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	25A178	A. BUILDING _____ B. WING _____	C 07/22/2022

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JASPER COUNTY NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CI) at the facility from 7/20/22 through 7/22/22. The facility was not in compliance with Medicare and Medicaid requirements of participation. The SA substantiated the facility reported incident CI MS #19394 and CI MS #19397 both related to an elopement when the facility failed to provide supervision to prevent Resident #1,who had a diagnosis of Puerperal Psychosis and was cognitively impaired from leaving the facility without supervision on 7/16/22. CI MS #19332, CI MS #19320, and CI MS #18829 for Quality of Care/Treatment were unsubstantiated. Resident #1 was allowed to exit the facility at 10:30 AM on 7/16/22. Resident #1 went out the main entrance exit door after a staff member unlocked the door and was off the facility grounds, without knowledge of the staff and unsupervised for approximately 30 minutes until a driver passing by on the street telephoned the facility and notified them of the resident's whereabouts. Resident #1 was located approximately 130 feet from the facility's main entrance on the side of the street the facility was located on near the edge of the eastern driveway of the church next door to the facility at approximately 11:00 AM. During the investigation of the complaint, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 7/16/22 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazard/Supervision/Devices (F689) - Scope and Severity "J".	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/22/2022

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F 000	Continued From page 1 The facility failed to provide supervision to prevent an elopement for Resident #1 who exited the door without staff knowledge and was unsupervised for approximately 30 minutes. Resident #1 was located on the side street and was returned to the facility by facility staff. This situation placed Resident #1 and other residents at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 7/21/22 at 2:02 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 7/16/22 through 7/18/22, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 7/18/22, prior to the SA's entrance on 7/20/22. At the time of survey, the facility held a license for 110 beds, with a census of 101.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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	F 689		

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F 689	Continued From page 2 by: The State Agency (SA) conducted a Complaint Investigation (CI) for CI MS #19394 and CI MS #19397 on 7/20/22 through 7/22/22 and substantiated CI MS #19394 and CI MS #19397 related to an elopement, when the facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility. Resident #1 was last seen by facility staff at approximately 10:30 AM, on 7/16/22. Resident #1 was missing, unsupervised and away from the facility for approximately thirty (30) minutes. The facility Ward Clerk was notified at approximately 11:00 AM by a driver passing by on the street that Resident #1 was in her wheelchair 130 feet north of the facility's main entrance and was perpendicular to a highway at the edge of a paved driveway of a church next door to the facility. At approximately 11:01 AM, the Ward Clerk and Registered Nurse (RN)#1 located the resident and assisted her to return to the facility. Resident #1 re-entered the facility at 11:05 AM. RN#1 immediately assessed Resident #1 and documented no injuries. The resident reported she had exited out of the main door. She was not able to explain why she left the facility premises. Resident #1 had been admitted by the facility on 6/30/20 and had been assessed for wandering behaviors, but negative for elopement risk. RN#1 notified the Administrator, the Director of Nurses (DON), the Resident Representative (RR) for Resident #1 and the Nurse Practitioner (NP) who was the designee for the resident's primary physician. The NP issued orders for Resident #1 to have an Accutech Safe Wandering Device applied and monitored by the facility nursing staff. She was added to the facility list of residents at risk for elopement that was posted at all nurses stations. On 7/16/22, the facility staff,	F 689	Past noncompliance: no plan of correction required.	

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Administrator, DON and RN #1 performed a resident headcount and ensured all residents were present and accounted for and the Administrator checked all the exit doors to ensure they were closed, locked and locks were operating properly. Facility staff assessed all residents for elopement risk. The Administrator and DON updated the "List of Residents at Risk of Elopement" posted at each nurse's station. The Administrator investigated the incident. The DON conducted a mandatory in-service training related to Elopements and Missing Residents.

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 a driver passing by the facility notified the facility. Resident #1 was propelling herself in her wheelchair. This situation place Resident #1 and other residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment or death.

