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F 000	INITIAL COMMENTS	F 000		

On 08/07/23 through 08/09/23 the State Agency (SA) conducted two (2) complaint investigations (CI) MS #22147 for alleged neglect/abuse of a resident admitted to the Emergency Room (ER) unresponsive; and CI MS #22279 for an elopement of a Resident from the facility. The SA determined that the facility was not in compliance with the Requirements for Participation in Medicare and Medicaid Services and deficiencies were cited at F656 and F689. MS #22147 was found to be in compliance and no deficiencies were cited.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 08/02/23, when the facility failed to provide supervision to prevent Resident #1 (Res #1) who was diagnosed with Dementia from leaving the facility without supervision on 08/02/23. Res #1 was an elopement risk on admission and was ordered for hourly checks. Res #1 was allowed to leave the facility, unnoticed and unsupervised until the local Law Enforcement found the resident 4.2 miles away from the facility. Res #1 exited the facility on 08/02/23 at approximately 12:45 PM. At 2:00 PM on 08/02/23 the facility Medical Director (MD) discovered that Res #1 was not in the facility when he began looking for Res #1 to complete the admission assessment. Res #1 was found by the local law enforcement in another nearby community approximately 4.2 miles away from the facility.

The facility's failure to prevent the elopement placed Res #1 and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment,

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

Electronically Signed | 08/23/2023

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F 000	Continued From page 1 or death. The SA notified the facility's Administrator of the IJ and SQC on 08/08/23 at 10:00 AM and provided IJ templates to the Administrator. The IJ began on 08/02/23 when Res #1 eloped from the facility unsupervised and existed at: §483.21(a)(1) Comprehensive Person-Centered Care Planning-Baseline Care Plans (F655) Scope/Severity = J IJ and SQC existed at: 42 CFR(s): 483.25(d) (1) (2)-Free of Accidents/Supervision/Devices (F689)-Scope/Severity=J Based on the facility's implementation of corrective actions completed on 08/04/23, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 08/05/23, prior to the SA's entrance on 08/07/23. At the time of the investigation the facility had a census of 109 and was licensed for 120 beds.	F 000		
F 655 SS=J	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		

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F 655	Continued From page 2 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to implement the baseline plan of care for Res #1	F 655	Past noncompliance: no plan of correction required.	

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who was a high risk for elopement, and had displayed exit seeking behaviors. Res #1 was one (1) of five (5) residents reviewed.

The facility failed to provide supervision as outlined in the baseline care plan for hourly visual checks to prevent an elopement for Res #1, who was diagnosed with Dementia. Res #1 was allowed to leave the facility, unnoticed and unsupervised until the local Law Enforcement found the resident 4.2 miles away from the facility.

During the investigation the State Agency (SA) identified an Immediate Jeopardy (IJ). The IJ had existed on 08/02/23 when Res #1 eloped from the facility unsupervised. The SA notified the facility's Administrator of the IJ on 08/08/23 at 10:10 AM and provide the IJ Template.

The elopement placed Res #1 and other residents at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death.

Based on the facility's implementation of corrective actions on 08/04/23, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed on 08/05/23, prior to the SA's entrance on 08/07/23.

Findings include:

The facility policy titled, "Comprehensive Person-Centered Care Plans," revised dated 3/18 stated, "Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide

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care."

The facility policy undated and titled, "Elopement Guidelines," stated, "The Elopement Risk Evaluation is to be done upon admission and quarterly & as needed with exit seeking behaviors. High risk residents are to be addressed on care plan and Pocket Care Guide. At the beginning and end of each shift the charge nurse is to make visual rounds on each high-risk resident to ensure that they can be in the facility. When exit seeking activity occurs consider 1:1 supervision or 15-minute checks."

Record review of the facility investigation revealed that Res #1 was allowed to exit the facility on 08/02/23 at approximately 12:45 PM. At 2:40 PM on 08/02/23 the facility Medical Director (MD) discovered that Res #1 was not in the facility when he began looking for Res #1 to complete the admission assessment. Res #1 had been newly admitted to the facility on 08/01/23 at approximately 3:00 PM and eloped from the facility on 08/02/23 at approximately 12:45 PM. The MD notified the facility Administrator (ADM) and the Director of Nursing (DON) and they called "Dr. Wander" and the facility staff began to search for Res #1. When Res #1 was not located within the building or on the immediate facility grounds, the DON, the Maintenance Director, and several other staff members, got in their vehicles and began searching the community for Res #1. 911 was notified and the local law enforcement agencies began the search for Res #1. The facility had no identifying photographs of Res #1 therefore, the description of his appearance was given for the search. At approximately 3:00 PM the local law enforcement agency called the facility and stated

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that they had Res #1 in their vehicle and would bring him back to the facility. Res #1 was found by the local law enforcement in another nearby community approximately 4.2 miles away from the facility. The MD assessed Res #1 and sent him out to the local Emergency Room (ER) for further evaluation. Res #1's family came and picked up Res #1 from the ER to live with them and the family discharged Res #1 from the facility.

