. The ST said the Resident scored a 27 out of 50, which indicated Resident #1 was mildly demented.

On 2/23/22 at 12:15 PM, in an interview with CNA # 4 revealed she is the Receptionist and was working the day of the elopement. She stated that she was stamping receipts and had her head down when the elopement occurred. CNA #4 stated the last time she saw Resident #1 he was standing in the front lobby entrance interacting with visitors and staff. She did not see the resident exit the building.

On 2/23/22 at 12:45 PM, in an interview with CNA #2 stated on 2/11/22 around 12:30 PM she arrived from taking another Resident to a doctor's appointment, when she noticed Resident #1 standing in the front entrance. Resident #1 smiled and continued to stand in the lobby. CNA #2 said she looked back at the door to make sure it locked and took the Resident to her room.

Record review of Resident #1's "Change in

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Condition (SBAR) (Situation Background Assessment and Recommendation)," with an effective date of 2/11/22, revealed " ...A. Situation 1. The change in condition, symptoms, or signs observed and evaluated is/are: resident noted to be out of facility unattended by (Name of Local Ambulance Company) staff. resident transported to ER for eval. (evaluation). no visible injuries noted EMT (Emergency Medical Technician). no c/o (complaints of) pain. Told EMT 'I'm gonna leave every chance I get'...B. Appearance 1. Summarize your observations and evaluation: resident returned to facility from ER. no skin impairments noted. New Wander guard placed on right lower leg. functionality of device checked. resident placed on one-on-one until further notice ..."

Record review of the Order Summary Report with active orders as of 2/11/22 revealed an order with an order and start date of 10/12/21 "Monitor wander guard (right wrist) for placement and function q (every) shift ..."

Record review of the February 2022 Treatment Administration Record (TAR) revealed "Monitor wander guard (right wrist) for placement and function q (every) shift exp (expiration) date 6/2024" discontinued 2/11/22. "Monitor wander guard (right leg) for placement and function q shift (exp. date 12/2024) every day and night shift for monitoring, start date 2/11/22".

Record review of Resident #1 's comprehensive care plan revised 10/20/21 revealed, "Focus: The resident is an elopement risk r/t (related to) history of attempts to leave facility unattended, impaired safety awareness, confusion ...Interventions: ...Distract resident from

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wandering by offering pleasant diversion, structured activities, food, conversation, television, book. Resident prefers. Electronic monitoring device. Check Wanderguard for PLACEMENT AND FUNCTIONING AS ORDERED. Nurse to check to assure Wander guard bracelet is in place every shift. Provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes."

The facility implemented the following Immediate Jeopardy (IJ) Removal Plan /Corrective Actions prior to the State Agency (SA) entrance on 2/18/22.

In response to the past Noncompliance IJ and SQC cited at 3:40 PM on 2/23/22, the facility submitted a summary of the event, including an IJ removal plan and corrective actions, taken by the facility to remove the IJ.

Brief Summary of Events:
At 3:40 PM on February 23, 2022, the State Agency (SA) notified the Executive Director (ED) of an immediate jeopardy, which began on February 11, 2022, related to the facility's failure to provide supervision for Resident #1 who left the facility unnoticed and unsupervised on February 11, 2022 at approximately 12:30 PM and was located approximately 23 minutes after the last observation by a staff member. An immediate jeopardy (IJ) template was provided to the ED by the SA. The IJ was cited Past Noncompliance (PNC).

On February 11, 2022, at approximately 12:53 PM Emergency Service personnel (EMS) #1 called the facility and notified the Director of

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Nursing (DON) that, while in route back to EMS headquarters, Resident #1 was found approximately 400 feet from the nursing facility. Resident #1 was in route to emergency room (ER).

Corrective Actions:

1. On February 11, 2022, at 12:55 PM Resident #1's primary physician was notified by DON. Responsible Party was notified at 1:32 PM by Social Services Director (SSD). Attorney General was notified at 4:38 PM by Assistant Director of Nursing (ADON). SA was notified at 2:30 PM by ADON.

2. On February 11, 2022, at 12:55 PM a visual headcount was initiated and completed at 1:00 PM by Licensed Practical Nurse #1, #2, #3, #4 and #5. Census on February 11, 2022, was 104. 103 residents were accounted for and noted to be in the facility. Resident # 1 remained in the ER at the time the visual headcount was completed.

3. On February 11, 2022, at 1:00 PM the Maintenance Supervisor (MS) validated that all 10 exit doors were functioning appropriately. Wander guard system at front door was functioning appropriately and door was opening and closing appropriately.

4. On February 11, 2022, at 1:15 PM LPN #1, #2, #3, #4 and #5 initiated validation of placement and function of wander guard devices, using visual observation and device transmitter, for residents currently residing in the facility who were previously identified as elopement risks. Placement and function validation was completed at 1:30 PM and documented in the electronic

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health record. Wander guard devices were noted to be appropriately placed and functioning.