On 7/21/22, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which occurred on 7/16/22 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 7/21/22 at 2:02 PM, and provided the Administrator with the IJ template.

The SA notified the facility's Administrator of the Past Non-Compliance (PNC) Immediate Jeopardy (IJ) on 7/21/22 at 2:02 PM.

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Based on the facility's implementation of corrective actions on 7/16/22 through 7/18/22, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed as of 7/18/22, prior to the SA's entrance on 7/20/22.

Based on interviews, record review, facility investigation review and facility policy review, the facility failed to provide adequate staff supervision to prevent the elopement of Resident #1, who had severe cognitive impairment, and was allowed out of the front door on 7/16/22 at 10:30 AM, by facility staff to sit outside without supervision. This failure allowed Resident #1 to be away from the facility unnoticed and unsupervised for approximately 30 minutes until a passerby observed and alerted the facility that Resident #1 was approximately 130 feet away from the facility main entrance on the side of the street. This concern was identified for one (1) of two (2) residents reviewed for wandering behavior and risk for elopement.

Findings include:

Record review of the facility policy titled "Elopement Policy", undated, revealed " ...Facts to consider- Anytime the resident is successful in getting off the facility premises, this is considered to be elopement ..."

Record review of the "Facility Investigation" prepared by the facility Administrator, dated 7/19/22, revealed the last staff observation of Resident #1 prior to the elopement was at 10:30 AM on 7/16/22. The facility received a telephone call from a driver passing by on the street in front of the facility at approximately 11:00 AM on

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7/16/22, who notified the Ward Clerk that there was a female in a wheelchair on the street headed toward the highway. The Ward Clerk and RN#1 ran outside, immediately observed Resident #1 on the street, and assisted her back into the facility where she was immediately assessed by the RN with no injuries noted. The facility staff conducted a resident headcount and confirmed all residents on the daily census were present and accounted for. An elopement risk assessment was completed and dated 7/16/22 for Resident #1. This was reported along with the elopement incident to the designee and NP for the Resident #1's primary physician on 7/16/22 at 11:30 AM. New physician orders dated 7/16/22 were obtained for a wandering device (bracelet) to be applied to Resident #1 and a urinalysis (UA). The Resident Representative (RR) for Resident #1 was notified by RN#1 on 7/16/22 at 11:35 AM. The Administrator reported to the facility and checked all exit doors to ensure they were closed and locked and functioning properly on 7/16/22 at 1:15 PM. On 7/18/22, the Minimum Data Set (MDS) Nurse updated the Care Plan for Resident #1.
The Quality Assessment and Performance Improvement (QAPI) committee held a meeting on 7/18/22 at 9:00 AM, attended by the NP as designee for the facility Medical Director who was on vacation, during which the facility policies related to elopement were reviewed.

Observation on 7/20/22 at 1:00 PM, revealed the facility was situated on a tree lined street, 0.1 mile (one tenth of a mile) off a two lane highway. There was a local church on the corner of the highway and the street. The facility faced the street and was located behind the church. The north-east corner of the facility property, where

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the elopement occurred, had a front lawn that was shared with the hospital portion of the building. The front lawn was flat and free of holes and trip hazards. There was approximately 80 feet from the main entrance into the facility to the three (3) foot wide sidewalk which ran from the main entrance of the facility toward the parking lot adjacent the street (between the facility and the street) and turned at the parking lot and ran the length of the facility and then to the Main Entrance of the hospital. There was an approximately fifty (50) foot wide parking lot with two rows of parking, one faced the facility, and one row faced the street. From the Main Entrance of the facility to the east side driveway of the church (from the street), was approximately one hundred twenty feet. There was a well-maintained side yard on the northeast corner of the facility property with a hill which led up to the church. There was a flat area from the front of the facility to the side of the church and the church's east driveway where the ground was flat, smooth, even and the grass was short and ran all the way to the street macadam with no curb. The facility was connected directly to the county hospital on the south end.