Record review of the "Baseline Care Plan," dated 08/01/23, revealed " ...Depression, anxiety, wandering, confusion .... Wander guard with visual checks, elopement risk. Check wander guard Q (every) shift, visual checks Q hour ..."

Record review of "Risk Elopement Evaluation," dated 08/01/23 stated, "Past history of leaving facility/previous residence."

Record review of the "eFlowsheet," dated 08/23, indicated that hourly visual checks were documented by the licensed nursing staff and were checked and initialed for the hours of 9 AM, 10 AM, 11 AM, 12 PM, and 1 PM for the date of 08/02/23 and indicated an "N" for the 2 PM and 3 PM hourly visual checks, indicating "Not Administered."

Interview on 08/07/23 at 11:00 AM, with the Director of Nursing (DON) stated that Res #1 had a baseline care plan and that he had been placed on hourly checks along with the placement of a wander guard bracelet on 08/01/23 on admission because the resident was a high elopement risk. The DON confirmed that based on the resident's history of prior elopement from his residence that they probably should have watched him more

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frequently than hourly.

Interview on 08/08/23 at 2:15 PM, with RN#2 revealed that she had assessed Res #1 upon his admission on 08/01/23 and that she placed the wander guard bracelet on Res #1 and placed him on hourly observation checks. RN#2 stated that prior to Res #1's admission to the facility she had read his history and physical and admitting information and she knew that he was at risk for elopement because his paperwork had documented that he had left his sister's house where he was living and had walked to his former home that he had once owned with his wife and broke in to the house and refused to leave when the new owners got home. Res #1 was confused at that time and thought that his dead wife and he were still living in their former home that had been sold to new owners. RN#2 stated that Res #1 had a history of confusion and elopement and that due to Res #1's history he was placed on close observation checks hourly and a wander guard was placed on his right leg. RN #2 stated that she and LPN#1 were together assessing Res #1 on 08/01/23 and that a baseline care plan for Res #1 was devised on 08/01/23 by her and LPN#1 and placed on Res #1's chart.

Record review of the "Face Sheet" of Res #1 revealed that he was admitted to the facility on 08/01/23 at 1:36 PM and was discharged on 08/02/23 at 4:00 PM. Res #1 was admitted to the facility with diagnoses of Unspecified Dementia with Psychotic Disturbance; Generalized Anxiety; and Insomnia, among other diagnoses.

Record review of Res #1 contained a Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 08/02/23 provided a Brief Interview

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for Mental Status (BIMS) score of 6 which indicated that he had severe cognitive impairment.

The facility implemented the following Corrective Action Plan prior to the State Agency's (SA) entrance on 08/07/23:

On August 2, 2023, at 2:20 PM the facility was notified by Medical Director that Resident #1 was not in his room for physical assessment. The nursing staff discovered the resident was not in last seen area or therapy department. At approximately 2:25 PM. a "Dr. Wander" was initiated by Business Office Manager in the facility and surrounding area. At 2:40 PM Business Office Assistant contacted Tupelo Police Department regarding missing elderly resident from the facility with description. At 3:15 PM Director of Nursing, called and notified facility that Lee County Sheriff had located Resident #1 approximated 4.2 miles from the facility toward (city proper name). At 3:18 PM Resident #1 was returned to the facility by Lee County Sheriff and escorted by Director of Nursing. An announcement of Dr. Wander all clear was initiated by Social Service Director. It was determined that Resident # 1 was last seen by facility staff at 12:45 PM and returned to facility at 3:18 PM. On August 8, 2023, at 10:00 AM the facility was verbally notified that IJ's were identified for Federal tag 656 Care Plans and Federal tag 689 Failure to Prevent Accidents and Hazards and the IJ templates were given to the facility.

Immediate Actions:

On 8/2/2023 at 3:03 PM Executive Director

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notified Resident # 1 Responsible Representative of possible elopement from facility.

On 8/2/23 at 3:18 PM the Mississippi State Department of Health was notified of missing resident by
Executive Director.

On 8/2/2023 facility completed a 100% head count of all other Residents to ensure they were accounted for.

On 8/2/2023 at 3:18 PM upon return to facility Resident # 1 was assessed by physician.

On 8/2/2023 at 4:15 PM Resident #1 was sent to emergency room for further evaluation.

On 8/2/2023 at 3:30 PM Executive Director and Director of Nursing begin official investigation of Resident #1 Elopement.