5. On February 11, 2022, at 3:30 PM the ADON initiated education with current employees on the topics of Elopement Guideline, Missing Resident Search, Elopement Assessment, Wander Guard Monitoring & Elopement Drill, and proper door code to exit facility. Education provided prior to the start of each employee's next scheduled shift. No employee will be a allowed to work without education.

6. On February 11, 2022, at 3:30 PM the Quality Assurance Performance Improvement (QAPI) Committee met to review the investigation, conduct the Root Cause Analysis (RCA) and review policy and procedures for any changes. Attendees of the QAPI Committee meeting included the ED, DON, SSD, Housekeeping Supervisor (HKS), Human Resources Director (HRD), Medical Records Clerk (MRC), Therapy Director (TD), Activities Director (AD), Dietary Manager (DM), and Medical Director (MD) . The RCA determined Resident #1 exited the front entrance door unnoticed and unsupervised by staff. The RCA also determined staff were using an override/ default door code that prevented the wander guard system from engaging alarms on door when wander guard device was in proximity of door. Policy and procedures for Elopement Guidelines, Missing Resident Search, Elopement Assessment, Wander Guard Monitoring and Elopement Drill, and proper door code to exit facility were reviewed and no changes to policy and procedures were made.

7. On February 11, 2022, at 4:00 PM there was a staff member put to monitor door continuously.

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There was a door monitor on the door until February 15, 2022, at 3:00 PM.

8. On February 11, 2022, at 4:15 PM Elopement Drills were initiated and conducted by the DON and MS with 15 employees and education was provided on Elopement Guidelines, Missing Resident Search, Elopement Assessment, Wander Guard Monitoring & Elopement Drill, and proper door code to exit facility.

9. On February 11, 2022, at 4:40 PM Resident #1 returned to the nursing facility by an ambulance transport. There was no injury reported. Resident #1 was placed on one on one observation upon return. Complete body audit was completed by DON and ADON at 4:43 PM. No injury noted. Resident #1's care plan was reviewed and updated to reflect new interventions.

10. On February 11, 2022, at 4:46 PM the Social Services Director (SSD) completed a Brief Interview for Mental Status (BIMS) for Resident # 1. Resident's score was a 7 which indicates cognition was severely impaired.

11. On February 11, 2022, at 5:00 PM ADON initiated reevaluation of current Residents identified to be an elopement risk. Reevaluations were completed at 6:00 PM and residents reevaluated were determined to remain elopement risk. No additional residents were identified at risk for elopement.

12. On February 11, 2022, at 5:30 PM Maintenance Supervisor (MS) #1 notified Vendor #1 to remove override code from wander guard system. The override code only affected the function of front door entrance. The override

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code was permanently disabled and verified by MS #1. Per Maintenance interview, he and the Administrator have an override code?

13. On February 11, 2022, at 6:00 PM the DON and ADON elopement binders were reviewed to ensure they contained current Residents at risk for elopement's identifying information. All elopement binders contained no issues.

14. On February 11, 2022, at 10:45 PM Resident #1 was reevaluated for elopement risk by the Assistant Director of Nursing (ADON). Based on potential risk factors Resident continues to be at risk for elopement.

15. On February 12, 2022, at 5:30 AM, an additional Elopement Drill was conducted by the DON and MS with 17 employees and education was provided on Elopement Guideline, Missing Resident Search, Elopement Assessment, and Wander Guard Monitoring & Elopement Drill.

16. On February 12, 2022, between 7:56 AM and 10:27 AM the Speech Therapist (ST) conducted a Brief Cognitive Assessment Tool (BCAT). Resident #1 scored 27 out of 50 which indicates mild Dementia. Based on results physician orders noted for Speech therapy 3 x weekly for 4 weeks to focus on reasoning skills related to safety awareness. Resident #1's care plan was updated to reflect ST's observations and interventions.

The facility alleges all corrective action to remove the immediate jeopardy was completed as of February 11, 2022, and the immediate jeopardy was removed February 12, 2022.

Validation:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

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

1. The SA validated through interview and record review that on February 11, 2022, at 12:55 PM Resident #1's primary physician was notified by DON. Responsible Party was notified at 1:32 PM by Social Services Director (SSD). Attorney General was notified at 4:38 PM by Assistant Director of Nursing (ADON). SA was notified at 2:30 PM by ADON.

2. The SA validated through interviews and record review that on February 11, 2022, at 12:55 PM a visual headcount was initiated and completed at 1:00 PM by Licensed Practical Nurse #1, #2, #3, #4 and #5. Census on February 11, 2022 was 104. 103 residents were accounted for and noted to be in the facility. Resident # 1 remained in the ER at the time the visual headcount was completed.

3. The SA validated through observation, interviews, and record reviews that on February 11, 2022, at 1:00 PM the Maintenance Supervisor (MS) validated that all 10 exit doors were functioning appropriately. Wander guard system at front door was functioning appropriately and door was opening and closing appropriately.

