MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	74BR	A. BUILDING: _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	314 ENOCHS ST TYLERTOWN, MS 39667

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) at the facility from 3/21/23 through 3/23/23. During the survey, the SA investigated the facility reported incident, CI MS# 21045, related to an elopement, and determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The facility failed to provide supervision to prevent Resident #1, who had diagnoses that included Vascular Dementia, and Senile Degeneration of the Brain, and was cognitively impaired from leaving the facility without supervision. Resident #1 was allowed the exit the facility, through a window in his room, at approximately 8:00 PM on 3/14/23. The facility staff were unaware of Resident #1's absence until staff entered his room for hourly monitoring and discovered that Resident #1 was not in his room. The facility completed a facility wide search and began to search the surrounding outdoor area. The Resident was located at 10:37 PM, by the Quality Assurance (QA) Nurse approximately five hundred (500) feet from the facility standing behind a local business. When located, Resident #1 had been off the facility grounds, and unsupervised for approximately two (2) hours and 37 minutes. During the investigation of the complaint, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/14/23 and existed at Rule 45.21.8 - Accidents (M 640) Level IV. The facility failed to provide supervision to prevent the elopement for Resident #1, who exited the facility through his window without staff	M 000		

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M 000	Continued From page 1 knowledge and was unsupervised for approximately two (2) hours and 37 minutes. Resident #1 was located at a nearby business, transferred and assessed at a local hospital emergency department for injury, and returned to the facility by family. 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 3/23/23 at 11:15 AM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 3/14/23 through 3/15/23, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 3/15/23, prior to the SA's entrance on 3/21/23.	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 Based on observations, interviews, record review, facility policy review, and facility investigation review, the facility failed to provide adequate supervision to prevent the elopement of Resident #1, who had severe cognitive impairment, from	M 640	Past non-compliance no POC required.	4/5/23

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M 640	Continued From page 2	M 640		

exiting the facility through a window on 3/14/23 at approximately 8:00 PM. This failure allowed Resident #1 to be away from the facility unnoticed and unsupervised for approximately two (2) hours and 37 minutes, until facility staff located the resident approximately 500 hundred feet away from the facility at a local business. This concern was identified for one (1) of four (4) residents reviewed for wandering behavior and risk for elopement.

The State Agency (SA) conducted a Complaint Investigation (CI) at the facility from 3/21/23 through 3/23/23. During the survey, the SA investigated the facility reported incident, CI MS# 21045, related to an elopement, and determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility. Resident #1 was last seen by the facility staff at approximately 8:00 PM, on 3/14/23. However, at approximately 9:00 PM, during an hourly observation, Resident #1 was not located. The facility initiated a facility wide search, at which time it was discovered that the window in the resident's room had been opened, with the screen knocked out behind the blinds. At approximately 9:23 PM, facility staff called 911, the Administrator, the Director of Nurses (DON), the Medical Doctor (MD), and the Resident's Representative (RR). The facility staff checked to make sure that all other residents were accounted for, and they expanded the search to include the area surrounding the facility. Resident #1 was located by facility staff at 10:37 PM, approximately 500 feet behind the facility, at a local business. Resident # 1 was transferred per ambulance to a local hospital. The hospital found no major injuries and released the resident back

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M 640	Continued From page 3 to the facility. The family transported the resident to the facility at 12:45 AM on 3/15/23, and one on one supervision was initiated. Resident #1 had been admitted to the facility on 1/20/23, and at that time, the facility's "Wandering Risk Assessment" revealed, that the resident was considered a moderate risk for wandering and hourly visuals had been initiated. Immediately following the elopement, the DON began an investigation of the incident and in-servicing the staff on the facility's policy for wandering and elopement. As part of the facility's corrective actions, no employees were allowed to work until they had attended the in-service on the" Elopements and Wandering Residents Policy." Facility staff assessed all current residents for elopement risk and updated the Elopement Binder kept at the Nurses Station. The Maintenance Supervisor began immediately to secure facility windows with self-tapping screws the prevent the windows from opening more than three (3) inches. The facility's failure to provide supervision to prevent the elopement for Resident #1, allowed the resident to be away from the facility, unnoticed and unsupervised until found standing behind a local business, by facility staff. This situation placed Resident #1 and other residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death. On 3/23/23, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which occurred on 3/14/23 and existed at Rule 45.21.8 Accidents M640 Level IV due to the facility's failure to provide adequate supervision to prevent an elopement of Resident #1.	M 640		