On 8/2/2023 at 3:30 PM all facility exit doors were checked for proper functioning by Maintenance Director.

On 8/2/2023 at 3:30 PM an educational in-service was initiated by Staff Development Coordinator to include "all staff" on Elopement Protocol, Abuse and Neglect, and Residents exhibiting exit seeking behaviors to be completed by August 7, 2023 with no staff allowed to work until in-service completed.

On 8/2/2023 at 3:30 PM Assistant Director of Nursing checked all residents at risk for elopement wander-guard bracelet for placement and function.

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On 8/2/23 at 4:10 PM Emergency AD HOC QA (Quality Assurance) committee and Medical Director (via phone) met and completed a root cause analysis related to the elopement, and implemented new interventions as a result of the findings.

New Interventions:

1) Facility initiated new protocol to immediately place any resident actively exit seeking on 1 on 1 staff monitoring of resident until calm and no longer attempting to exit building, then to immediately notify the Executive Director and or Director of Nursing. All licensed nurses educated on this new protocol by 8/4/23. Any nurse who has not completed in-service education by 8/4/23 will be required to complete education prior to starting a shift
2) Signage was posted on the front door cautioning visitors not to allow anyone to exit with them that they do not know.
3) Photographs of elopement risk residents posted at the receptionist desk for quick reference to identify anyone at risk.
4) Also, the topic of "new elopement risk residents" was added to the daily stand-up meeting (department head meeting) format to ensure communication of risk to key personnel.

On 8/2/2023 After investigating and interviewing All facility employees, the elopement for Resident #1 from facility was substantiated.

On 8/2/23 at 4:30 PM all residents with risk of elopements were reevaluated, the pocket care guide and care plans were updated by Director of Nursing, Social Service and Unit Managers to ensure all residents for risk for elopement had

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appropriate interventions in place. This was completed on 8/2/23.

On 8/3/23 at 6:32 AM Executive Director followed up with Resident #1 Responsible Representative regarding resident's condition. Executive Director was informed that resident was home with Representative.

On 8/3/2023 at 8:00 AM Business Office Manager officially discharged resident from facility effective 8/2/2023

On 8/3/2023 at 10:00 AM the facility security cameras were serviced for malfunctioning by an outside contractor.

On 8/3/2023 at 11:00 AM the Maintenance Director installed new security camera system in the facility.
On 8/3/23, Social Service initiated an Elopement Alarm Drill with the 3pm-11pm shift employees.

On 8/4/2023 Social Service initiated an Elopement Alarm Drill with the 7a-3p and 11p-7a shift employees.

Mandatory Elopement Alarm Drills will be conducted by the Social Service Director weekly times one month on each shift and thereafter, monthly on each shift.

On 8/3/23 a picture of all residents at risk for elopement was placed on a secure wall at the Receptionist area for immediate viewing.

The facility removed the IJ on August 5, 2023, at 8:00 AM and alleges compliance.

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F 655	Continued From page 11 VALIDATION OF THE CORRECTIVE ACTION PLAN: The State Agency (SA) validated the facility's Past Non-Compliance (PNC) Removal Plan /Corrective Action on 08/09/23: The SA validated through interviews and record review that on 8/2/2023 at 3:03 PM Executive Director notified Resident # 1 Responsible Representative of possible elopement from facility. The SA validated through interview and record reviews that on 8/2/23 at 3:18 PM the Mississippi State Department of health was notified of missing resident by Executive Director. The SA Validated through interviews and record reviews that on 8/2/2023 facility completed a 100% head count of all other Residents to ensure they were accounted for. The SA validated through interviews and record reviews that on 8/2/2023 at 3:18 PM upon return to facility Resident # 1 was assessed by physician. SA validated through interviews and record reviews that on 8/2/2023 at 4:15 PM Resident #1 was sent to emergency room for further evaluation. SA validated that on 8/2/2023 at 3:30 PM Executive Director and Director of Nursing begin official investigation of Resident #1 Elopement. SA validated that through interviews and record review that on 8/2/2023 at 3:30 PM all facility exit	F 655		

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doors were checked for proper functioning by Maintenance Director.

The SA validated through interviews and record reviews that on 8/2/2023 at 3:30 PM an educational in-service was initiated by Staff Development Coordinator to include "all staff" on Elopement Protocol, Abuse and Neglect, and Residents exhibiting exit seeking behaviors to be completed by August 7, 2023 with no staff allowed to work until in-service completed.

The SA validated through interviews and record reviews that on 8/2/2023 at 3:30 PM Assistant. Director of Nursing checked all residents at risk for elopement wander-guard bracelet for placement and function.

