STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. BUILDING _____ B. WING _____	C 05/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MOSS POINT	3401 MAIN STREET MOSS POINT, MS 39563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a Complaint Investigation (CI), MS #21546, at the facility from 5/17/23 through 5/19/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #21546 for Accidents/Safety and cited F689.

Resident #1 exited the facility without the knowledge of staff and was unsupervised approximately 10 minutes until a driver passing by the street entered the facility and notified the staff that a resident was outside of the facility at 6:45 AM. Resident #1 was last observed inside of the facility by staff at 6:40 AM and was located at 6:50 AM approximately 100 yards from the facility walking on the sidewalk in front of a local business.

During the investigation of the complaint, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/14/23 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity of "J".

The facility's failure to provide adequate supervision to prevent the elopement of Resident #1 placed this resident, and other residents at risk for wandering and elopement, 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 5/18/2023 at 3:10 PM and provided the Administrator with the IJ template.

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

Electronically Signed | 06/01/2023

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F 000	Continued From page 1 The facility submitted an acceptable Removal Plan on 5/18/2023, in which they alleged all corrective actions to remove the IJ were completed and the IJ removed on 5/18/2023. The SA validated the Removal Plan on 5/19/2023 and determined the IJ was removed on 5/18/2023, prior to exit. Therefore, the scope and severity of CFR 483.25(d)(1)(2) Free of Accidents Hazard/Supervision/Devices (F689) was lowered to a Scope and Severity of "D" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of survey, the facility was licensed for 160 beds and had a census of 98 residents.	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 by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent Resident #1, who was previously identified as an exit-seeker and elopement risk, from exiting the facility unnoticed and unsupervised for one (1) of	F 689	***Immediate Corrective Actions for Resident # 1: Resident #1 returned to the facility 5/14/23 @ 6:50 a.m. by Licensed Practical Nurse (LPN) #1 and placed 1:1 supervision with	6/7/23

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F 689	Continued From page 2 four (4) residents reviewed. Resident #1. Resident #1 exited the facility on 5/14/2023 without the knowledge of staff and was unsupervised approximately 10 minutes until a driver passing by the street entered the facility and notified the staff that a resident was outside of the facility at 6:45 AM. Resident #1 was last observed inside of the facility by staff at approximately 6:40 AM and was located at 6:50 AM approximately 100 yards from the facility walking on the sidewalk in front of a local business. The facility's failure to provide adequate supervision to prevent the elopement of Resident #1 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/14/23 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity of "J". The SA notified the facility's Administrator of the IJ and SQC on 5/18/2023 at 3:10 PM and provided the Administrator with the IJ template. The facility submitted an acceptable Removal Plan on 5/18/2023, in which they alleged all corrective actions to remove the IJ were completed and the IJ removed on 5/18/2023. The SA validated the Removal Plan on 5/19/2023 and determined the IJ was removed on 5/18/2023, prior to exit. Therefore, the scope and severity of CFR 483.25(d)(1)(2) Free of Accidents	F 689	LPN #1. Wander guard bracelet placement and function verified immediately by Director of Nursing 5/14/23. Resident #1's bracelet in place and functioning properly. Full body audit was completed of Resident #1 on 5/14/23 @ 6:55 a.m.by LPN #1 with no injuries noted. Responsible Party (RP) notified 5/14/23 @ 7:10 a.m. by LPN #1. Medical Doctor (M.D) notified 5/14/23 @ 7:20 a.m. by LPN #1.. Administrator notified by LPN #2 5/14/23 @ 6:45 a.m. Director of Nursing Services(DNS) was notified by Administrator on 5/14/23 @ 6:50 a.m. Elopement risk assessments performed on all residents 5/14/23 by Director of Nursing Services (DNS). Care plan reviewed and updated 5/14/23 by DNS with continued monitoring of resident□s whereabouts. State Agency notified by Administrator 5/14/23 @ 5:25 p.m. Attorney General Compliant completed online by DNS 5/14/23 @ 4:57 p.m. ***Immediate Action take to Identify Others at Risk: Staff completed a room to room audit of all residents to assure all were safe and accounted for on 5/14/23 @ 6:40 □ 7:00 a.m. by nursing staff. All residents with Wander guard bracelets	