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M 640	Continued From page 4 The SA notified the facility's Administrator of the Past Noncompliance (PNC) IJ and SQC on 3/23/23 at 11:15 AM, and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 3/14/23 through 3/15/23, the SA determined the IJ to be PNC and the IJ was removed on 3/15/23, prior to the SA's entrance on 3/21/23. Findings include: Review of the facility's policy, "Elopements and Wandering Residents Policy," revised 9/2017, revealed, "Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement 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... 6. d. Adequate supervision will be provided to help prevent accidents or elopements ..." Record review of the "Facility Investigation" prepared by the Director of Nurses (DON) revealed Licensed Practical Nurse (LPN) #1 noted seeing Resident #1 in his room at 8:00 PM, however, he was not in his room at 9:00 PM when Certified Nurse Aide (CNA) #1 went into Resident #1's room for an hourly observation. CNA #1 immediately reported to LPN #1 that Resident #1 was not in his room and facility staff initiated a resident headcount, with only Resident #1 unaccounted for. The staff initiated a search for Resident #1 inside and outside the facility. It was noted by staff, that behind his closed window blinds, the window was opened and the window screen was knocked out. At 9:23 PM, the local	M 640		

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M 640	Continued From page 5 police department, the Administrator, the Director of Nurses (DON), Resident #1's Responsible Representative (RR), and his primary physician (who was also the facility's Medical Director) were notified by LPN #1, that Resident #1 could not be located. Resident #1 was located behind the facility at a local business by the Quality Assurance (QA) Nurse at 10:37 PM and transported by ambulance to the local hospital emergency department (ED) for assessment. As the resident had no major injuries, he returned to the facility at 12:45 AM on 3/15/23, by family. An observation on 3/21/23 at 9:00 PM, revealed the Northwest corner of the facility property was located approximately 500 feet from the intersection of a highway and adjacent street. The property was situated on the corner lot and backed up to a densely wooded area between the facility property and the backyards of the residences and the local business, which faced the next closest parallel street to the north. There was only one car seen driving down the street in front of the local business where Resident #1 had been located. The facility property was well lit with multiple streetlights on the property. The wooded area was very dark. There was a five-foot-high chain link fence around the facility property; the gates at the Northwest and Northeast corners of the property, which served the driveway that ran behind the facility (and provided service for the kitchen and other delivery and utility vehicles) were both wide open. There were houses and buildings across the street from the facility with streetlights in their yards on the East and West sides. Observation of Resident #1's room window revealed the bottom edge of the window was four (4) feet and seven (7) inches above the ground. The parking lot on the East side of the building was well lit by the streetlight and the streetlights	M 640		

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of neighboring properties. The grassy yard area between the building and Street on the South side of the property were well lit by streetlights.

Review of the weather report during investigation, revealed that the temperature during the time of Resident #1's elopement had been approximately 55 degrees Fahrenheit with no rain noted, clear with a full moon. Weather report for 1/14/23 was obtained from https://www.timeanddate.com.

On 3/21/23 at 10:00 PM, during an interview with Registered Nurse (RN) #1 she confirmed she was on duty at the facility on the 6:00 PM to 6:00 AM shift on 3/14/23. She stated that at approximately 9:00 PM, LPN #1 informed her that Resident #1 was not in his room. RN #1 confirmed that all staff members were notified of the "missing resident" and a search was conducted beginning inside the building and continued outside the building. She reported that LPN #1 had contacted the local police department, Resident #1's primary physician, the resident's RR, the DON, and the Administrator. RN #1 said that she was notified at approximately 10:40 PM, that Resident #1 had been located and was taken to the local hospital emergency department. She confirmed the DON conducted an In-Service on the facility's "Elopements and Wandering Residents Policy," the evening of 3/14/23, for all staff present and announced that one hundred percent (100%) of all staff were required to complete the In-Service training prior to working at the facility again. RN #1 noted she had observed the Maintenance Supervisor at the facility securing windows in resident rooms on the evening of 3/14/23 and early hours of 3/15/23. The nurse confirmed Resident #1 returned to the facility from the local ED at approximately 12:45 AM on 3/15/23, and orders were received to

