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	255182	A. BUILDING _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	**16411 ROBINSON ROAD GULFPORT, MS 39503**

(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 Complaint Investigations (CIs), MS #21516, MS #21548, MS #21562, MS #21563, MS #21567, and MS #21584 at the facility from 5/16/2023 through 5/22/2023. Due to additional complaints received, the SA returned to the facility and conducted CIs for MS #21668 and MS #21677 from 5/30/2023 through 5/31/2023. The facility was found to not be in compliance with the requirements of participation in Medicare and Medicaid. The SA investigated MS #21562 and MS #21668 related to resident assessment/neglect and cited no deficiencies related to these complaints. The SA investigated MS #21563 related to an allegation of resident-on-resident abuse and cited no deficiencies. The SA investigated MS #21567 related to accidents due to a resident fall and cited no deficiencies. The SA investigated MS #21677 related to an allegation of a medication error and cited no deficiencies. The SA investigated MS #21584 which was a Facility Reported Incident (FRI) related to verbal abuse by facility staff and cited F600. The SA also investigated MS #21516 (FRI) and MS #21548 related to an elopement and cited F689.

Resident #1, who was an elopement and wandering risk, exited the facility through a window on 5/11/2023 and was away from the facility unnoticed and unsupervised until a staff member located the resident on the front east side of the property, sitting on a stump at 4:15 PM, which was approximately 15 minutes after Resident #1 was last seen by facility staff.

During the investigation, the SA identified an

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

Electronically Signed | 06/12/2023

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F 000	Continued From page 1 Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 5/17/23 and existed at: 42 CRF(S): 483.25 (d)(1)(2)-Free of Accidents, Hazards/Supervision/Devices (F689) - Scope and Severity "J". The facility's failure to provide supervision for Resident #1, with a known elopement risk, put Resident #1 and all other residents at risk for wandering and elopement, at risk for serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 5/17/2023 at 1:00 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 5/11/23, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 5/12/23, prior to the SA's first entrance on 5/16/23. At the time of the survey, the facility was licensed for 105 and had a census of 88.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		6/13/23

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F 600	Continued From page 2 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review the facility failed to prevent staff to resident verbal abuse for one (1) of four (4) sampled residents. Resident #2. Findings include: A review of the facility's "Abuse, Neglect and Exploitation/Misappropriation Policy,", revised 3/19/2020, revealed, " ...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by ...implementing written policies and procedures that prohibit and prevent abuse ...'Verbal Abuse' means the use of oral ...communication ...that willfully includes disparaging and derogatory terms to residents ...or within their hearing distance ..." On 5/19/23 at 10:00 AM, in an interview with the Administrator, she stated that earlier today (5/19/23), Resident #2 had asked Licensed Practical Nurse (LPN) #5 for his medications and then both began exchanging harsh, loud words. Following the incident, the Director of Nursing (DON) and the Administrator had a conference with LPN #5 and he confirmed that during his morning medication pass, Resident #2 was upset about his medications. He stated that Resident #2 called him a harsh name and LPN #5 then called the resident the same name. The Administrator terminated LPN #5 for unprofessional conduct toward the resident.	F 600	*LPN (License Practical Nurse) #5 displayed unprofessional verbal conduct towards resident #2 on 5/19/23. The administrator terminated LPN #5 on 5/19/23 for unprofessional verbal conduct. **All residents have the potential to be affected by this same unprofessional conduct. ***An in-service on Abuse/Neglect and Exploitation/Misappropriation, Stress and Workplace Burnout was conducted with all staff on 5/19/23. ****Social services and/or Minimum Data Set (MDS) assessment nurses will interview five cognitive resident's on professional verbal conduct from staff starting on 5/22/23 weekly X four weeks and then monthly X three months and results will be brought to monthly Quality Assurance (QA) meeting X three months beginning 6/13/23.	

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F 600	Continued From page 3	F 600		

On 5/19/23 at 1:50 PM, in an interview with LPN #5, he confirmed that he called the resident an "asshole" because the resident had called him names and said mean things to him. The resident was angry because he felt the nurse was late administering his medications.