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F 689	Continued From page 3 Hazard/Supervision/Devices (F689) was lowered to a Scope and Severity of "D" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy, "Elopement", dated April 2017, revealed, " ...To establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements ...Door Alarm Protocol ...Once Doors/exit alarms are activated a resident search is completed ensuring there is no missing resident...Tools Resource List for Interventions to Address Elopement Risk ...Utilize alarmed doors at time of meals to prevent wandering off units ..." On 5/17/23 at 5:00 PM, observations revealed the facility was located on the main street through town. There were local businesses on both sides of the street on each side of the facility. There were thirty (30) automobiles traversing the three (3) lane street (turn lane in the middle) in a five-minute period. The front door faced the street directly and was approximately sixty (60) feet from the street. There was an exit door perpendicular to the main street at the end of each of two wings which ran north and south of the front entrance. There was a four (4) foot wide, well-maintained sidewalk in front of the facility which separated the parking lot and grassy yard from the street. From the front, southern corner of the building of the facility where the "East Hall" exit door was located to the railroad tracks which intersect the street that the facility was located on was approximately one hundred (100) yards. The	F 689	were checked for functionality and positioning with all in place noted on 5/14/23 @ 7:10 a.m. by DNS. All Wander guard bracelets were in place and functioning properly. All residents at risk for wandering had their care plan and elopement book reviewed on 5/14/23 by DNS with pictures and current care plans in place. Administrator (ADM) began an investigation and Root Cause Analysis on 5/14/23 @ 6:45 a.m. to determine how resident went outside; East Wing North End door was not locking and employee placed at door to monitor and ensure no one enters or exits center through door. Employee remained at door through 3-11 shift 5/15/23 when parts were obtained and door demonstrated proper locking function when repeatedly check by Maintenance Supervisor. All doors were checked for proper function and operation 5/14/23 by Maintenance Director. All doors secure and functioning properly except East Wing North End door noted to not properly lock. Repair to East Wing North End door on 5/15/23 by Maintenance Director. ***Systemic Changes and Education Completed to Avoid Reoccurence: DNS and Director of Clinical Education Immediately initiated an in-service with all staff regarding our elopement policy guideline (including nursing, maintenance,	

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F 689	Continued From page 4 condition of the parking lot and yard was well maintained. Record review of the facility's "Investigation Template", dated 5/17/23, revealed, " ...Description of the Allegation: At approximately 6:50 am, resident was noted to be outside of the facility. Staff were able to redirect and bring resident inside within a few minutes. A full body assessment was performed on resident, no issues or injuries noted ...Center response: Resident was redirected back inside. A full body assessment was performed on resident, no issues or injuries noted. Building administration was notified, incident called into Reporting line at 5:25 pm. Abuse/Neglect & Elopement in-servicing started for all staff. The resident was dressed appropriately wearing slacks, a blouse and a light jacket, and not at risk for weather related issues .... Investigation Summary: At approximately 6:50 am, resident was noted to be outside of the facility. Staff were able to redirect and bring resident inside within a few minutes ...Summary of interview: "At 0635 (6:35 AM) I saw (Proper Name of Resident #1) on South wing talking to the nurse ...a lady came to the door at 0645 (6:45 PM) and asked if we had anyone missing. She said a lady with long gray was walking down the road ...The nurse got in the car with the lady and I got in my car. She was right up the street ...We returned to the facility ...Person interviewed: (Proper Name of Certified Nurse Aide (CNA) #1 ...Summary Investigation ... (Proper Name of Resident #1) was walking with another resident at 6:40a (AM) ...(Proper Name of CNA #1) ran up the hallway and notified me that (Proper Name of Resident) had gotten outside the building ...Body assessment was completed upon returned, no skin tears or	F 689	office personnel, dietary, housekeeping, therapy, and any volunteers) on 5/14/23 and completed on 5/15/23. Any staff member that was not educated at that time will be educated prior to working. Education for all staff on abuse, neglect, prevention of accidents and supervision of residents by DNS and Director of Clinical Education on 5/14/23 and completed on 5/15/23 Any staff member that was not educated on this date will be educated prior to starting next shift. Social Services Director (SSD) conducted an elopement drill on all three shifts beginning 5/14/23-5/16/23, then weekly on all three shifts for 4 weeks; then monthly for 3 months. Licensed Nursing Staff to check for proper placement of Wander guard bracelets every shift beginning 5/14/23, with documentation on the Treatment Administration Record (TAR). Door monitored by staff member 5/14/23 through 5/15/23, with vendor repairing door on 5/19/23. The Administrator, Maintenance Director or Nurse will assure that all exit doors will be checked after any power failure to assure they are in proper working order beginning on 5/17/23. On 5/17/23 when East Wing North door opened without disarming alarm, a staff member was place at the door for monitoring and to remain until repaired.	