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M 640	Continued From page 7 place the resident on one-on-one monitoring. She stated she had not noted any change of behavior in Resident #1 since the incident. On 3/21/23 at 10:30 PM, in an interview the Administrator, he confirmed he was notified at approximately 9:25 PM on 3/14/23, that Resident #1 had exited the facility through the window in his room and the staff had not located him. He stated the facility admitted Resident #1 on 1/20/23. Upon admission, the resident had been assessed for wandering/elopement risk and was deemed a "Moderate" elopement risk and the staff had been making hourly visual observations of the resident. He stated that he confirmed LPN #1 had conducted a "headcount" of all residents and that Resident #1 was the only resident unaccounted for and all appropriate notifications had been made per facility policy. He stated that at approximately 10:40 PM, he was notified that the resident was located and was being taken to the local ED for assessment and treatment as needed. He confirmed that the facility immediately started in-service training for all staff regarding missing residents and elopement policy and procedures. He stated Resident #1 was changed from hourly monitoring to one-on-one monitoring and that the Maintenance Supervisor had installed window stops on all resident windows which allowed the windows to open no more than three (3) inches. He revealed he had attended a Quality Assessment and Performance Improvement (QAPI) committee meeting on 3/15/23, and that all committee members, including the facility Medical Director were in attendance. During the meeting, the "Elopement and Wandering Residents" policy was reviewed and the incident, including interventions to provide for residents' safety and the prevention of future elopements.	M 640		

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M 640	Continued From page 8 On 3/22/23 at 11:40 AM, an interview with the Maintenance Supervisor revealed, that he was made aware of the elopement of Resident #1 on 3/14/23 at approximately 9:30 PM and had reported to the facility and assisted in a search for the resident. He stated he arrived at the facility approximately five (5) minutes after the Administrator notified him of the elopement. Upon his arrival, he noted he immediately went and looked at the resident's window on the outside and then walked the streets surrounding the building with a flashlight. He said he saw all Department Heads, city police, sheriff's department personnel and volunteer firefighters searching on foot or in cars. He confirmed Resident #1 was located at approximately 10:30 PM, and after he had been notified, he went to work placing self-tapping screws into the window sash on each window of each resident room in the facility, which prevented windows from opening more than three (3) inches. He said that since then he has placed self-tapping screws in all windows of all common areas as well, which included the dining room and the activity room. On 3/22/23 at 12:10 PM, during an interview with the QA Nurse, she confirmed she had been notified at approximately 9:30 PM on 3/14/23, by LPN #1 of the elopement of Resident #1. She stated she reported to the facility and participated in the search. She revealed she located him approximately five hundred (500) feet behind the facility standing at a local business. She explained that the back of the facility property backed up to the back of the business. She said Resident #1 was wearing a red flannel button up shirt, gray warm-up pants, and black diabetic shoes with Velcro closures. She stated that Resident #1 was then transferred to the local	M 640		

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hospital ED. The QA Nurse confirmed that she had attended an in-service about missing residents, elopement and supervision after Resident #1 eloped on 3/14/23. She confirmed she had taken part in an elopement drill as well. She noted that Resident #1 remains on one-on-one monitoring since his return from the ED on 3/15/23. The QA Nurse also confirmed that she had attended a QAPI committee meeting on 3/15/23, during which the facility policy, "Elopements and Wandering Residents Policy" was reviewed, along with the incident, and the interventions with methods for measuring efficacy.

On 3/22/23 12:17 PM, a telephone interview with the facility Ombudsman revealed he had been notified of the elopement of Resident #1 and had visited the facility on 3/15/23. He stated he had visited Resident #1 and observed that a CNA was with the resident. He confirmed the resident had no visual injuries.

On 3/23/23 at 5:20 PM, an interview with LPN #1, she confirmed she was working the 6:00 PM to 6:00 AM shift at the facility on 3/14/23, and at approximately 9:00 PM, CNA #1 reported to her that Resident #1 was not in his room. At that time, LPN #1 notified all staff present that Resident #1 was missing. She stated that she had never observed Resident #1 exit seeking. LPN #1 confirmed that she had attended an in-service about missing residents, elopement, and supervision, after Resident #1 eloped on 3/14/23. She confirmed she had taken part in an elopement drill as well. She also confirmed that Resident #1 had been on one-on-one monitoring since his return from the ED on 3/15/23.