On 5/19/23 at 2:00 PM, in an interview with the Occupational Therapist (OT), she stated that this morning (5/19/23) at about 9:15 AM, she was in her office in the therapy gym and the door was open. Resident #2 was in his wheelchair at the therapy gym entrance. She heard loud, harsh talking between two males, so she stepped out of her office and noticed it was Resident #2 and LPN #5 arguing about the resident's medication being late. The resident informed the nurse, "You are not a doctor," then the nurse said, "I'm a nurse." Resident #2 said, "No, you are an asshole," then the nurse said, "No, you are an asshole." She stated they were both talking in a loud voice and hollering. She confirmed that she and another nurse separated the resident and the nurse.

On 5/19/23 at 2:30 PM, in an interview with Resident #2, he confirmed that he was upset because he felt his medications were late and he was upset. He said that when LPN #5 brought his medications, the nurse was being rude, and they both began calling each other names in a loud voice.

On 5/22/23 at 11:46 AM, in an interview with the Certified Occupational Therapist Assistant (COTA-L) she confirmed that on the morning of 5/19/23, Resident #2 had requested his medications and was upset because he felt they

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F 600	Continued From page 4 were late. She said that she was in the therapy room, and Resident #2 was outside of the therapy room door when she heard Resident #2 and LPN #5 yelling back and forth with each other and name-calling. She then heard each of them call each other "asshole". A record review of the facility's investigation, dated 5/19/2023, revealed that Resident #2 expressed to the COTA/L that he had not received his morning medication. The COTA/L informed LPN #5 that Resident #2 was requesting his medication, and he was upset. Resident #2 and LPN #5 had a verbal altercation calling each other names in a loud voice. Following the investigation, LPN #5 was escorted out of the building and terminated for unprofessional conduct toward a resident. Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 5/1/23 and he had diagnoses including Fracture of Left Arm and Hemiplegia following Cerebral Infarction. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/23 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated his cognition was moderately impaired.	F 600		
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	F 689		

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F 689	Continued From page 5 §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 the elopement of Resident #1 for one (1) of four (4) residents reviewed with wandering and elopement behaviors. Resident #1 exited the facility through a window, unnoticed and unsupervised until License Practical Nurse (LPN) #2 found Resident #1 approximately 500 feet from the facility sitting on a tree stump at the front east side of the property. The facility's failure to provide supervision for Resident #1, with a known elopement risk, put Resident #1 and all other residents with wandering and elopement behaviors, at risk for serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 5/11/23 when Resident #1 exited the facility through a window in her room. The facility Administrator was notified of the IJ on 5/17/23 at 1:00 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 5/11/23, the SA determined the IJ and Substandard Quality of Care (SQC) to be Past Non-Compliance (PNC) and the IJ was removed as of 5/12/23, prior to the SA's first entrance on 5/16/23. Findings include:	F 689	Past noncompliance: no plan of correction required.	

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A review of the facility's "Elopement Policy," revised 12/28/20, revealed, " ...Definition: An Elopement is considered to be when a (cognitively impaired resident, wanders without staff visually monitoring to an unsafe place inside or outside the facility ...Facts to Consider ...Anytime a resident is successful in exiting the facility unsupervised, this constitutes elopement ..."

On 5/16/23 at 4:00 PM, in an interview with the Administrator, she stated that Resident #1 was admitted by the facility on 2/6/23, had a diagnosis of Alzheimer's disease, and was assessed for wandering and exit seeking behaviors. Resident #1 was deemed to be an elopement risk at that time because she exhibited wandering behaviors and made statements that she wanted to go home. On 5/11/23, the resident exited the facility through her window and was last seen by facility staff at 3:20 PM. At 4:00 PM, a nurse saw that the resident's windows were opened, and the window screens were outside of her windows, as if they had been pushed out. The Administrator confirmed that Resident #1 was located at 4:15 PM, approximately 500 feet from her room on the east side of the facility. Resident #1 was calm and approachable, and she was fully clothed in pants, a top, a jacket, and shoes. She had a skin tear on her wrist. She was transferred to the local Emergency Department (ED) for evaluation and returned to the facility the same day. The Administrator commented that following the incident, all residents were accounted for and were assessed for wandering behaviors. Resident #1 was placed on one-on-one supervision when she returned to the facility from the ED and window screws were installed so the

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windows would only open to six (6) inches for residents with exit-seeking behaviors.