Observation on 7/20/22 at 1:10 PM, revealed there was one main entrance into the facility. The door was locked and the facility staff had to disengage the lock to allow entrance into the building. All other exterior doors had magnetic locking mechanism in place which prevented the doors from opening unless the fire alarm system was engaged in the event of a fire. The main entrance required staff to press a button from the front nurses station to open.

On 7/20/22 at 1:30 PM, the SA attempted to

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contact the RR for Resident #1 without success. A message was left with a request for the RR to return a telephone call to the SA. The RR did not return a phone call to the SA.

On 7/20/22 at 2:10 PM, interview and observation revealed Resident #1 was sitting up in her room in her wheelchair. She was wearing a wandering device (bracelet) on her left wrist. She was alert and able to communicate well verbally. Her mood was pleasant. She indicated to the SA she did not want to talk about the 7/16/22 elopement incident. She did not respond when asked why she had left the facility.

On 7/20/22 at 3:00 PM, an interview with the facility Director of Nurses (DON) revealed she reported to the facility on 7/16/22 following notification by RN#1 of the elopement incident at approximately 11:35 AM. The DON confirmed RN#1 completed an incident report and performed an elopement risk assessment for Resident #1. She confirmed the staff had completed a resident headcount and all residents were accounted for and that the Administrator had personally checked all exit doors and locks to ensure they were closed, locked and locks were operating properly. The DON said she applied the safe wander bracelet to Resident #1 and confirmed proper functioning. She stated the Administrator updated the list of residents at risk for elopement at each nurses station with the name and photo of Resident #1 on 7/16/22 at approximately 1:30 PM, and had posted a notice to nursing staff with instructions that no resident was to exit the facility without direct staff supervision at approximately 2:40 PM. She stated she and the Administrator started mandatory in-service training on 7/16/22 at 2:45 PM,

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addressing the topics of elopement and missing residents, during which verbal instructions were issued to all staff for monitoring/assessment of all residents for elopement risk and that no resident was to exit the facility without direct staff supervision. The DON confirmed the care plan for Resident #1 was reviewed and updated by the MDS Nurse on 7/18/22 at 8:00 AM. She confirmed she had attended a QAPI committee meeting on 7/18/22 at 9:00 AM, that was attended by the NP, designee for the Medical Director (on vacation) during which the facility policy on elopement was reviewed with no changes made.

Website review from (Formal name of website) revealed the weather in the area on 7/16/22 was warm and dry. The temperature was 86 to 90 degrees Fahrenheit between 9:56 AM and 11:09 AM during the timeframe when the resident was out of the facility unsupervised. The wind speed was three to five (3-5) miles per hour.

On 7/20/22 at 3:30 PM, observation and an interview with Registered Nurse (RN) #1 revealed Resident #1 was last observed by facility staff at approximately 10:25 AM propelling herself in her wheelchair in the hallway. He stated that he was notified by the Ward Clerk who received a telephone call from a bystander and both immediately went outside where they saw Resident #1 on the side of the street at the driveway of the church next door, off the facility premises at approximately 11:00 AM. He stated they returned into the facility with the resident at approximately 11:05 AM, and he immediately assessed the resident and noted no injuries. He said the resident was not able to explain why she left the facility grounds on 7/16/22 or where she

