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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) of Facility Reported Incident CI MS #19263 at the facility from 6/23/22 to 6/27/22. During the survey, the SA substantiated the complaint for Incident/Accident related to an elopement. The facility failed to provide adequate supervision to prevent the cognitively impaired Resident #1's elopement from the facility on 6/19/22 at 7:03 PM. Upon video surveillance footage, the Resident #1 was unsupervised and away from the facility for approximately 57 minutes . The facility was not aware of Resident #1's absence from the facility. Resident #1 was discovered in a church parking lot one-half mile from the facility shortly before 8:00 PM on 6/19/22. During the survey, the SA determined the facility was not in compliance with the requirements for the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M 640. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 6/19/22, when the facility failed to provide adequate supervision to prevent an elopement for Resident #1, who was an elopement and wander risk, allowed the cognitively impaired resident to leave the facility, unnoticed and unsupervised until the Resident Representative (RR) of Resident #1 returned him to the facility at 8:00 PM. The facility's failure to provide adequate supervision placed Resident #1 and other at risk residents in a situation that was likely to cause serious injury, harm, impairment or death. The SA notified the facility's Administrator of the IJ and SQC on 6/24/22 at 2:22 PM and provided	M 000		

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M 000	Continued From page 1 the facility Administrator with the IJ Template. The IJ and SQC existed at Rule 45.21.8 - Accidents (M 640) Level IV Past Non Compliance. Based on the facility's implementation of corrective actions on 6/20/22, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 6/20/22, prior to the SA's entrance on 6/23/22. The facility held a license for 121 beds, with a census of 111.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Past Non-compliance Based on interviews, record review, facility investigation review and facility policy review, the facility failed to provide adequate staff supervision to prevent Resident #1's elopement from the facility at 7:03 PM on 6/19/22, per video surveillance. Resident #1 was last seen by facility staff at 6:40 PM. The 3 PM to 11 PM shift Licensed Practical Nurse (LPN) #1/Charge Nurse/Staff Development Nurse was notified by Resident #1's Resident Representative (RR) at 8:00 PM, that she had been telephoned by a	M 640		

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family friend that Resident #1 was observed walking around the church parking lot and the RR had immediately gone to the church, one half mile from the facility, and picked up Resident #1 and returned him to the facility. This concern was identified for one (1) of four (4) residents reviewed for wandering behavior and risk for elopement.

Facility staff were not aware that Resident #1 left the facility without staff knowledge or supervision until approximately 8:00 PM on 6/19/22. The resident had been assessed by the facility as "High Risk for Elopement". During the facility investigation, staff reviewed the security surveillance video and discovered the resident walked out the front door behind a group of visitors at 7:03 PM on 6/19/22. The front door was kept locked and required the intervention of staff to open. Staff members at the "100 Hall" nurses station had viewed a line of visitors in line at the front door on a video screen at the nurses station and disengaged the lock which allowed the door to open. Resident #1 was not in view of the surveillance camera at the front door because he was at the end of the line of visitors and out of camera view. Resident #1 followed the visitors out of the facility's front door. Video footage from the surveillance camera outside the facility showed the resident walked off of the facility property at 7:07 PM. Resident #1's RR received a telephone call from a family friend who told her that they observed Resident #1 in the church parking lot one-half mile from the facility. Resident #1's RR went to the church, picked up the resident and returned him to the facility at 8:00 PM. Resident #1's assigned nurse, LPN #2 performed a head-to-toe body audit immediately upon his return to the facility which revealed no injuries; he was also immediately placed on

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one-on-one monitoring until he was transported to another facility with a dementia unit. The resident reported to the Staffing Development Nurse that he had "gone to visit his mother and niece (RR)". Resident #1's most recent Minimum Data Set (MDS), dated 3/17/22, revealed he scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. Resident #1 was identified on his "Wandering Elopement Assessment" dated 9/21/21 as "Resident at risk for wandering/elopement", and he was independently ambulatory.