On 5/16/23 at 4:30 PM, during an observation, Resident #1's windows were approximately eight (8) feet from the ground (sidewalk). The outside of the building was brick. The SA walked with the Administrator and Director of Nurses (DON) the route the resident most likely took when she exited the facility. The area was a scattered growth of bushes and trees with a trail, and the ground was flat, with no large holes.

On 5/16/23 at 4:40 PM, in an observation and interview with Resident #1, she was resting in her bed and was able to state her name, however, she was unable to recall the current date, time, or her whereabouts. She stated that she "just wanted to go home."

On 5/17/23 at 9:00 AM, in an interview with LPN #1, she confirmed on 5/11/23 at approximately 3:20 PM, she observed Resident #1 lying on the bed in her room. She stated that at 4:00 PM, while conducting her medication pass, she observed that the resident's door was closed. She entered the resident's room and noticed her windows were open and the window screens were missing. LPN #1 said she looked for the resident in the room and then immediately notified the charge nurse that Resident #1 was missing. She said that prior to the event, Resident #1 was calm and was not exhibiting exiting seeking behaviors.

On 5/17/23 at 9:30 AM, an interview with LPN #2, she stated that on 5/11/23 at approximately 4:00 PM, she was informed that Resident #1 was missing from her room, and she began searching

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for the resident outside. She started walking and calling for the resident and then spotted her at 4:15 PM, sitting on a tree stump. She had stains on her clothing that appeared to be from dirt.

On 5/17/23 at 11:00 AM, in an interview with the Maintenance Manager, he stated that following the elopement of Resident #1, he evaluated all resident windows to ensure there were no problems with the windows. He installed window screws so the windows would only open six (6) inches for the residents identified as an elopement risk.

Record review of the facility's investigation, dated 5/12/2023, completed by the Administrator revealed, " ...Incident report date: 05/11/2023 ...1520 (3:20 PM) 3-11 (shift) cart nurse observed resident lying in bed 1600 (4:00 PM) 3-11 nurse passed resident room and noticed resident was missing and both windows were open. Nurse searched resident's bathroom and immediately notified charge nurse of resident missing and window open. All staff immediately began looking for resident ...1612 (4:12 PM) the administrator was notified ...of resident missing. 1613 (4:13 PM) DON was notified ...of resident missing ...1615 (4:15 PM) resident was located on the front eastside of property sitting on a stump ...Resident placed on 1:1 (one on one) staff monitoring ..."

Record review of the weather history for 5/11/23 revealed the weather at 3:53 PM was cloudy and 79 degrees.

Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 2/6/23 with a diagnosis of Alzheimer's disease with late onset.

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Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/23 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated she had severe cognitive impairment.

Record review of the "Risk Factors For Elopement" for Resident #1, dated 2/6/23, revealed, " ...Elopement Risk Summary ...High Risk ..."

The facility implemented the following Corrective Action Plan prior to the SA's entrance on 5/16/23:

1. Brief summary of events: Resident #1 exited the building through her window on 05/11/2023. She was reported missing by Licensed Practical Nurse (LPN) #1 at 4 pm. Resident was located and assessed at 4:15pm by LPN #2 and transferred to the hospital for further assessment on 05/11/2023. Resident returned to the facility at 10:49pm on 05/11/2023 with no major injuries noted. Upon arrival resident #1 was moved to an interior room opening only to the enclosed courtyard and placed on 1:1 supervision. Care Plan was updated by Minimum Data Set (MDS) nurses registered nurse (RN) #1 and LPN 3#. The state agency (SA) presented the administrator with an immediate jeopardy (IJ) template.