The SA validated through record review and interviews that on 8/2/23 at 4:10 PM Emergency AD HOC QA committee and Medical Director (via phone) met and completed a root cause analysis related to the elopement and implemented new interventions as a result of the findings.

New Interventions:

1) Facility initiated new protocol to immediately place any resident actively exit seeking on 1 on 1 staff monitoring of resident until calm and no longer attempting to exit building, then to immediately notify the Executive Director and or Director of Nursing. All licensed nurses educated on this new protocol by 8/4/23. Any nurse who has not completed in-service education by 8/4/23 will be required to complete education prior to starting a shift.
2) Signage was posted on the front door cautioning visitors not to allow anyone to exit with

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them that they do not know.
3) Photographs of elopement risk residents posted at the receptionist desk for quick reference to identify anyone at risk.
4) Also, the topic of "new elopement risk residents" was added to the daily stand-up meeting (department head meeting) format to ensure communication of risk to key personnel.

All the above new interventions were validated by the (SA) through interviews, observations, and record reviews from 08/07/23-08/09/23 that the facility had implemented and educated the staff on the new Interventions.

The SA validated through record reviews and interviews that on 8/2/2023 After investigating and interviewing All facility employees, the elopement for Resident #1 from facility was substantiated.

The SA validated through interview and record review that on 8/2/23 at 4:30 PM all residents with risk of elopements were reevaluated, the pocket care guide and care plans were updated by Director of Nursing, Social Service and Unit Managers to ensure all residents for risk for elopement had appropriate interventions in place. This was completed on 8/2/23.

The SA validated through record review and interviews that on 8/3/23 at 6:32 AM Executive Director followed up with Resident #1 Responsible Representative regarding resident's condition. Executive Director was informed that resident was home with Representative.

SA validated through interviews and record reviews that on 8/3/2023 at 8:00 AM Business Office Manager officially discharged resident from

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F 655	Continued From page 14 facility effective 8/2/2023. SA validated through observations, interviews, and record reviews that on 8/3/2023 at 10:00 AM the facility security cameras were serviced for malfunctioning by an outside contractor. SA validated through observations, record reviews, and interviews that on 8/3/2023 at 11:00 AM the Maintenance Director installed new security camera system in the facility. . SA validated through record review and interview that on 8/3/23, Social Service initiated an Elopement Alarm Drill with the 3pm-11pm shift employees. On 8/4/2023 Social Service initiated an Elopement Alarm Drill with the 7a-3p and 11p-7a shift employees. The SA validated through interview with the facility Social Worker that Mandatory Elopement Alarm Drills will be conducted by the Social Service Director weekly times one month on each shift and thereafter, monthly on each shift. The SA validated through observations, interviews, and record reviews that on 8/3/23 a picture of all residents at risk for elopement was placed on a secure wall at the Receptionist area for immediate viewing. The SA validated through policy reviews, observations, and record reviews that the facility removed the IJ on August 5, 2023, at 8:00 AM and alleges compliance.	F 655		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 15 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 staff interviews, record review and facility policy review the facility failed to provide supervision to prevent a resident from leaving the facility unsupervised for one (1) of five (5) residents reviewed, Resident #1. The facility failed to provide supervision to prevent the elopement of Res #1 who was an elopement risk and had an order for visual checks every hour. Resident #1 was diagnosed with Dementia with Psychotic Disturbance. He was last seen by staff at approximately 12:20 PM on 08/02/23. He was allowed to leave the facility, unnoticed and unsupervised. Res #1 walked approximately 4.2 miles away from the facility in 94 degree weather along a busy highway before he was found by the local law enforcement at approximately 3:00 PM. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that existed on 08/02/23 when Res #1 eloped from the facility unsupervised. The SA notified the facility's Administrator (ADM) on 08/08/23 at 10:15 AM and provided the IJ template. The facility's failure to provide adequate staff	F 689	Past noncompliance: no plan of correction required.	

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supervision for Resident #1, with a history of elopement risk, placed this resident and other residents who exhibit wandering behavior in a situation that was likely to cause serious harm, injury, impairment or death.

Based on the facility's implementation of corrective actions on 08/04/23, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 08/05/23, prior to the SA's entrance on 08/07/23.

Findings include:

Record review of the facility policy titled "Accident & Incident Documentation & Investigation Resident Incident" with a history dated 7/18 revealed " ... Policy ...An "incident" is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident ..."

Record review of the facility policy titled "Missing Resident / Elopement" reviewed 1/15 revealed, " ... Procedure: It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical..."