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F 689	Continued From page 5 lacerations noted. All doors were checked, side door on East wing was the only door unlocked. Staff also completed a head count of every resident in the building ...Person Interviewed: (Proper Name of Licensed Practical Nurse (LPN) #1 ..." On 5/17/23 at 5:50 PM, in an interview with the Director of Nursing Services (DNS) and the Administrator, the DNS confirmed that Resident #1 was last observed in the facility at 6:40 AM, walking down the hall on the "South Hall" with another resident. At 6:45 AM, the report of a passerby alerted staff that Resident #1 was outside the facility unaccompanied approximately one hundred yards down the street from the facility. The DON stated that an investigation revealed that the exit door on the North end of the East Hall had an alarm and a magnetic locking mechanism that was not working properly. The resident was returned to the facility at 6:50 AM. On 5/17/23 at 6:00 PM, observation and an interview with Resident #1 revealed she was in her room sitting on her bed with call light in reach. She was not able to answer questions but was polite and pleasant. On 5/17/23 at 7:00 PM, during an observation, the exit door at the North end of the East Hall opened with a push by the DNS without the numeric code being entered into the wall mounted keypad beside the door. On 5/17/23 at 11:30 PM, during a telephone interview with LPN #1 revealed she was working at the facility on the morning of 5/14/23.At 6:40 AM she observed Resident #1 and Resident #2 walking together on the North Hall. She stated	F 689	***QAPI: A focused/Adhoc Quality Assessment Performance Improvement (QAPI)meeting addressing the findings was initiated and completed on May 15, 2023 with participation of the Administrator, Medical Director, DNS, Assistant DNS, Unit Manager. Evaluation of process with placement of staff member at door until parts obtained and placed 5/15/23 and proper door function noted. After the door malfunctioned on 5/17/23, a 2nd QAPI meeting was held to re evaluate processes and additional corrective action to check all doors after electrical storms or power outages. The QAPI meeting was completed on May 17, 2023, with the participation of the Administrator, Medical Director, DNS, Assistant DNS, Infection Preventionist/DCE. Reevaluated process also included placing a staff member at door for monitoring to remain in place until repaired on 5/19/23. Door checks were conducted on each shift for three days beginning 5/14.23, then daily to assure proper function by Director of Maintenance/Assistant Director of Maintenance/Licensed Nurse or Administrator indefinitely. Diversicare of Moss Point alleges all corrective actions were completed on 5/17/23 with IJ removal 5/18/23. A QA meeting will be held on 6/5/23 to evaluate findings from all audits pertaining to this Plan of Correction and will continue monthly x3 months.	

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F 689	Continued From page 6	F 689		

she was not aware that Resident #1 had exited the facility until a passerby entered the facility and notified her that she was concerned that a resident was walking down the sidewalk in front of the facility. She stated the nursing staff immediately called a "Code Adam" per facility protocol for a missing resident using the overhead announcement system and conducted a 100% headcount of all residents. Resident #1 was not accounted for. She stated she located Resident #1 down the street, on the same side of the street as the facility and assisted the resident back to her room in the facility. She stated that the nursing staff had checked all exit doors and determined that the side exit door at the end of East Hall had a locking mechanism issue and the alarm had failed. She said that the door should not have opened without a numeric code being entered into the keypad beside the door. If the door opened, an alarm should have sounded to alert the staff, but the door opened without the code and the alarm did not sound upon opening the door.