The facility's failure to provide adequate supervision to prevent an elopement for Resident #1 who was at risk for elopement allowed the resident to be away from the facility, unnoticed and unsupervised until the resident's RR returned him to the facility. This placed Resident #1, and other residents at risk for elopement, in a situation likely to cause serious injury, harm, impairment or death.

On 6/24/22, the SA identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC), which began on 6/19/22, when Resident #1 exited the facility through the front door and was located just prior to 8:00 PM one-half mile away in a church parking lot and returned to the facility at 8:00 PM.

The IJ and SQC existed at Rule 45.21.8 - Accidents (M 640) Level IV Past Non Compliance.

The SA notified the facility's Administrator of the IJ and SQC on 6/24/22 at 2:22 PM, and provided the IJ template.

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M 640	Continued From page 4 Based on the facility's implementation of corrective actions on 6/20/22, the SA determined the IJ was removed as of 6/20/22, prior to the SA's first entrance on 6/23/22. Findings include: Record review of the facility policy titled "RESIDENT AT RISK FOR WANDERING BEHAVIOR" dated 4/26/22 revealed, "This facility ensures that residents who exhibit wandering behavior receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk." Further review revealed "The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for unsafe wandering ...Adequate supervision will be provided to help prevent accidents or elopements". Record review of the facility's investigation dated 6/19/22 confirmed the last time Resident #1 was seen was at 6:40 PM. At 8:00 PM, the RR of Resident #1 delivered him to the facility. The facility's investigation revealed staff immediately completed a count of all residents to ensure that other residents were accounted for with no concerns noted. Exit doors and windows were checked by the staff and were operating correctly. On 6/23/22 at 6:30 PM, observation revealed the resident walked approximately one hundred fifty-six (156) feet from the front door to the sidewalk, then one-half (1/2) mile to the nearby church parking lot. The facility was situated approximately 55 yards off the road, posted speed limit thirty-five (35) miles per hour, with a fifteen (15) foot sidewalk and five (5) foot strips of	M 640		

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grass on each side of the sidewalk. There was a white, broad board fence separating the road and the side yard of the facility. The road was parallel to the east side of the facility. The front of the facility faced a cement parking lot. The grass of the lawn was short, trimmed, and well-maintained. The parking lot was cement, clear, clean, free of holes and tripping hazards. The four lane street ran north to the red light at the intersection with a bank on the right (same side of the street as the facility) on the block on the corner 0.2 miles from the facility. From the bank it was 0.3 miles to the church across the two lane street (left side of the street) with a posted speed limit of thirty-five (35) miles per hour. The church was 0.5 miles from the facility.

Record review of "weather conditions in Clinton, MS on 6/19/22" according to website 'localconditionscom' revealed that at the time of elopement 7:00 PM until 7:15 PM, the temperature was 89.6 degrees Fahrenheit, clear with three (3) mile an hour northerly wind.

Record review of the "sunrise-sunset.org" website revealed that on 6/19/22 the sun set at 8:12 PM.

On 6/23/22 at 7:10 PM, observation from the east facing window of the facility revealed in a one-minute timed observation, there were fifteen (15) vehicles counted total (north to south and south to north).

On 6/23/22 at 7:11 PM, observation from the east facing window of the facility revealed in a one-minute timed observation, there were twenty-five (25) vehicles counted total (north to south and south to north).

On 6/23/22 at 8:15 PM, observation out of the

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window of the living room revealed the area was well lit and there was adequate natural lighting to see without problem.