Record review of the investigation revealed Res #1 was allowed to exit the facility on 08/02/23 at approximately 12:45 PM. At 2:40 PM on 08/02/23 the facility Medical Director (MD) discovered that Res #1 was not in the facility when he began looking for Res #1 to complete the admission assessment. Res #1 had been newly admitted to the facility on 08/01/23 at approximately 1:36 PM

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and eloped from the facility on 08/02/23 at approximately 12:45 PM. The MD notified the facility Administrator (ADM) and the Director of Nursing (DON) and they called "Dr. Wander" and the facility staff began to search for Res #1. When Res #1 was not located within the building or on the immediate facility grounds, the DON, the Maintenance Director, and several other staff members, got in their vehicles and began searching the community for Res #1. 911 was notified and the local law enforcement agencies began the search for Res #1. The facility had no identifying photographs of Res #1 therefore, the description of his appearance was given for the search. At approximately 3:00 PM the local law enforcement agency called the facility and stated that they had Res #1 in their vehicle and would bring him back to the facility. Res #1 was found by the local law enforcement in another nearby community approximately 4.2 miles away from the facility. The MD assessed Res #1 and sent him out to the local Emergency Room (ER) for further evaluation. Res #1's family came and picked up Res #1 from the ER to live with them and the family discharged Res #1 from the facility.

Record review of the Admission/Readmission Evaluation' dated 8/1/23 revealed, " ...Elopement Evaluation: 1 .... Intermittent confusion ...Exhibited wandering behaviors/Dementia ...2. History of wandering ... "Yes" If YES, when? Prior to admission ...3. Mobility ...Ambulates independently ...If yes, resident is at risk---Place appropriate intervention of Care Plan. Location Monitoring, (checked), Notify staff (checked), Personal Alarm (checked)."

Record review of the "Risk Elopement

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Evaluation," dated 08/01/23 revealed, "...Past history of leaving facility/previous residence..."

Record review of the "eFlowsheet," dated 08/23, indicated that hourly visual checks were documented by the licensed nursing staff and were checked and initialed for the hours of 9 AM, 10 AM, 11 AM, 12 PM, and 1 PM for the date of 08/02/23 and indicated an "N" for the 2 PM and 3 PM hourly visual checks, indicating "Not Administered."

Record review of the "Departmental Notes," dated "08/02/23 4:31 PM Addendum. Note based on conversation with res at approx. (approximately) 1230 pm. Resident stood at nurses' station and spoke with nurse about why he was here in the facility. Resident was showing some confusion." Departmental Notes, dated "08/02/23 4:36 PM Approx 220 pm this nurse and (Proper Name of Physician) went to resident's room. Resident was not in room, after walking through the facility for approx. 5 min (minutes) and not seeing resident a code Dr Wander was initiated..."

Interview on 08/07/23 at 8:00 AM, with the Ombudsman revealed that on 08/02/23 at approximately 2:40 PM she was in the conference room of the nursing home talking to the Director of Nursing (DON) and the facility Administrator (ADM) when the facility physician and Medical Director, (MD) came to the conference room and told the ADM that (Res #1) was missing from the facility. The MD, the DON, the ADM, along with many other staff members, and the Ombudsman, all searched the facility and the grounds for Res #1 and he was not found, so they all got in their separate vehicles and began

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searching for Res #1 in the community. The police department was notified of the missing resident. The facility had not made any pictures of Res #1 and had no photos to provide the law enforcement for their search. The staff determined that the last time they saw resident (Res #1) was at 12:20 PM wearing a camo shirt and a cap and that he was a white male approximately 73 years old that looked younger than his stated age. None of the facility staff or Ombudsman were able to locate Res #1. The Police department called the facility at approximately 3:00 PM and reported that they had found the resident walking along the side of a busy highway in a nearby community which was approximately 4.2 miles from the facility. The DON went to meet the police and found Res #1 sitting in the back seat of the police car. The resident was brought back to the facility at approximately 3:20 PM on 08/02/23. The facility physician assessed Res #1 at the facility and then sent Res #1 out to the local hospital (ER) for a second assessment.

Record review of the weather in (proper name of city) on 08/02/23 documented that the temperature was 94 degrees Fahrenheit.

In an interview on 08/07/23 at 11:00 AM, the ADM stated that Res #1 had on a wander guard ankle monitoring bracelet, but Res #1 had taken the "wander guard" monitoring bracelet off prior to leaving the facility and the ankle bracelet was never found in the facility. ADM stated that the facility MD had discovered that Res #1 was missing from the facility when he came to evaluate Res #1 on 08/02/23 after the lunch hour. The MD came to the conference room and told ADM that Res #1 was missing. The search for

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Res #1 began at approximately 2:40 PM on 08/02/23. The facility called 911 and reported that Res #1 was wearing blue jeans, a short sleeve camo print shirt and hat. The ADM confirmed that the facility had no identifying photographs of Res #1 because he was admitted to the facility on 08/01/23. The ADM stated that the facility had put in place and had completed an action plan immediately after Res #1 eloped.