On 5/18/23 at 11:34 AM, during an interview with the Maintenance Director, he said he reported to the facility on Sunday (5/14/23) after he was notified of the elopement of Resident #1. He stated that he assessed the side door at the end of the East Hall and determined that the door alarm, nor the locking mechanism operated correctly. He confirmed that on 5/14/23 the side door at the end of the East Hall opened without the numeric code being entered into the wall mounted keypad beside the door and the alarm did not sound upon opening of the door.

Record review of local website weather information revealed the weather for the city on

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5/14/2023 at 6:31 AM was 68 degrees Fahrenheit, foggy, with no wind.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/05/21 (with an original admission date listed as 9/19/16) and she had diagnoses including Alzheimer's Disease and Dementia.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/07/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated she had severe cognitive impairment. MDS review also revealed that Resident #1 was ambulatory without assistance.

Record review of the "Clinical Health Status Evaluation ...Section 11. Elopement", dated 5/9/23, indicated that Resident #1 had a history of wandering or elopement, wanders aimlessly about the facility and/or exhibits night wandering, and was determined to be "at risk" for elopement.

Record review of the Care Plan for Resident #1 revealed she had a "Focus" of " ...Exhibits Exit seeking behavior R/T (related to) periods of confusion.." with a "Goal" of " ...will not attempt to leave the facility without being accompanied by staff or family member..", and "Interventions" included " ...Wander Guard to left ankle, check placement each shift ..."

The facility provided the following Removal Plan:

At approximately 6:40 am, Resident #1 was noted to be outside of the facility. Staff were able to redirect and bring resident inside within a few minutes. A full body assessment was performed

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F 689	Continued From page 8	F 689		

on resident, no issues or injuries noted. The resident was dressed appropriately wearing slacks, a blouse and a light jacket, and not at risk for weather related issues. The temp was 69 degrees according to the National Weather Association at the time the resident was out of the building. Based on interviews with the staff and timeline, the resident was out of the building for a brief 10 minutes. We were able to redirect easily. Resident #1 was last seen prior to incident at 6:40 a.m. in hallway ambulating with another resident. Upon investigation and door securement checks the East Wing North door released for Administrator and deemed the point of exit for Resident #1. F 689 The facility failed to ensure the resident's environment was free from accident hazards and that Resident #1 received adequate supervision. Resident #1, who was determined by the facility to be an elopement risk, left the facility on 5/14/2023 at 6:40 AM unnoticed and unsupervised through an exit door that was not functioning properly.

Immediate Corrective Actions for Resident # 1:
Resident #1 returned to the facility 5/14/23 @ 6:50 a.m. by Licensed Practical Nurse (LPN) #1 and placed 1:1 supervision with LPN #1.
Wander guard bracelet placement and function verified immediately by Director of Nursing 5/14/23. Resident #1's bracelet in place and functioning properly.
Full body audit was completed of Resident #1 on 5/14/23 @ 6:55 a.m.by LPN #1 with no injuries noted.
Responsible Party (RP) notified 5/14/23 @ 7:10 a.m. by LPN #1.
Medical Doctor (M.D) notified 5/14/23 @ 7:20 a.m. by LPN #1..
Administrator notified by LPN #2 5/14/23 @ 6:45