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was going. The resident was dressed in pants, a short sleeved shirt and a pair of loafers at the time of the elopement. He said the facility staff performed a headcount of all facility residents and confirmed all were accounted for. He confirmed Resident #1 was assessed for risk of elopement on 7/16/22. He stated he notified Resident #1's NP at approximately 11:30 AM. He said new orders were received which included application of a safe wandering device, orders for routine monitoring of the device and a urinalysis. He stated he notified the Administrator and the DON and the RR for Resident #1 at approximately 11:35 AM. The SA and RN #1 toured the elopement scene and confirmed the site where the resident was located at the edge of the driveway on the east side of the church (same side of the street as the nursing home) approximately fifty (50) yards from the highway which was at the end of the street, perpendicular to the street the facility was on. He stated he had not witnessed or had staff report any exit seeking behavior by Resident #1 prior to the incident. He stated the resident's risk factors for elopement included her diagnosis of Psychosis and wandering behavior. He added that following the incident the NP ordered a urinalysis which indicated a urinary tract infection which can result in change of behavior in the elderly. He confirmed Resident #1 was added to the list of residents at risk for elopement posted at the nurses stations on 7/16/22 at approximately 2:40 PM by the Administrator. RN #1 confirmed that the Administrator and the DON had reported to the facility following the incident on 7/16/22 at approximately 2:45 PM. A mandatory in-service training was provided by the DON and Administrator which included no residents were to be allowed outside the building without direct staff

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supervision. He stated the RR arrived at the facility following the incident and was involved in decisions regarding interventions. He said that generally he uses direct visual observation to monitor staff to ensure they were implementing care-planned interventions. He confirmed the name and photograph of Resident #1 was added to the list of residents at risk for elopement at the nurses stations by the Administrator.

On 7/20/22 at 4:00 PM, an interview with the Administrator revealed he had been notified by staff at approximately 11:45 AM on 7/16/22 that Resident #1 had left the facility premises unattended. He said he reported to the facility on 7/16/22 at 1:15 PM and checked all doors to ensure proper locking and functioning. He said at approximately 1:30 PM on 7/16/22, he had updated the elopement risk list with Resident #1's name and photograph and distributed the updated list to each nurses station. He stated that at 1:44 PM on 7/16/22, he reported the elopement to the SA. He said Resident #1 was assessed for risk of elopement and a monitoring device had been ordered for and applied to Resident #1's left wrist by the DON. He stated that at approximately 2:40 PM on 7/16/22, he posted notices at the main nurses stations, adjacent to the main exit which stated no resident was to exit the facility without direct staff supervision. He said that at 2:45 PM on 7/16/22, he and the DON presented an in-service training to all staff present on elopement and missing residents, which included verbal instructions for nursing staff to monitor/audit/assess all residents for elopement risk. He said no other residents had been identified on 7/16/22 as elopement risk. He said the in-service training also included verbal instructions that no resident was to be

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allowed to exit the building without direct staff supervision. He said the care plan for Resident #1 was updated on 7/18/22 at 8:00 AM by the MDS Nurse. The Administrator reported that a QAPI committee meeting was held on 7/18/22 at 9:00 AM, during which the facility elopement policy was reviewed with no changes made to the policy.

On 7/22/22 at 10:02 AM, an interview with the facility MDS Nurse revealed she was able to confirm that RN #1 had completed an elopement assessment of Resident #1, and new orders had been received on 7/16/22 for a wandering bracelet and monitoring. She stated she had updated the care plan for Resident #1 on 7/18/22 at 8:00 AM to include elopement risk as a 'Problem/Need' with appropriate interventions according to facility policy and resident need. She reported the resident had not had any elopement incidents since admission prior to 7/16/22. She stated Resident #1 had been assessed upon admission and every three months following for risk of elopement and did not assess as at risk. She stated she believed the resident's UTI had a causal effect because the resident had not displayed exit seeking behaviors prior to the incident. She confirmed Resident #1's care plan been reviewed and revised as indicated to reflect changes as a result of the elopement incident. She confirmed there were no injuries related to the incident assessed. She confirmed changes in the resident's elopement risk was correctly identified and communicated with staff by mandatory in-service training, elopement risk lists at all nurses stations and verbal instructions by the Administrator and DON.

Record review of laboratory results (urinalysis

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results) dated 7/17/22, Progress Notes dated 7/17/22, and Physician Orders for Resident #1 dated 7/17/22, pertinent to incident, revealed the resident had a positive result for urinary tract infection (UTI). The Progress Notes review revealed the NP was notified of the urinalysis results on 7/17/22. The Physician Orders review revealed new orders dated 7/17/22 were documented for an antibiotic prescription (Macrobid) for UTI.