Interview on 08/07/23 at 11:00 AM, with the Director of Nursing (DON) confirmed that the last time anyone saw the resident was around 12:20 PM when he was observed at the nurse's desk voicing his concerns as to why he was at the facility. The staff that she interviewed confirmed that they last saw him walking to the front lobby to sit down in a chair. DON confirmed that after they found the resident and he was sent to the ER that the QA (Quality Assurance) committee met and discussed supervision and elopement of all residents. The DON confirmed that based off the resident's history of elopement from his previous residence and his exit seeking behaviors that the resident probably should have been monitored more frequently than every hour. The DON stated that throughout the investigation the facility was never sure how the resident got out of the facility unnoticed unless he went out the door with a visitor. The DON confirmed that they were never really sure and that when the resident was returned that he did not have the wander guard on his leg, and he stated that he had removed it. The DON stated that they never found the wander guard in the facility.

Interview on 08/07/23 at 2:00 PM, Licensed Practical Nurse (LPN#1) stated that she was the nurse on 08/02/23 for the unit where Res #1

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resided. She stated that she had assisted with the admission of Res #1 on 08/01/23 and that he was well dressed and looked much younger than his stated age of 73. LPN#1 stated that she and another nurse, Registered Nurse (RN#2) obtained a wander guard bracelet from the Social Worker (SW) and tested it to make sure it was functioning properly, and they placed the wander guard on Res #1 on 08/01/23 at approximately 3:00 PM. LPN #1 confirmed that they did that because the resident had eloped from his residence and was found in a house that was previously his own but had been sold and he was confused and had some agitation and was not pleased about being admitted to the nursing home. She stated that Res #1 was at the nursing station on 08/02/23 at approximately 12:20 PM asking why he was admitted here and that he needed to go to his house and check things. Res #1 didn't appear agitated, and he was easily redirected and left the nursing station. LPN#1 stated that she talked to Res #1 for about 10 minutes, and he was confused and was not oriented to the situation. LPN#1 stated that she was with the MD on 08/02/23 when he discovered that Res #1 was missing from the building.

Interview on 08/08/23 at 9:30 AM, with Medical Director (MD) revealed that he had talked to Res #1 on 08/01/23 via Face Time along with his Nurse Practitioner. MD stated that he was able to see Res #1 on Face Time and that was how he knew who to look for on 08/02/23 when he was unable to find Res #1 in the facility. MD stated that he went to the facility on 08/02/23 after the noon lunch hour to assess Res #1 as a new admission to the facility and upon searching for Res #1 and asking staff where he was they discovered he was gone from the facility, and

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they began the search and called 911. The MD stated that Res #1 was not injured when he was returned to the facility from his elopement but was confused and refusing the nursing home placement when he assessed him. The MD sent Res #1 out to the local ER for further assessment and for a psychological evaluation. Res #1 did not return to the facility from the ER.

Interview on 08/08/23 at 2:15 PM, with Registered Nurse (RN#2) revealed that she had assessed Res #1 upon his admission to the nursing home on 08/01/23. She stated that she placed the wander guard bracelet on Res #1 and she placed him on hourly observation checks because she had read his history and physical and she knew that he was at risk for elopement because his paperwork had documented that he had left his sister's house where he was living and had walked to his former home. RN#2 stated that due to Res #1's history he was placed on hourly checks that was documented by the nurses and a wander guard was placed on his right leg.

Interview on 08/09/23 at 9:20 AM, with the Maintenance Director revealed that on a regular basis and each week and on 08/02/23 he checked the doors of the facility on all halls, and all exits for functioning, locking, and proper movement. He found no issues with the doors, and he checked the functioning of the wander guard system and found no issues with functioning, and it was all in working order.

Interview on 08/09/23 at 10:00 AM, with Certified Nursing Assistant (CNA#3) revealed that on 08/02/23 she was assigned as the CNA for Res #1 and at approximately 12:20 PM on 08/02/23 she last saw him at the nursing station talking to

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the nurse and asking why he was admitted to the nursing home. CNA #3 stated that at approximately 2:40 PM on 08/02/23 the MD stopped her in the hallway and asked if she had seen Res #1. CNA #3 began looking for Res #1 and was not able to find him. CNA #3 confirmed that she was not informed to make sure she had a visual check on the resident every hour, nor was she instructed to document any visual checks of the resident.

Record review of the "Face Sheet" revealed that Res #1 was admitted to the facility on 08/01/23 with diagnoses that included Unspecified Dementia with Psychotic Disturbance; Generalized Anxiety and Insomnia, among other diagnoses.