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a.m.
Director of Nursing Services(DNS) was notified by Administrator on 5/14/23 @ 6:50 a.m.
Elopement risk assessments performed on all residents 5/14/23 by Director of Nursing Services (DNS).
Care plan reviewed and updated 5/14/23 by DNS with continued monitoring of resident's whereabouts.
State Agency notified by Administrator 5/14/23 @ 5:25 p.m.
Attorney General Compliant completed online by DNS 5/14/23 @ 4:57 p.m.
Immediate Action take to Identify Others at Risk:
Staff completed a room to room audit of all residents to assure all were safe and accounted for on 5/14/23 @ 6:40 - 7:00 a.m. by nursing staff.
All residents with Wander guard bracelets were checked for functionality and positioning with all in place noted on 5/14/23 @ 7:10 a.m. by DNS. All Wander guard bracelets were in place and functioning properly.
All residents at risk for wandering had their care plan and elopement book reviewed on 5/14/23 by DNS with pictures and current care plans in place.
Administrator (ADM) began an investigation and Root Cause Analysis on 5/14/23 @ 6:45 a.m. to determine how resident went outside; East Wing North End door was not locking and employee placed at door to monitor and ensure no one enters or exits center through door. Employee remained at door through 3-11 shift 5/15/23 when parts were obtained and door demonstrated proper locking function when repeatedly check by Maintenance Supervisor.
All doors were checked for proper function and operation 5/14/23 by Maintenance Director. All doors secure and functioning properly except

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East Wing North End door noted to not properly lock. Repair to East Wing North End door on 5/15/23 by Maintenance Director.
Systemic Changes and Education Completed to Avoid Reoccurrence:

DNS and Director of Clinical Education Immediately initiated an in-service with all staff regarding our elopement policy guideline (including nursing, maintenance, office personnel, dietary, housekeeping, therapy, and any volunteers) on 5/14/23 and completed on 5/15/23. Any staff member that was not educated at that time will be educated prior to working.
Education for all staff on abuse, neglect, prevention of accidents and supervision of residents by DNS and Director of Clinical Education on 5/14/23 and completed on 5/15/23 Any staff member that was not educated on this date will be educated prior to starting next shift.
Social Services Director (SSD) conducted an elopement drill on all three shifts beginning 5/14/23-5/16/23.
Licensed Nursing Staff to check for proper function and placement of Wander guard bracelets every shift beginning 5/14/23, with documentation on the Treatment Administration Record (TAR).
Door checks will be conducted on each shift for three days, then daily to assure proper function by Director of Maintenance/Assistant Director of Maintenance/Licensed Nurse or Administrator beginning 5/14/23.
Door monitored by staff member 5/14/23 through 5/15/23
The Administrator, Maintenance Director or Nurse will assure that all exit doors will be checked after any power failure to assure they are in proper working order beginning on 5/17/23.

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On 5/17/23 when East Wing North door opened without disarming alarm, a staff member was place at the door for monitoring and to remain until repaired.

QAPI:
A focused/Adhoc Quality Assessment Performance Improvement (QAPI)meeting addressing the findings was initiated and completed on May 15, 2023 with participation of the Administrator, Medical Director, DNS, Assistant DNS, Unit Manager. Evaluation of process with placement of staff member at door until parts obtained and placed 5/15/23 and proper door function noted.

After the door malfunctioned on 5/17/23, a 2nd QAPI meeting was held to re evaluate processes and additional corrective action to check all doors after electrical storms or power outages. The QAPI meeting was completed on May 17, 2023, with the participation of the Administrator, Medical Director, DNS, Assistant DNS, Infection Preventionist/DCE. Reevaluated process also included placing a staff member at door for monitoring to remain in place until repaired.

Diversicare of Moss Point alleges all corrective actions were completed on 5/17/23 with IJ removal 5/18/23.

The SA validated the facility's investigation of the incident and implementation of the Removal Plan through observations, facility record review, and interviews.

SA validated that Resident #1 returned to the facility 5/14/23 at 6:50 AM, by Licensed Practical Nurse (LPN) #1 during a telephone interview with

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LPN #1 on 5/17/23 at 11:30 PM and record review of the Facility Investigation.

SA validated that Wander Guard bracelet placement and function was validated immediately by the DNS on 5/14/23 with Resident #1's bracelet in place and functioning properly during an interview with the DNS on 5/18/23 at 11:10 AM.