On 6/23/22 at 8:35 PM, an interview with the Administrator revealed that the facility reported incident identified as "Elopement" was discovered on 6/19/22 at 8:39 PM, when Resident #1's Resident Representative (RR), niece, returned Resident #1 to the facility side door and LPN #1 let them in and notified the Administrator, immediately observed Resident #1 for injury and dehydration and encouraged fluids by mouth, supervised a one-hundred percent (100%) head count/room check with resident census and performed a door check on all exit doors to ensure they were closed and locked. The Administrator stated the LPN #1 notified the Director of Nurses (DON) and performed interviews of facility staff for the facility investigation. The Administrator said Resident #1's RR reported the elopement to the facility and the Administrator reported the elopement to the State Agency on 6/19/22 at 9:29 PM. The Administrator stated that she had viewed surveillance camera footage of the front door and observed that the resident exited the front door at 7:03 PM on 6/19/22 by following behind a "family group" which included two people in wheelchairs, which she said, "made the length of the line of people leaving out of the front door longer". She confirmed the resident had been wearing a pair of pants, a short-sleeved shirt and regular shoes at the time of elopement. She explained "You can't put a code in on the outside (to open any of the doors), you must wait for someone to put in a code on the inside for each door". She stated that 8 AM-5 PM, the receptionist, Business Office Manager (BOM) and Administrator have a button at their desks that will open the front door. She

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stated, "The Administrator has a monitor, the receptionist and BOM have windows they can see out. There's a doorbell outside the front door and the "100 hall" or rehab nurses station has a little screen which shows view of camera with microphone of the front door and the nurses at the nurses station can open the front door from the nurses' station on the "100 hall", down the hall from the front door. The Administrator reported that surveillance camera footage revealed Resident #1 left out of the front door at 7:03 PM and left the facility property at 7:07 PM, and staff reports Resident #1 returned at approximately 8:00 PM. Resident #1 was gone from the facility for "about an hour and a half". The Administrator stated that Resident #1 did not suffer any injuries of any kind during or due to the elopement. The Administrator revealed the facility completed a Quality Assurance and Assessment (QAA)/Quality Assurance Performance Improvement (QAPI) meeting on 6/20/22 in which the appropriate members were in attendance and policies were discussed with no changes to facility policies. She stated the facility conducted in-services/training related to elopements in which staff would not be able to work until in-serviced. The Administrator reported that she audited all residents at the facility that had been previously assessed as "High Risk For" unsafe wandering or elopement. She stated she that her audit revealed Resident #1 was the only resident at the facility who had been confirmed as having "High Risk for Elopement". She stated she audited the remaining residents and it was her conclusion that no other residents were at more than "Moderate Risk for Elopement". The care plans were reviewed for all residents at "Moderate Risk for Elopement".

On 6/23/22 at 9:00 PM, an interview with LPN #1

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revealed she said she was working the night of 6/19/22 on the 3 PM-11 PM shift. She stated the elopement was discovered when "family brought him (Resident #1) back to the facility at 8:00 (PM)". Resident #1 was wearing a pair of pants, a short-sleeved shirt, and regular shoes at the time of elopement. LPN #1 stated Resident #1 was gone from the facility for "about an hour and a half". The LPN stated that as soon as Resident #1's RR returned him to the facility at 8:00 PM, she telephoned the Administrator, recommended and provided cold water for the resident, then she completed a check of all the facility exit doors while the nursing staff performed a full body audit of Resident #1, conducted room checks and confirmed the presence of all residents compared to the printed daily census. No injuries or signs/symptoms of dehydration were noted. LPN #1 said the RR for Resident #1 told her that a family friend observed Resident #1 in the parking lot of a nearby church and telephoned the RR who had immediately gone to the church and picked the resident up and brought him to the facility.

On 6/23/22 at 9:30 PM, an interview with the Director of Nurses (DON) revealed that prior to elopement, the resident was assessed as being at risk for elopement. She confirmed she had attended the Quality Assessment Performance Improvement (QAPI) meeting on 6/20/22 and the facility elopement policy was reviewed.

On 6/24/22 at 3:00 PM, a telephone interview with the Resident Representative (RR) for Resident #1 revealed that she was contacted by telephone "a little before 8:00 PM" on 6/19/22 by a family friend who told her they had just seen Resident #1 in the parking lot of the nearby Church. She said she immediately went and picked Resident #1 up

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and took him to the facility. She stated Resident #1 had no noted injuries and no signs of dehydration or heat injury at the time. She stated she had conferred with the Administrator on 6/20/22 for care planning and was informed of a "sister facility" a short distance away which had a 'Dementia Care Unit' and she had agreed for Resident #1 to be transferred to the "sister facility" upon recommendation of the Nurse Practitioner.