Record review of Res #1 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/02/23 provided a Brief Interview for Mental Status (BIMS) score of six (6) which indicated that he had severe cognitive impairment.

The facility implemented the following Corrective Action Plan prior to the State Agency's (SA) entrance on 08/07/23:

On August 2, 2023, at 2:40 PM the facility was notified by Medical Director that Resident #1 was not in his room for physical assessment, a "Dr. Wander" was initiated by Business Office Manager in the facility and surrounding area. At 2:40 PM Business Office Assistant contacted Police Department regarding missing elderly resident from the facility with description. At 3:15 PM Director of Nursing, called and notified facility that County Sheriff had located Resident #1

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approximated 4.2 miles from the facility. At 3:18 PM Resident #1 was returned to the facility by County Sheriff and escorted by Director of Nursing. An announcement of Dr. Wander all clear was initiated by Social Service Director. It was determined that Resident # 1 was last seen by facility staff at 12:45 PM and returned to facility at 3:18 PM. The facility was notified that IJ's were identified for Federal tag 656 Care Plans and Federal tag 689 Failure to Prevent Accidents and Hazards on 08/08/23 at 10:00 AM.

Immediate Actions:

On 8/2/2023 at 3:03 PM Executive Director notified Resident # 1 Responsible Representative of possible elopement from facility.

On 8/2/23 at 3:18 PM the Mississippi State Department of Health was notified of missing resident by the Executive Director.

On 8/2/2023 facility completed a 100% head count of all other Residents to ensure they were accounted for.

On 8/2/2023 at 3:18 PM upon return to facility Resident # 1 was assessed by physician.

On 8/2/2023 at 3:30 PM all facility exit doors were checked for proper functioning by Maintenance Director.

On 8/2/2023 at 3:30 PM Executive Director and Director of Nursing begin official investigation of Resident #1 Elopement.

On 8/2/2023 at 3:30 PM an educational in-service was initiated by Staff Development Coordinator to

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include "all staff" on Elopement Protocol, Abuse and Neglect, and Residents exhibiting exit seeking behaviors to be completed by August 7, 2023, with no staff allowed to work until in-service completed.

On 8/2/2023 at 3:30 PM Assistant Director of Nursing checked all residents at risk for elopement wander-guard bracelet for placement and function.

On 8/2/23 at 4:10 PM Emergency AD HOC QA committee and Medical Director (via phone) met and completed a root cause analysis related to the elopement and implemented new interventions as a result of the findings.

On 8/2/2023 at 4:15 PM Resident #1 was sent to emergency room for further evaluation.

New Interventions:

1) Facility initiated new protocol to immediately place any resident actively exit seeking on 1 on 1 staff monitoring of resident until calm and no longer attempting to exit building, then to immediately notify the Executive Director and or Director of Nursing. All licensed nurses educated on this new protocol by 8/4/23. Any nurse who has not completed in-service education by 8/4/23 will be required to complete education prior to starting a shift.
2) Signage was posted on the front door cautioning visitors not to allow anyone to exit with them that they do not know.
3) Photographs of elopement risk residents posted at the receptionist desk for quick reference to identify anyone at risk.
4) Also, the topic of "new elopement risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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residents" was added to the daily stand-up meeting (department head meeting) format to ensure communication of risk to key personnel.

On 8/2/2023 After investigating and interviewing All facility employees, the elopement for Resident #1 from facility was substantiated.

On 8/2/23 at 4:30 PM all residents with risk of elopements were reevaluated, the pocket care guide and care plans were updated by Director of Nursing, Social Service and Unit Managers to ensure all residents for risk for elopement had appropriate interventions in place. This was completed on 8/2/23.

On 8/3/23 at 6:32 AM Executive Director followed up with Resident #1 Responsible Representative regarding resident's condition. Executive Director was informed that resident was home with Representative.

On 8/3/2023 at 8:00 AM Business Office Manager officially discharged resident from facility effective 8/2/2023

On 8/3/2023 at 10:00 AM the facility security cameras were serviced for malfunctioning by an outside contractor.

On 8/3/2023 at 11:00 AM the Maintenance Director installed new security camera system in the facility.
On 8/3/23, Social Service initiated an Elopement Alarm Drill with the 3pm-11pm shift employees.

On 8/4/2023 Social Service initiated an Elopement Alarm Drill with the 7a-3p and 11p-7a shift employees.

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Mandatory Elopement Alarm Drills will be conducted by the Social Service Director weekly times one month on each shift and thereafter, monthly on each shift.

On 8/3/23 a picture of all residents at risk for elopement was placed on a secure wall at the Receptionist area for immediate viewing.

The facility removed the IJ on August 5, 2023, at 8:00 AM and alleges compliance.