On 7/22/22 at 2:05 PM, a telephone interview with the NP revealed she confirmed the facility staff notified her on the afternoon of 7/16/22 of the elopement of Resident #1. She confirmed she was present at a QAPI committee meeting on 7/18/22 at 9:00 AM. She said she had issued orders for Resident #1 to have a safe wandering device applied as well as accompanying monitoring orders and a urinalysis (UA) to check for urinary tract infection. She said that upon receipt of the UA results she prescribed antibiotics for Resident #1 for a UTI. The NP confirmed that a symptom of UTI in the elderly was behavior changes and could have been a causal factor in the elopement incident.

Record review of the Face Sheet for Resident #1 revealed Resident #1 had been admitted by the facility on 6/03/20. Resident #1 had diagnoses of Puerperal Psychosis, Aphasia, Hemiplegia following Cerebral Infarction Affecting Right Dominant Side, Urinary Tract Infection and Type 2 Diabetes Mellitus.

Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/22 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of

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8 which indicated moderate cognitive impairment. She had 'Behavior' of 'Wandering' "one (1) to three (3) days but was not assessed as an elopement risk. Further MDS review revealed Resident #1 required extensive one-person assistance for walking.

Record review of the Care Plan for Resident #1 dated 7/16/22, revealed "Problem/Need (Formal name of Resident #1) IS AT RISK FOR ELOPEMENT ...GOAL ...(Formal Name of Resident #1) WILL BE PROVIDED WITH A SAFE ELOPEMENT DETERRENT ENVIRONMENT ...INTERVENTIONS ...*2. APPLY WANDERING BRACELET ..."

Record review of the Physicians Orders for Resident #1 revealed an order dated 7/16/22 for "Check for Wander Bracelet" Daily and "Check for Wander Guard Battery Placement/Replacement Weekly" Every Sunday.

The facility implemented the following Corrective Action Plan prior to the SA's entrance on 7/20/22:

Corrective Action Plan

On July 16, 2022, at 10:30 AM Resident #1, exited the facility. Video evidence shows that resident exited the Station 3 door. At 11:01 AM, Ward Clerk, received a telephone call from a bystander stating that a lady in a wheelchair was on local street in front of facility heading north toward local highway. This represented an Immediate Jeopardy (IJ) and the Administrator was presented with an IJ template on July, 21, 2022 at 2:02 PM by the State Agency (SA).

On July 16, 2022, at 10:30 AM Resident #1,

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exited the facility. Video evidence shows that resident exited the Station 3 door. At 11:01 AM, Ward Clerk, received a telephone call from a bystander stating that a lady in a wheelchair was on local street in front of facility heading north toward local highway. This represented an Immediate Jeopardy (IJ) and the Administrator was presented with an IJ template on July, 21, 2022 at 2:02 PM by the State Agency (SA).

1. On July 16, 2022, Registered Nurse #1 (RN#l), and Registered Nurse #2 (RN#2), completed a full body assessment on Resident # 1 at 11:20 AM. No injuries were noted upon assessment.

2. Family Nurse Practitioner (FNP) was notified at 11:30 AM on July 16, 2022, of resident elopement. Order was received to apply a wanderguard bracelet to Resident #1 and to collect a urine specimen for urinalysis, which was accomplished by RN #1.

3. On July 16, 2022, at 11:35, AM, RN# 1 notified Resident #1's responsible party of the elopement as well as the Director of Nursing (DON), and Administrator.
4. Vital signs were able to be obtained on July 16, 2022, at approximately 12:27 PM and were within normal range.

5. On July 16, 2022, at approximately 12:30 PM, each unit verified all residents were accounted for by facility staff present making rounds.