On 6/27/22 at 3:00 PM, an interview with CNA #1 confirmed she was working North Hall on the 3 PM-11 PM on the evening of 6/19/22 and visually observed Resident #1 on the North Hall at approximately 6:40 PM. She stated that Resident #1 "walked around a lot", "he didn't always stay on his unit; he left his unit every day".

Record review of the "Admission Record" for Resident #1 revealed he was admitted by the facility on 6/25/21.

Record review of the "Diagnosis Information" for Resident #1 revealed he had diagnoses of Encephalopathy, Dementia and Generalized Muscle Weakness.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/17/22, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognitive impairment. Further review of the MDS revealed Resident #1 was independently ambulatory.

Record review of the "Wandering Elopement Assessment" for Resident #1, dated 9/21/21, revealed the evaluation stated "Resident at risk for wandering/elopement".

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M 640	Continued From page 10 The facility implemented the following Corrective Action Plan prior to the SA's entrance on 6/23/22: Corrective Action Plan 1. On 6/19/2022, at 7:03 PM, Resident #1 exited the facility unsupervised, through the facility's front door with visitors holding door for Resident #1, after staff had disengaged the door for visitors. This represented an Immediate Jeopardy, and the Administrator was presented with an IJ template 6/24/2022 at 2:22 PM by the State Surveying Agency (SSA). 2. On 6/19/2022, at 8:00 PM, Resident #1's niece who is the Responsible Party (RP) returned him to the facility. She was greeted by Licensed Practical Nurse (LPN) #1. She stated someone had seen him and called her and she went and got him from the church (0.5 miles from facility) and is returning him to the facility. 3. On 06/19/22 at 8:00 PM, an investigation was initiated by LPN #2 and a body audit was completed for Resident #1 and there were no injuries noted. 4. On 6/19/22, upon return to facility, 8 PM, Resident #1 was placed on 1:1 observation by facility staff until Discharged. 5. On 6/19/22, at 8:10 PM, LPN #2, notified the physician on call of the incident and there were no new orders given. 6. On 6/19/22, 8:10 PM, LPN #1, completed a head count and bed checks. All other residents were accounted for.	M 640		

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M 640	Continued From page 11 7. On 6/19/22, at 8:30 PM, LPN #1, checked all doors for proper functioning and locking. All doors were secured, locked and functioning properly. 8. On 6/19/22, at 8:35 PM, LPN #1 notified the Administrator and the Director of Nursing (DON) via phone. 9. Resident #1's care plan was reviewed and updated on 6/19/22, at 8:40 PM by LPN #1 and LPN #2. LPN #1 obtained statements from those working for any knowledge of the incident. 10. On 6/19/22, at 9:29 PM, the Administrator notified the State Agency via Complaint Line of Resident #1 exiting the facility. On 6/19/22, at 9:38 PM LPN #1, initiated an In-service education to staff, on Door release and observation, 1:1 to continue, Policy on Elopement or Missing Resident, including what to do if employee observes resident leaving premises, procedure for locating missing resident and Procedures Post-elopement. Also included in the in-service "wandering elopement assessments", Adequate supervision to help prevent accidents or elopements (The staff will observe the door, not just the remote camera, henceforth), and Abuse/Neglect. No staff will be allowed to work until in-serviced by LPN #1, Staff Development Coordinator or DON. 11. On 6/19/22, statements obtained by LPN #1 at 9:40 PM, reveal CNA #1 last saw resident at 6:40 PM on South Unit. 12. On 6/19/22 at 9:40 PM, the Administrator audited Wandering Assessments and Care plans in Electronic Health Record remotely. All residents who are at high or moderate risk for	M 640		

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wandering were audited, by review of most recent Elopement Assessments and Brief Interview of Mental Status (BIMS) scores. No other high-risk residents were identified. All moderate risk residents were also reviewed to determine risk score and that appropriate plan of care and interventions were in place. There were no new at risk identified and no other care plans updated as a result of the audit.