VALIDATION:

The State Agency (SA) validated the facility's Past Non-Compliance (PNC) Removal Plan /Corrective Action on 08/09/23:

The SA validated through interviews and record review that on 8/2/2023 at 3:03 PM Executive Director notified Resident # 1 Responsible Representative of possible elopement from facility.

The SA validated through interview and record reviews that on 8/2/23 at 3:18 PM the Mississippi State Department of health was notified of missing resident by Executive Director.

The SA Validated through interviews and record reviews that on 8/2/2023 facility completed a 100% head count of all other Residents to ensure they were accounted for.

The SA validated through interviews and record reviews that on 8/2/2023 at 3:18 PM upon return to facility Resident # 1 was assessed by physician.

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SA validated through interviews and record reviews that on 8/2/2023 at 4:15 PM Resident #1 was sent to emergency room for further evaluation.

SA validated that on 8/2/2023 at 3:30 PM Executive Director and Director of Nursing begin official investigation of Resident #1 Elopement.

SA validated that through interviews and record review that on 8/2/2023 at 3:30 PM all facility exit doors were checked for proper functioning by Maintenance Director.

The SA validated through interviews and record reviews that on 8/2/2023 at 3:30 PM an educational in-service was initiated by Staff Development Coordinator to include "all staff" on Elopement Protocol, Abuse and Neglect, and Residents exhibiting exit seeking behaviors to be completed by August 7, 2023, with no staff allowed to work until in-service completed.

The SA validated through interviews and record reviews that on 8/2/2023 at 3:30 PM Asst. Director of Nursing checked all residents at risk for elopement wander-guard bracelet for placement and function.

The SA validated through record review and interviews that on 8/2/23 at 4:10 PM Emergency AD HOC QA committee and Medical Director (via phone) met and completed a root cause analysis related to the elopement and implemented new interventions as a result of the findings.

New Interventions:

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1) Facility initiated new protocol to immediately place any resident actively exit seeking on 1 on 1 staff monitoring of resident until calm and no longer attempting to exit building, then to immediately notify the Executive Director and or Director of Nursing. All licensed nurses educated on this new protocol by 8/4/23. Any nurse who has not completed in-service education by 8/4/23 will be required to complete education prior to starting a shift.
2) Signage was posted on the front door cautioning visitors not to allow anyone to exit with them that they do not know.
3) Photographs of elopement risk residents posted at the receptionist desk for quick reference to identify anyone at risk.
4) Also, the topic of "new elopement risk residents" was added to the daily stand-up meeting (department head meeting) format to ensure communication of risk to key personnel.

All the above new interventions were validated by the (SA) through interviews, observations, and record reviews from 08/07/23-08/09/23 that the facility had implemented and educated the staff on the new Interventions.

The SA validated through record reviews and interviews that on 8/2/2023 after investigating and interviewing all facility employees, the elopement for Resident #1 from facility was substantiated.

The SA validated through interview and record review that on 8/2/23 at 4:30 PM all residents with risk of elopements were reevaluated, the pocket care guide and care plans were updated by Director of Nursing, Social Service and Unit Managers to ensure all residents for risk for elopement had appropriate interventions in place.

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This was completed on 8/2/23.

The SA validated through record review and interviews that on 8/3/23 at 6:32 AM Executive Director followed up with Resident #1 Responsible Representative regarding resident's condition. Executive Director was informed that resident was home with Representative.

SA validated through interviews and record reviews that on 8/3/2023 at 8:00 AM Business Office Manager officially discharged resident from facility effective 8/2/2023.

SA validated through observations, interviews, and record reviews that on 8/3/2023 at 10:00 AM the facility security cameras were serviced for malfunctioning by an outside contractor.

SA validated through observations, record reviews, and interviews that on 8/3/2023 at 11:00 AM the Maintenance Director installed new security camera system in the facility. .

SA validated through record review and interview that on 8/3/23, Social Service initiated an Elopement Alarm Drill with the 3pm-11pm shift employees.

The SA validated through interview with the Social Worker that on 8/4/2023 Social Service initiated an Elopement Alarm Drill with the 7a-3p and 11p-7a shift employees.

The SA validated through interview with the facility Social Worker that Mandatory Elopement Alarm Drills will be conducted by the Social Service Director weekly times one month on each shift and thereafter, monthly on each shift.

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F 689	Continued From page 31 The SA validated through observations, interviews, and record reviews that on 8/3/23 a picture of all residents at risk for elopement was placed on a secure wall at the Receptionist area for immediate viewing. The SA validated through policy reviews, observations, and record reviews that the facility removed the IJ on August 5, 2023, at 8:00 AM and alleges compliance.	F 689		