SA validated that a full body audit was completed for Resident #1 on 5/14/23 at 6:55 AM by LPN #1 with no injuries noted during a telephone interview with LPN #1 on 5/17/23 at 11:30 AM and record review of the Progress Notes for Resident #1 dated 5/14/23 18/23 and the Facility Investigation.

SA validated that the Responsible Party (RP) for Resident #1 was notified on 5/14/23 at 7:10 AM by LPN #1 during a telephone interview with LPN #1 on 5/17/23 at 11:30 PM.

SA validated that the Medical Doctor (MD) of Resident #1 was notified on 5/14/23 at 7:20 AM by LPN #1 during a telephone interview with LPN #1 on 5/17/23 at 11:30 PM.

SA validated that the facility Administrator was notified on 5/14/23 at 6:45 AM by LPN #2 during a telephone interview with LPN #1 on 5/17/23 at 11:30 PM and during an interview with the Administrator on 5/18/23 at 10:55 AM. and during an interview with the DNS on 5/18/23 at 11:10 AM.

SA validated that the DNS was notified by the Administrator on 5/14/23 at 6:50 AM during an interview with the Administrator on 5/18/23 at

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10:55 AM and during an interview with the DNS on 5/18/23 at 11:10 AM.

SA validated that elopement risk assessments were performed on all residents 5/14/23 by the DNS and during an interview with the DNS on 5/18/23 at 11:10 AM and record review of the elopement risk assessments for Resident #1, Resident #2, Resident #3 and Resident #4.

SA validated that the Care Plan for Resident #1 was reviewed and updated on 5/14/23 by DNS with continued monitoring of resident's whereabouts by record review of Resident #1's Care Plan.

SA validated that State Agency (SA) was notified by the Administrator on 5/14/23 at 5:25 PM during an interview with the Administrator on 5/18/23 at 10:55 AM.

SA validated that an Attorney General Compliant was completed online by the DNS on 5/14/23 at 4:57 PM during an interview with the DNS on 5/18/23 at 11:10 AM.

SA validated that Staff completed a room-to-room audit of all residents to assure all were safe and accounted for on 5/14/23 at 6:40 - 7:00 AM by nursing staff during an interview with the DNS on 5/18/23 at 11:10 AM and during a telephone interview with LPN #1 on 5/17/23 at 11:30 PM.

SA validated that all residents with Wander Guard bracelets were checked for functionality and bracelet positioning with all in place noted on 5/14/23 at 7:10 AM by DNS and that all Wander guard bracelets were in place and functioning properly a telephone interview with LPN #1 on

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5/17/23 at 11:30 PM and during an interview with the DNS on 5/18/23 at 11:10 AM.

SA validated that all residents at risk for wandering had their care plan and elopement book reviewed on 5/14/23 by DNS with pictures and current care plans in place during an interview with the DNS on 5/18/23 at 11:10 AM and record review of the elopement books at the nurses stations.

SA validated that the Administrator began an investigation and Root Cause Analysis on 5/14/23 at 6:45 AM to determine how resident went outside; East Wing North End door was not locking and employee placed at door to monitor and ensure no one enters or exits center through door and that an employee remained at door through 3-11 shift 5/15/23 when parts were obtained and door demonstrated proper locking function when repeatedly check by Maintenance Director during an interview with the DNS on 5/18/23 at 11:10 AM and during an interview with the Maintenance Director on 5/18/23 at 11:34 AM.

SA validated through an interview with the DNS on 5/18/23 at 11:10 AM and during an interview with the Maintenance Director on 5/18/23 at 11:34 AM. that all doors were checked for proper function and operation on 5/14/23 by the Maintenance Director. All doors were secure and functioning properly except East Wing North End door noted to not properly lock and that repair to East Wing North End door was performed on 5/15/23 by the Maintenance Director.