2. All residents who are at risk for wandering have the potential to be affected by this same deficient practice.

3. An Emergency Quality Assurance (QA) meeting was held on 05/11/2023 at 4:43pm to

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include: The Administrator, Director of Nursing, Medical Director, Nurse Practitioner, Infection Preventionist (IP), MDS RN #1, MDS LPN #3, QA RN #2, and QA LPN #4 regarding Resident #1 exiting the building on 05/11/2023. Elopement and Missing Resident policies were discussed and no changes made to policies.

4. All residents were assessed for elopement risk by MDS RN#1, MDS LPN #3 and QA LPN #4 on 05/11/2023 and one additional resident was identified at risk.

5. The resident care plan was updated on 05/11/2023 by MDS RN #1 and Elopement binders at both nurse's stations were updated by QA RN #2 and DON RN #3 to include a picture of resident identified.

6. Wander guard placed by QA RN #2 on 05/11/2023 to resident identified.

7. All windows in residential area were checked by Maintenance and RN#3 on 05/11/2023 at 6:20pm to ensure there were no cracks, to make sure windows locked and that there were screens on windows. Windows of residents who are at risk for wandering were secured to open six inches on 05/11/2023 by maintenance.

8. In-services of elopement and missing person policies were started on 05/11/2023 with present staff. All other staff were in-serviced prior to beginning their next shift. No staff is allowed to work before being in-serviced.

9. All wander guard and security doors were checked by maintenance on 05/11/2023 to make sure all were functioning properly.

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10. Monitoring procedures are: Quarterly elopement drills beginning 05/15/2023 Residents at risk for elopement reviewed at weekly Patients at Risk (PAR) meeting on 05/24/2023 for new interventions needed and care plans updated, QA will monitor the resident at risk for elopement procedures in the QA meeting for three months beginning 05/11/2023.

11. The facility alleges all corrective actions were completed on 5/11/23 and the immediate jeopardy was removed on 05/12/2023.

The SA validated the facility's corrective action on 5/22/23:

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 5/11/23. The actions taken to ensure the provision of adequate supervision to meet Resident #1's needs were verified with evidence of verification of the in-services, elopement drills, re-assessments, and wander guard checks.

The SA verified that LPN #2 had located Resident #1 on 5/11/23 at 4:15 PM, she was transported to a local hospital and returned to the facility with no adverse findings.

The SA verified all residents were assessed for elopement risk by MDS RN#1, MDS LPN #3 and QA LPN #4 on 05/11/2023 and one additional resident was identified at risk.

The SA validated through record review and

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interviews, care plan was updated on 05/11/2023 by MDS RN #1 and Elopement binders at both nurse's stations were updated by QA RN #2 and DON RN #3 to include a picture of resident identified.

The SA validated through record review and interviews wander guard placed by QA RN #2 on 05/11/2023 to the resident identified.

The SA validated through observation, interviews and record review that all windows in the residential area were checked by Maintenance and RN#3 on 05/11/2023 at 6:20 pm to ensure there were no cracks, to make sure windows were locked, and that there were screens on windows. Windows of residents at risk for wandering were secured to open six inches on 05/11/2023 by maintenance. The SA observed the windows of residents identified as "exit seekers" to only open six (6) inches.

The SA validated through interviews and record reviews in-services of elopement and missing person policies were started on 05/11/2023 with present staff. All other staff were in-serviced prior to beginning their next shift. No staff is allowed to work before being in-serviced.

The SA validated through interviews and record reviews, wander guard and security doors were checked by maintenance on 05/11/2023 to make sure all were functioning properly.

The SA validated through interviews and record reviews, monitoring procedures are: Quarterly elopement drills beginning 05/15/2023 Residents at risk for elopement reviewed at weekly Patients at Risk (PAR) meeting on 05/24/2023 for new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 689	Continued From page 13 interventions needed and care plans updated, QA will monitor the resident at risk for elopement procedures in the QA meeting for three months beginning 05/11/2023.	F 689		