6. At approximately 12:45 PM, on July 16, 2022, all current elopement risk residents' wanderguard bracelets were checked for placement and proper function by the unit medication nurse.

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7. On July, 16, 2022, the Administrator, arrived at the facility at approximately 1:00 PM and began the investigation. Employees with knowledge of the elopement were spoken with and asked to write statements.

8. On July 16, 2022, at approximately 1:15 PM, all exit doors, including locks and alarms were checked by the Administrator.

9. On July 16, 2022, at approximately 1:30 PM, a picture of Resident #1 was taken by the Administrator and added to the Wander Alert sheet kept at each nurses station.

10. On July 16, 2022, the Administrator sent an email at 1:44 PM notifying the SA of elopement. Attorney General's Office was notified of elopement per eForm at 2:01 PM.

11. On July 16, 2022, at approximately 2:30 PM, the Director of Nursing (DON), applied wanderguard bracelet to the right wrist of Resident #1, and verified function of the bracelet. Per facility protocol and Doctor orders: the placement of the wanderguard bracelet is checked by the nurse every shift. Battery is checked by nurse weekly.

12. On July 16, 2022 at approximately 2:40 PM, the Administrator posted a sign at the Station 3 (Main Entrance) nurses station informing staff that no resident can exit the Station 3 entrance doors without supervision. Staff present at the time the sign was posted were verbally informed of this decision.

13. Staff were inserviced on the facility

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elopement policy and that no resident can exit Station 3 entrance without supervision by the Administrator and DON at approximately 2:45 PM on July 16, 2022, which was required for every staff member prior to reporting to their assigned unit. No staff will be allowed to work until they have completed the inservice training.

14. On July 16, 2022 at approximately 2:50 PM, the Administrator directed the RN #1, Licensed Practical Nurse #1, etc. to review all residents for wandering/elopement behavior. No other residents were identified as an elopement risk at that time.

15. On Monday, July 18, 2022, Resident #1's care plan was reviewed and updated by the Minimum Data Set, (MOS) Coordinator at approximately 8:00 AM.

16. On Monday, July 18, 2022 at 9:00 AM members of the Quality Assurance and Performance Improvement (QAPI) committee met and discussed elopement of Resident #1 and potential modifications to the facility premises to prevent future elopements. The committee also reviewed the elopement policy and recommended no changes be made. The committee scheduled a drill to be conducted for Tuesday, July 19, 2022 and the facility will repeat elopement drills at least quarterly.

Based on the steps the facility initiated and completed for this incident, the facility alleges that the immediate jeopardy was removed as of July 18, 2022, at 11:00 AM.

VALIDATION

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

1. SA validated through record review of the Progress Notes and Facility Investigation and interview with RN#1 that on July 16, 2022, Registered Nurse #1 (RN#l), and Registered Nurse #2 (RN#2), completed a full body assessment on Resident # 1 at 11:20 AM. No injuries were noted upon assessment.

2. SA validated through record review of the Progress Notes, Physician Orders, Facility Investigation and interview with the FNP that the Family Nurse Practitioner (FNP) was notified at 11:30 AM on July 16, 2022, of resident elopement. Order was received to apply a wanderguard bracelet to Resident #1 and to collect a urine specimen for urinalysis, which was accomplished by RN #1.

3. SA validated through record review of the Progress Notes, Physician Orders, Facility Investigation and interview with RN #1 and the Administrator that on July 16, 2022, at 11:35, AM, RN# 1 notified Resident #1's responsible party of the elopement as well as the Director of Nursing (DON), and Administrator.

4. SA validated through record review of the Progress Notes vital signs were able to be obtained on July 16, 2022, at approximately 12:27 PM and were within normal range.

5. SA validated through interview with the Administrator, RN #1, and LPN #1 that on July 16, 2022, at approximately 12:30 PM, each unit

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verified all residents were accounted for by facility staff present making rounds.