On 3/23/23 at 5:35 PM, an interview with the

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M 640	Continued From page 10 DON revealed she was made aware of the elopement of Resident #1 on 3/14/23 at approximately 9:23 PM, and had called other nursing staff to request assistance in locating Resident #1. Upon arrival at the facility, she confirmed she had interviewed staff and confirmed the safety of the other residents. Once the resident was located, she confirmed LPN #1 had made notifications to the primary physician and RR to notify them that the resident had been located and transferred to the local hospital ED. The DON confirmed she attended a QAPI committee meeting on 3/15/23 at 2:00 PM, during which the elopement of Resident #1 was discussed, and the Elopement policy was reviewed with no changes recommended to the policy. She stated the committee reviewed the interventions and staff education efforts and discussed monitoring the efficacy of the interventions enacted to prevent further elopements. She revealed she and the MDS Nurse reviewed/reassessed the fifty (50) current residents and updated the wandering/elopement assessments and binder. She stated staff education/In-Services regarding wandering/elopement began the night of the elopement and continued until all staff had received the education prior to working at the facility. She confirmed she reported the incident to SA at approximately 5:00 PM on 3/15/23. She stated elopement drills were completed quarterly for both shifts and In-Service training was provided at least twice a year which included elopement drills. She stated the facility had scheduled elopement drills for all shifts monthly and planned to review results and determine future frequency. The DON reported the Interdisciplinary Team (IDT) reviewed the Wandering/Elopement Binder every Tuesday during the Weekly High-Risk Meeting. She	M 640		

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confirmed that she had been involved with the MDS Nurse in the update of the Care Plan for Resident #1, on 3/14/23.

Record review of the "Admission Record" for Resident #1 revealed, the facility admitted Resident #1 on 1/20/23. Resident #1's medical diagnoses included Vascular Dementia with Other Behavioral Disturbance and Senile Dementia of the Brain.

Record review of the "Wandering Risk Assessment," completed on 1/20/23, revealed Resident #1 had a moderate risk for wandering.

Record review of the Care Plan for Resident #1 revealed it was updated on 3/14/23, to reflect the 3/14/23 elopement, and new interventions included one on one monitoring, a secured window, and use of the Wander ID band (red band) to his wrist.

Review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/27/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of "99" which reflected the resident was unable to complete the interview. The Assessment for Mental Status revealed, Resident #1 exhibited a short-term memory problem, and his Cognitive Skills for Daily Decision Making were severely impaired. Section E revealed that Resident #1 had exhibited wandering behavior one (1) to three (3) days of the seven (7) days reviewed.

Record review of the QAPI committee meeting sign in sheet and "Corrective Action Plan" dated 3/15/23 at 2:00 PM revealed the meeting was attended by the Administration, DON, all department heads, and facility Medical Director.

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M 640	Continued From page 12 Review revealed the committee reviewed the facility policy titled "Elopements and Wandering Residents Policy" and the incident of the elopement of Resident #1 on 3/14/23 and formed a plan to ensure residents' safety and prevent elopements. The facility implemented the following Corrective Action Plan prior to the SA's entrance on 3/21/23: CORRECTIVE ACTIONS Resident #1 was last seen at approximately 8:00 PM. He was unable to be located at the 9:00 PM visual observation check. The facility interior and exterior search was conducted with the census and all other residents were accounted for. The facility search was expanded, and he was located by facility staff at approximately 10:37 p.m. at a local business near the facility. The Administrator and Director of Nurses were notified at 9:23 PM on 3/14/2023. The resident representative, his daughter, was notified at 9:29 PM on 3/14/2023. The resident's Physician was notified at 9:29 PM on 3/14/2023. Resident's care plan was updated on 3/14/2023, by the Minimum Data Set Coordinator nurse to include increased monitoring. An in-service was started on 3/14/2023, by the Director of Nursing for the staff that were available in the facility on the facility's wandering and missing resident policy, the facility search, review of the doors including codes and locks, evaluating the residents of being at risk and wandering, the one on one intervention to decrease the risk of elopement and the elopement risk binders and contents. The Staff Development Nurse is continuing this in-service,	M 640		

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	74BR	A. BUILDING: _____ B. WING _____	C 03/23/2023