4. The SA validated through observation, interviews and record review that on February 11, 2022, at 1:15 PM LPN #1, #2, #3, #4 and #5 initiated validation of placement and function of wander guard devices, using visual observation and device transmitter, for residents currently

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residing in the facility who were previously identified as elopement risks. Placement and function validation was completed at 1:30 PM and documented in the electronic health record. Wander guard devices were noted to be appropriately placed and functioning.

5. The SA validated through interview and record review that on February 11, 2022, at 3:30 PM the ADON initiated education with current employees on the topics of Elopement Guideline, Missing Resident Search, Elopement Assessment, Wander Guard Monitoring & Elopement Drill and proper door code to exit facility. Education provided prior to the start of each employee's next scheduled shift. No employee will be allowed to work without education.

6. The SA validated through interviews and record review that on February 11, 2022, at 3:30 PM the Quality Assurance Performance Improvement (QAPI) Committee met to review the investigation, conduct the Root Cause Analysis (RCA) and review policy and procedures for any changes. Attendees of the QAPI Committee meeting included the ED, DON, SSD, Housekeeping Supervisor (HKS), Human Resources Director (HRD), Medical Records Clerk (MRC), Therapy Director (TD), Activities Director (AD), Dietary Manager (DM), and Medical Director (MD) . The RCA determined Resident #1 exited the front entrance door unnoticed and unsupervised by staff. The RCA also determined staff were using an override/ default door code that prevented the wander guard system from engaging alarms on door when wander guard device was in proximity of door. Policy and procedures for Elopement Guidelines, Missing Resident Search, Elopement

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Assessment, Wander Guard Monitoring and Elopement Drill, and proper door code to exit facility were reviewed and no changes to policy and procedures were made.

7. The SA validated through observation, interviews, and record review that on February 11, 2022, at 4:00 PM there was a staff member put to monitor door continuously. There was a door monitor on the door until February 15, 2022 at 3:00 PM.

8. The SA validated through interviews and record review that on February 11, 2022, at 4:15 PM Elopement Drills were initiated and conducted by the DON and MS with 15 employees and education was provided on Elopement Guidelines, Missing Resident Search, Elopement Assessment, Wander Guard Monitoring & Elopement Drill, and proper door code to exit facility.

9. The SA validated through interviews and record review that on February 11, 2022, at 4:40 PM Resident #1 returned to the nursing facility by an ambulance transport. There was no injury reported. Resident #1 was placed on one-on-one observation upon return. Complete body audit was completed by DON and ADON at 4:43 PM. No injury noted. Resident #1's care plan was reviewed and updated to reflect new interventions.

10. The SA validated through staff interview and record review that on February 11, 2022, at 4:46 PM the Social Services Director (SSD) completed a Brief Interview for Mental Status (BIMS) for Resident # 1. Resident's score was a 7 which indicates cognition was severely impaired.

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11. The SA validated through record review that on February 11, 2022, at 5:00 PM ADON initiated reevaluation of current Residents identified to be an elopement risk. Reevaluations were completed at 6:00 PM and residents reevaluated were determined to remain elopement risk. No additional residents were identified at risk for elopement.

12. The SA validated through interview and record review that on February 11, 2022, at 5:30 PM Maintenance Supervisor (MS) #1 notified Vendor #1 to remove override code from wander guard system. The override code only affected the function of front door entrance. The override code was permanently disabled and verified by MS #1.

13. The SA validated through record review that on February 11, 2022, at 6:00 PM the DON and ADON elopement binders were reviewed to ensure they contained current Residents at risk for elopement's identifying information. All elopement binders contained no issues.

14. The SA validated through record review that on February 11, 2022, at 10:45 PM Resident #1 was reevaluated for elopement risk by the Assistant Director of Nursing (ADON). Based on potential risk factors Resident continues to be at risk for elopement.

15. The SA validated through record review that on February 12, 2022, at 5:30 AM, an additional Elopement Drill was conducted by the DON and MS with 17 employees and education was provided on Elopement Guideline, Missing Resident Search, Elopement Assessment, and

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F 689	Continued From page 29 Wander Guard Monitoring & Elopement Drill. 16. The SA validated through interview and record review that on February 12, 2022, between 7:56 AM and 10:27 AM the Speech Therapist (ST) conducted a Brief Cognitive Assessment Tool (BCAT). Resident #1 scored 27 out of 50 which indicates mild Dementia. Based on results physician orders noted for Speech therapy 3 x weekly for 4 weeks to focus on reasoning skills related to safety awareness. Resident #1's careplan was updated to reflect ST's observations and interventions. Review of the Facility's educational in-service record, dated 2 /11/22, revealed the facility provided all the staff and in- service on elopement which included following orders for visual checks /monitoring resident location, function of wander guard per orders, answering alarms in a timely manner, and door/wander guard alarms.	F 689		