13. On 6/19/21, at 10:45 PM, Employee #1, included steps of Elopement Drill (Code Adam), as part of the in-service training for Wandering Risk Residents/Elopement Procedures.

14. On 6/20/22 at 7:00 AM the Administrator arrived at facility for review of Video Camera footage. Camera footage confirmed at 7:03 PM, a group of visitors exited the facility through the front door, including two in a wheelchair and 4 others. The staff released the door lock for the visitors to exit. As each visitor exited the facility they held the door open for the next person, the last visitor exiting the facility held the door open for Resident #1 to exit. Resident #1 walked with the visitor group through the parking lot to their cars. Resident #1 continue to walk the perimeter of the parking lot around to the sidewalk at approx. 7:06-7:10 PM. Resident #1 was returned to facility at approx. 8:00 PM.

15. On 6/20/22 at 8:00 AM, Maintenance #1, checked all the doors and locks again to ensure/validate appropriate functioning. All door locks were secure and functioning appropriately.

16. On 6/20/22, at 8:30 AM, the Administrator notified the facility's Medical Director of the incident.

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M 640	Continued From page 13 17. On 6/20/22, the Nurse Practitioner (NP) recommended Resident #1 be transferred to a dementia unit. 18. On 6/20/22 at 8:00 AM -10 AM, an AD HOC Quality Assurance Performance Improvement (QAPI) meeting held with the NP, Administrator, DON, Staff Development Coordinator/LPN#1, infection preventionist and Registered Nurse (RN) unit Managers. The NP is the Medical Director's designee for the QAPI meeting. QAPI Committee Recommendations followed: On 6/20/22 at 10:00 AM, Referral sent to local facility with a dementia unit. Continue In-service education to staff, on Door release and observation, 1:1 to continue, Policy on Elopement or Missing Resident, including what to do if employee observes resident leaving premises, procedure for locating missing resident and Procedures Post-elopement. Also included in the in-service "wandering elopement assessments", Adequate supervision to help prevent accidents or elopements (The staff will observe the door, not just the remote camera, henceforth), and Abuse/Neglect. No staff will be allowed to work until in-serviced by LPN #1, Staff Development Coordinator or DON. Resident care plan reviewed and updated on 6/19/22. Continue 1:1 observation until transfer to Dementia unit complete. Reviewed 06/19/22 audits of all resident's identified at risk for elopement. No new recommendations. No other HIGH risk residents present at this time. Door Screener's hours to be increased on 6/20/22 to 7 PM, Business Office Manager (BOM) to ensure Coverage and schedule. DON reviewed Elopement Binder, on 06/20/22. Resident #1 remains only high risk for	M 640		

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elopement and resident information (face sheet and picture are in the binders).

The Administrator, DON, LPN #1 and SDC to monitor for compliance.

Wandering Resident and elopement Policy and Procedure Reviewed on 6/20/22, with no revisions recommended by the QAPI committee.

19. 06/20/22 9:30 AM, the Attorney General's Office was notified via Phone by the Administrator and DON.

The facility alleges all corrective action to remove the immediate jeopardy was completed as of 6/20/22.

VALIDATION:

On 6/27/22, the SA validated the facility's investigation of the incident and implementation of the Corrective Action through observations, facility record review and interviews.

1. SA validated through interviews with LPN #1 and the facility Administrator, record reviews of the facility investigation, 'Incident Report' dated 6/19/22 and Resident #1's 'Progress Notes' and observation of facility surveillance video that on 6/19/2022, at 7:03 PM, Resident #1 exited the facility unsupervised, through the facility's front door with visitors holding door for Resident #1, after staff had disengaged the door for visitors. This represented an Immediate Jeopardy, and the Administrator was presented with an IJ template 6/24/2022 at 2:22 PM by the State Surveying Agency (SSA).