6. SA validated through interview with the DON and LPN #1 that at approximately 12:45 PM, on July 16, 2022, all current elopement risk residents' wanderguard bracelets were checked for placement and proper function by the unit medication nurse.

7. SA validated through record review of the 'Facility Investigation' and interviews with the Administrator and RN #1 that on July, 16, 2022, the Administrator, arrived at the facility at approximately 1:00 PM and began the investigation. Employees with knowledge of the elopement were spoken with and asked to write statements.

8. SA validated through interviews with the Administrator and RN #1 that on July 16, 2022, at approximately 1:15 PM, all exit doors, including locks and alarms were checked by the Administrator.

9. SA validated through observation of "Wander Alert" sheet at various nurses stations and interview with the Administrator that on July 16, 2022, at approximately 1:30 PM, a picture of Resident #1 was taken by the Administrator and added to the Wander Alert sheet kept at each nurses station.

10. SA validated through record review of correspondence with SA (eForm) that on July 16, 2022, the Administrator sent an email at 1:44 PM notifying the SA of elopement. Attorney General's Office was notified of elopement per eForm at 2:01 PM.

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11. SA validated through interview with the DON and LPN #1 and record review of the Treatment Administration Record (TAR) 7/22 for Resident #1 on July 16, 2022, the Director of Nursing (DON), applied wanderguard bracelet to the right wrist of Resident #1, and verified function of the safe wandering bracelet. Per facility protocol and Doctor orders: the placement of the wandergaurd bracelet is checked by the nurse every shift. Battery is checked by nurse weekly.

12. SA validated through observation of the posted printed notification at the Station 3 nurses station and on July 16, 2022 at approximately 2:40 PM, the Administrator posted a sign at the Station 3 (Main Entrance) nurses station informing staff that no resident can exit the Station 3 entrance doors without supervision. Staff present at the time the sign was posted were verbally informed of this decision.

13. SA validated through record review of facility "In-Service Training" sheets with attached Sign-In sheets dated 7/16/22 and interviews with RN#1, DON, LPN#1, CNA#1 and CNA#2 that staff were inserviced on the facility elopement policy and that no resident can exit Station 3 entrance without supervision by the Administrator and DON beginning approximately 2:45 PM on July 16, 2022, which was required for every staff member prior to reporting to their assigned unit. No staff will be allowed to work until they have completed the inservice training. The DON interview revealed the facility continued the training until one hundred percent (100%) of staff had received the training.

14. SA validated through interview with RN #1,

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LPN #1, and the Administrator on July 16, 2022 at approximately 2:50 PM, the Administrator directed RN #1, Licensed Practical Nurse #1, etc. to review all residents for wandering/elopement behavior. No other residents were identified as an elopement risk at that time.

15. SA validated through record review of the care plan, dated 7/18/22 for Resident #1 and interview with the MDS Nurse that on Monday, July 18, 2022, Resident #1's care plan was reviewed and updated by the Minimum Data Set, (MDS) Coordinator at approximately 8:00 AM.

16. SA validated through record review of the committee meeting minutes with attached sign-in sheet dated 7/18/22 and interviews with the Administrator, the Maintenance Supervisor, the DON and the MDS Nurse that on Monday, July 18, 2022 at 9:00 AM members of the Quality Assurance and Performance Improvement (QAPI) committee met and discussed elopement of Resident #1 and potential modifications to the facility premises to prevent future elopements. The committee also reviewed the elopement policy and recommended no changes be made. The committee scheduled a drill to be conducted for Tuesday, July 19, 2022 and the facility will repeat elopement drills at least quarterly.

Based on all the steps taken by the facility and have been successfully completed, the facility alleges the Immediate Jeopardy was removed as of 7/18/22 the facility alleges that the Immediate Jeopardy was removed as of July 18, 2022, at 11:00 AM and this represents a Past Non-compliance.

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F 689	Continued From page 21 The SA validated that all corrective action to remove the Immediate Jeopardy was completed as of 7/18/22, prior to entrance.	F 689		