SA validated through an interview with the DNS on 5/18/23 at 11:10 AM and during an interview with the Maintenance Director on 5/18/23 at 11:34

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AM. that the DNS and the Director of Clinical Education Immediately initiated an in-service with all staff regarding elopement policy guideline (including nursing, maintenance, office personnel, dietary, housekeeping, therapy, and any volunteers) on 5/14/23 and completed on 5/15/23. Any staff member that was not educated at that time to be educated prior to working. The SA also validated through staff interviews that all staff received the in-service including with Cook, on 5/19/23 at 1:27 PM, Housekeeper on 5/19/23 at 1:30 PM, LPN #2 on 5/19/23 at 1:38 PM, LPN #3 on 5/19/23 at 1:40 PM, and OT on 5/19/23 at 1:42 PM, and the Director of Clinical Education (and Infection Preventionist) on 5/19/23 at 1:48 PM.

SA validated through an interview with the DNS on 5/18/23 at 11:10 AM and during an interview with the Maintenance Director on 5/18/23 at 11:34 AM. that the DNS and the Director of Clinical Education initiated an in-service with all staff regarding abuse, neglect, prevention of accidents and supervision of residents on 5/14/23 and completed on 5/15/23. Any staff member that was not educated at that time to be educated prior to working. The SA also validated through staff interviews that all staff received the in-service including with Cook, on 5/19/23 at 1:27 PM, Housekeeper on 5/19/23 at 1:30 PM, LPN #2 on 5/19/23 at 1:38 PM, LPN #3 on 5/19/23 at 1:40 PM, and OT on 5/19/23 at 1:42 PM, and the Director of Clinical Education (and Infection Preventionist) on 5/19/23 at 1:48 PM.

SA validated through record review of "Patient/Resident Elopement Drill Worksheets" dated 5/14/23, 5/15/23 and 5/16/23 that the Social Services Director (SSD) conducted an elopement drill on all three shifts beginning

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5/14/23-5/16/23.

SA validated through record review of the Treatment Administration Record (TAR) that Licensed Nursing Staff were to check for proper function and placement of Wander guard bracelets every shift beginning 5/14/23, with documentation on the TAR.

SA validated through record review of "LOGBOOK DOCUMENTATION" sheets that door checks were conducted on each shift for three days, then daily to assure proper function by Director of Maintenance/Assistant Director of Maintenance/Licensed Nurse or Administrator beginning 5/14/23.

SA validated through record review of the "Door Monitor" schedule and during an interview with the DNS on 5/18/23 at 11:10 AM, an interview with CNA #2 on 5/18/23 at 10:00 AM and CNA #3 on 5/18/23 at 4:00 PM and during an interview with the Maintenance Director on 5/18/23 at 11:34 AM that the East Wing North door was monitored by staff member 5/14/23 through 5/15/23.

SA validated through observation on 5/17/23 at 7:00 PM that after East Wing North door opened without the numeric code entered into the wall mounted keypad, a staff member was placed at the door for monitoring and to remain until repaired on 5/19/23. SA validated through observation and interview with the alarm repairman on 5/19/23 at 12:48 PM that the repairman performed maintenance on the East Wing North door and repeatedly tested the door to ensure proper functioning of the locking mechanism.

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SA validated through record review of the "Quality Assurance and Performance Improvement (QAPI) Meeting" sheet dated 5/15/23, including sign-in of committee members that a focused/Adhoc Quality Assessment Performance Improvement (QAPI)meeting addressing the findings was initiated and completed on May 15, 2023, with participation of the Administrator, Medical Director, DNS, Assistant DNS, Unit Manager. Evaluation of process with placement of staff member at door until parts obtained and placed 5/15/23 and proper door function noted.

SA validated through record review of the "Quality Assurance and Performance Improvement (QAPI) Meeting" sheet dated 5/17/23, including sign-in of committee members that after the door malfunctioned on 5/17/23, a 2nd QAPI meeting was held to reevaluate the processes and additional corrective action to check all doors after electrical storms or power outages. The QAPI meeting was completed on May 17, 2023, with the participation of the Administrator, Medical Director, DNS, Assistant DNS, Infection Preventionist/DCE. The reevaluated process also included placing a staff member at door for monitoring to remain in place until repaired.

The SA validated through observation, record reviews, policy reviews and interviews that the facility completed all corrective actions on 5/17/23 with IJ removal 5/18/23.