2. SA validated through interviews with Resident #1's RP and LPN #1 and record review of the facility investigation, that on 6/19/2022, at 8:00

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PM, Resident #1's niece who is the Responsible Party (RP) returned him to the facility. She was greeted by Licensed Practical Nurse (LPN) #1. She stated someone had seen him and called her and she went and got him from the church (0.5 miles from facility) and is returning him to the facility.

3. SA validated through record review of the facility investigation, 'Incident Report' dated 6/19/22, and Resident #1's Progress Notes and interview with LPN #2 that on 06/19/22 at 8:00 PM, an investigation was initiated by LPN #2 and a body audit was completed for Resident #1 and there were no injuries noted.

4. SA validated through record review of "1:1 Resident Observation Form's dated 6/19/20 through 6/22/22, the facility investigation, 'Incident Report' dated 6/19/22, and Resident #1's Progress Notes and interview with LPN #1, LPN #2 and the Administrator that on 6/19/22, upon return to facility, at 8:00 PM, Resident #1 was placed on 1:1 observation by facility staff until discharged.

5. SA validated through record review of the 'Incident Report' dated 6/19/22 that on 6/19/22, at 8:10 PM, LPN #2, notified the physician on call of the incident and there were no new orders given.

6. SA validated through record review of the facility "Census" dated 6/19/22 used as a checkoff and the facility investigation, and interviews with LPN #1 and the Administrator that on 6/19/22, at 8:10 PM, LPN #1 completed a head count and bed checks. All other residents were accounted for.

7. SA validated through record review of the

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facility investigation and interview with LPN #1 that on 6/19/22, at 8:30 PM, LPN #1 checked all doors for proper functioning and locking. All doors were secured, locked and functioning properly.

8. SA validated through record review of the facility investigation and interview with LPN #1 that on 6/19/22, at 8:35 PM, LPN #1 notified the Administrator and the Director of Nursing (DON) via phone.

9. SA validated through record review of the care plan for Resident #1 and the facility investigation that Resident #1's care plan was reviewed and updated on 6/19/22, at 8:40 PM by LPN #1 and LPN #2. LPN #1 obtained statements from those working for any knowledge of the incident.

10. SA validated through record review of the facility investigation and interview with the Administrator that on 6/19/22, at 9:29 PM, the Administrator notified the State Agency via Complaint Line of Resident #1 exiting the facility.

SA validated through record review of "In-Service Training" forms with sign-in sheets attached and interview with LPN #1 and CNA #1 that on 6/19/22, at 9:38 PM, LPN #1 initiated an In-service education to staff, on door release and observation, 1:1 to continue, Policy on Elopement or Missing Resident, including what to do if employee observes resident leaving premises, procedure for locating missing resident and Procedures Post-elopement. Also included in the in-service "wandering elopement assessments", adequate supervision to help prevent accidents or elopements (The staff will observe the door, not just the remote camera,

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henceforth), and Abuse/Neglect. No staff will be allowed to work until in-serviced by LPN #1, Staff Development Coordinator or DON.

11. SA validated through interview with CNA #1 and record review of the facility investigation, including the written, signed statements of staff working the 3-11 shift that on 6/19/22, statements obtained by LPN #1 at 9:40 PM, reveal CNA #1 last saw Resident #1 at 6:40 PM on South Unit.

12. SA validated through interview with the Administrator and record review of sampled resident's clinical health records (Resident #2, Resident #3 and Resident #4), and reports printed by the Administrator that on 6/19/22 at 9:40 PM, the Administrator audited Wandering Assessments and Care plans in Electronic Health Record remotely. All residents who are at high or moderate risk for wandering were audited, by review of most recent Elopement Assessments and Brief Interview for Mental Status (BIMS) scores. No other high-risk residents were identified. All moderate risk residents were also reviewed to determine risk score and that appropriate plan of care and interventions were in place. There were no new at risk identified and no other care plans updated as a result of the audit.