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M 640	Continued From page 13 and staff will not be allowed to work until they have completed this in-service. Post event: 1. Resident # 1 was sent to the emergency room by ambulance and returned to the facility at 12:45 am on 3/15/2023. He was accompanied by his daughter. He did not have any injuries. Resident # 1 was placed on one on one observation on 3/15/2023 and continues to receive one on one observation. 2. A skin audit was completed on 3/15/2023, by the Licensed Practical Nurse # 1 and there were no injuries noted. 3. Pain monitoring was completed on 3/15/2023, after the emergency room visit by the Licensed Practical Nurse #1 and no pain was voiced by resident #1. 4. The Maintenance Director secured all resident rooms windows and ensured they only open 3-4 inches on 3/15/2023. The security company came to the facility on 3/15/2023, to check the exit doors to ensure they were secure. 5. On 3/15/2023, the Director of Nurses and the Minimum Data Set Coordinator and the interdisciplinary team performed an audit of the 50 current residents to identify risk for wandering and elopement. 6. Six (6) residents were identified to be at risk for wandering and elopement. The wandering and elopement binder were reviewed by the Social Service Director on 3/15/2023, to ensure that the residents had current pictures with current information, updated care plans and checked bracelet placement and updated	M 640		

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M 640	Continued From page 14 wandering risk assessments. The wandering risk assessments will be completed on new admissions, quarterly and upon significant change in status. The facility Maintenance Director is monitoring the windows weekly times four weeks which started on 3/15/2023. On 3/15/2023, the facility Quality Assurance Performance Improvement Committee conducted an emergent meeting and reviewed the facility policy on wandering and elopement. There were no changes made to the policy. The Quality Assurance Performance Improvement team reviewed the process that was done to secure the windows. The windows will open 3-4 inches. The team also reviewed the process for checking the doors which will be continued to be done weekly to ensure that they are working properly this is being done by the Maintenance Director. The residents that are identified for wandering and elopement will be observed for the presence of the alert bracelet five times weekly by the Social Service Director. The residents that are identified as being at risk will be reviewed weekly in the interdisciplinary high-risk meeting to identify any changes that need to be made to their plan of care. The attendees of the Quality Assurance Performance Improvement Committee were the Administrator, Director of Nursing, Infection Preventionist, Staff Development, Maintenance Director, and the Medical Director. Facility will increase the frequency of the Elopement drills. The facility alleged that the immediate jeopardy was removed on 3/15/2023 at 2:00 PM. VALIDATION The State Agency (SA) validated the facility's	M 640		

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M 640	Continued From page 15 corrective action: 1. The SA validated through record review of the local hospital emergency department (ED) report dated 3/14/23 and facility Progress Notes for Resident #1, and interview that he was transferred to the ED by ambulance, with no injuries noted, and returned to the facility at 3/15/23 at 12:45 AM via family vehicle. 2. The SA validated through record review of Progress Notes for Resident #1, and interview that a skin audit was completed for Resident #1 by LPN #1 upon return to the facility on 3/15/23 with no injuries noted. 3. The SA validated through record review of Progress Notes for Resident #1, and interview that a pain audit was completed for Resident #1 by LPN #1 upon return to the facility on 3/15/23 with no complaints of pain noted. 4. The SA validated through observations and interviews that all resident room windows had been secured and opened no more than four (4) inches, and that the security company came to the facility on 3/15/23 and assessed exit doors. 5. The SA validated through interviews that the DON and MDS Coordinator along with the Interdisciplinary Team (IDT) audited all residents for wandering and elopement risk. 6. The SA validated through record review of assessment documentation, Elopement Binder, and interviews that six (6) residents were identified to be at risk for wandering and elopement, the Elopement Binder and Care Plans were updated, and wander bracelets were correctly placed for the six (6) identified residents	M 640		

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M 640	Continued From page 16 by the Social Service Director on 3/15/23. The SA validated through record review and interviews that the facility discussed Resident #1's incident of elopement from the facility at an emergency Quality Assurance and Performance Improvement (QAPI) meeting on 3/15/23. The actions taken to ensure the provision of adequate supervision to meet Resident #1's needs were verified was evidenced by verification of the in-services, re-assessments, elopement drills, wander bracelet checks, and audit tools. The SA verified that Resident #1's Care Plan was updated on 3/14/23 to reflect elopement risk and one-on-one observation. The SA verified that the wander bracelet was applied to Resident #1's wrist and that Resident #1's was monitored constantly by one-on-one monitoring. The SA also validated through Resident #1's monitoring documentation and interview that Resident #1 was on constant one-on-one observation. The SA validated that the Social Services Director had updated the Elopement Binder. The SA validated through interviews and record review of In-Service Sign-In sheets that Elopement Drills were conducted on all shifts with employees. The SA validated through interviews and sign-in sheets that beginning 3/14/23, the DON conducted mandatory in-services with all facility staff on elopement and missing resident policy, protocol, and procedures. The SA validated that all corrective actions to remove the Immediate Jeopardy were completed as of 3/15/22, prior to entrance.	M 640		

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