13. SA validated through interviews with LPN #1 and CNA #1 and record review of "In-Service Training" forms with sign-in sheets attached that on 6/19/21, at 10:45 PM, Employee #1, included steps of Elopement Drill (Code Adam), as part of the in-service training for Wandering Risk Residents/Elopement Procedures.

14. SA validated through interview with the Administrator and observation of facility surveillance video that on 6/20/22 at 7:00 AM the

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administrator arrived at facility for review of Video Camera footage. Camera footage confirmed at 7:03 PM, a group of visitors exited the facility through the front door, including two in a wheelchair and 4 others. The staff released the door lock for the visitors to exit. As each visitor exited the facility they held the door open for the next person, the last visitor exiting the facility held the door open for Resident #1 to exit. Resident #1 walked with the visitor group through the parking lot to their cars. Resident #1 continue to walk the perimeter of the parking lot around to the sidewalk at approximately. 7:06-7:10 PM. Resident #1 was returned to facility at approximately. 8:00 PM.

15. SA validated through interview with the Administrator and record review of the facility investigation that on 6/20/22 at 8:00 AM, Maintenance #1, checked all the doors and locks again to ensure/validate appropriate functioning. All door locks were secure and functioning appropriately. SA confirmed through observation that all door locks were secure and functioning appropriately.

16. SA validated through record review of the 'Incident Report' dated 6/19/22 that on 6/20/22, at 8:30 AM, the Administrator notified the facility's Medical Director of the incident.

17. SA validated through record review of the 'Progress Notes' for Resident #1 dated 6/20/22 that on 6/20/22, the Nurse Practitioner (NP) recommended Resident #1 be transferred to a dementia unit.

18. SA validated through record review of the QAPI meeting minutes with attached sign-in sheet that on 6/20/22, Resident #1's 'Progress

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Notes', "1:1 Resident Observation" forms, "In-Service Training" sheets, Resident #1's Care Plan, facility Elopement Binders, Interview with the on duty Door Screener, Administrator, LPN #1 and DON that at 8:00 AM -10 AM, an AD HOC Quality Assurance Performance Improvement (QAPI) meeting held with the NP, Administrator, DON, Staff Development Coordinator/LPN#1, infection preventionist and Registered Nurse (RN) unit Managers. The NP is the Medical Director's designee for the QAPI meeting. QAPI Committee Recommendations followed:

On 6/20/22 at 10:00 AM, Referral sent to local facility with a dementia unit.

Continue In-service education to staff, on Door release and observation, 1:1 to continue, Policy on Elopement or Missing Resident, including what to do if employee observes resident leaving premises, procedure for locating missing resident and Procedures Post-elopement. Also included in the in-service "wandering elopement assessments", Adequate supervision to help prevent accidents or elopements (The staff will observe the door, not just the remote camera, henceforth), and Abuse/Neglect. No staff will be allowed to work until in-serviced by LPN #1, Staff Development Coordinator or DON.

Resident care plan reviewed and updated on 6/19/22. Continue 1:1 observation until transfer to Dementia unit complete.

Reviewed 06/19/22 audits of all resident's identified at risk for elopement. No new recommendations. No other HIGH risk residents present at this time.

Door Screener's hours to be increased on 6/20/22 to 7 PM, Business Office Manager (BOM) to ensure Coverage and schedule.

DON reviewed Elopement Binder, on 06/20/22. Resident #1 remains only high risk for

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M 640	Continued From page 20 elopement and resident information (face sheet and picture are in the binders). The Administrator, DON, LPN #1 and SDC to monitor for compliance. Wandering Resident and elopement Policy and Procedure Reviewed on 6/20/22, with no revisions recommended by the QAPI committee. 19. SA validated through interview with the Administrator and record review of the facility investigation that on 6/20/22 at 9:30 AM, the Attorney General's Office was notified via phone by the Administrator and DON. The facility alleges all corrective action to remove the immediate jeopardy was completed as of 6/20/22. The SA validated that all corrective action to remove the immediate jeopardy was completed as of 6/20/22 and the Immediate Jeopardy was removed on 6/20/22, prior to entrance.	M 640		