

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/05/2024
NAME OF PROVIDER OR SUPPLIER YAZOO CITY REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 925 CALHOUN AVENUE YAZOO CITY, MS 39194		
(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 The State Agency (SA) conducted two (2) Complaint Investigations (CI MS # 24618 and CI MS # 24667) from 4/3/24 through 4/5/24. During the investigation the facility was found to be out of compliance with the Requirements of Participation in Medicare and Medicaid. The SA identified deficient practice related to CI MS #24618 allegations of neglect and care plan revision, and CI MS #24667 related to elopement and care plan revision. These findings constituted Substandard Quality of Care and an Extended Survey was conducted on 4/4/24. The SA identified two separate Immediate Jeopardy (IJ) situations. 1) The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/31/24 when the facility failed to revise Resident#1's care plan to reflect a decrease in the resident's cognitive ability. The facility allowed the severely cognitively impaired resident to leave the facility unsupervised. On 3/31/24 at approximately 8:30 PM, the Director of Nursing (DON) contacted the Administrator and stated the local police had identified Resident #1 in the community unsupervised. The Administrator contacted the Interim DON, who was at the facility, and verified Resident #1 was not in the facility. The local police supervised the resident until the facility picked up Resident #1 and returned Resident #1 to the facility at 9:29 pm. The facility's failure to provide supervision resulted in elopement and placed this resident and other cognitively impaired residents in a situation which was likely to cause serious injury,	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/24/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 harm, impairment, or death. 2) The SA also identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/21/24, when the facility neglected to ensure a resident was transported to a surgical appointment which resulted in the rupture of an aneurysm and large volume blood loss and hospital admission on 3/22/24 for Resident #2. The facility's failure to transport this dialysis resident to the appointment placed other dialysis residents at risk, and in a situation which was likely to cause serious injury, serious harm, serious impairment, or death. On 4/3/24 at 5:31 PM, the SA notified the Administrator of the IJ and Substandard Quality of Care (SQC) and provided the facility with the IJ templates. IJ and SQC existed at: 42 CFR(s) 483.12(a)(1) - Abuse and Neglect (F600) - Scope and Severity - "J", 42 CFR(s) 483.25(d)(1)(2) Free of Accidents Hazard/supervision/devices (F689) Scope/Severity "J". IJ existed at: 42 CFR 483.21 (b)(2) Care Plan Timing and Revision (F657)- Scope/Severity "J". The facility provided an acceptable Removal Plan on 4/4/24, in which the facility alleged all corrective actions were completed to remove the	F 000			

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F 000	Continued From page 2 IJ on 4/4/24, and the IJ was removed on 4/5/24. The State Agency (SA) determined the IJ was removed on 4/5/24, prior to exit, and the scope and severity for 42 CFR(s) 483.12(a)(1) - Abuse and Neglect (F600), 42 CFR(s) 483.25(d)(1)(2) Free of Accidents Hazard/supervision/devices (F689), and 42 CFR 483.21 (b)(2) Care Plan Timing and Revision (F657) was lowered from a "J" to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	F 000			
F 600 SS=J	The census at the time of survey was 145, and the facility held a license for 165 beds. 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- §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 dialysis center staff interviews, facility staff interviews, resident interview, record review,	F 600	On 4/4/2024, the Interim DON contacted Resident #2 general surgeon office to		5/2/24

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F 600	Continued From page 3 and facility policy review, the facility failed to ensure the right to be free from neglect when the facility failed to transport a dialysis resident to a scheduled surgical procedure to ligate (to tie up or close off an artery) an arteriovenous (AV) fistula scheduled on 03/21/24 resulting in the resident being admitted to the hospital on 03/22/24 with a bleeding aneurysm of the AV fistula requiring a blood transfusion with (4) four units of blood for one (1) of four (4) residents on dialysis reviewed. (Resident #2) The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 03/21/24, when the facility neglected to transport Resident #2 to his appointment for a scheduled surgical procedure. The facility's failure to transport this dialysis resident to the appointment placed this resident and other residents in a situation which was likely to cause serious injury, serious harm, serious impairment, or death. On 04/03/24 at 5:31 PM, the SA informed the Nursing Home Administrator (NHA) of the IJ and SQC and presented the IJ Template to the Administrator. The facility submitted a Removal Plan on 04/04/24, at 7:10 PM, in which the facility alleged all corrective actions to remove the IJ were completed on 4/04/2024 and the IJ removed as of 4/05/2024. The SA validated the Removal Plan on 04/05/2024 and determined the IJ was removed on 4/05/24, prior to exit; therefore, the scope and severity for Abuse and Neglect (F600) was lowered from a "J" to a "D", while the facility	F 600	confirm phone for communication that is currently in their file and provide the facility contact information for any further communication. The Administrator held a one-to-one in-service with Admission Coordinator on the appointment scheduling process to include communication, scheduling and following up on appointments. The facility has determined that each of the 140 residents has the potential to be affected. On 4/4/2024, the Admission Coordinator conducted an audit of current dialysis patients to review for appointments by contacting the dialysis center and verifying any outside appointments to ensure facility followed up correctly. There are currently twelve (12) dialysis patients. All appointments were followed up on. On 04/04/2024, the Staff Development initiated in-servicing with all licensed nurses, transportation, front desk receptionist on communication with appointments to include the process with signing resident in and out of facility, the daily transportation log along with the sign out binder. Inservice also includes adding a step to the appointment communication process with Admission Coordinator to review the communication tab within the electronic records to ensure all appointments are listed. No staff will be		

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F 600	Continued From page 4 develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility policy titled, "Abuse Prohibition," revised 11/07/2023, revealed this protocol was intended to assist in the prevention of neglect. Each resident has the right to be free from neglect. Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services that are necessary to a resident to avoid physical harm, mental anguish, or emotional distress. Review of a statement on facility letterhead dated 04/04/24 and signed by the Administrator revealed the facility has no policy related to appointments. Review summary of an anonymous complaint the State Agency (SA) received on 03/25/24, revealed Resident #2 is a dialysis patient who resides at the nursing home. Resident #2 needed a life sustaining surgery to prevent his dialysis access from rupturing causing an estimated (4) four-pint blood loss. The facility was made aware of the surgery date and time and reported they would take the resident to the surgery. Record review of the Hemodialysis communication form for Resident #2 dated 03/18/24, revealed, "Follow-up includes: appointment on 03/19/24 at 12:00 PM to have catheter placement to femoral artery and surgery on Thursday 03/21/24 to have ligation of the access".	F 600	allowed to return to work without completing. Beginning 4/8/24, Admissions will monitor three (3) residents per week for twelve (12) weeks that are on dialysis who have appointments to verify that appointment process is being followed correctly. A report beginning on 05/01/24 will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Admission Coordinator is responsible for monitoring and compliance.		

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F 600	Continued From page 5 Record review of an appointment card for Resident # 2 in the medical record, revealed date 03/21/24 Ligate Access. Time TBA (to be announced). Record review of nurse's notes by an agency Licensed Practical Nurse (LPN) #4 dated 03/18/24 at 3:45 PM, revealed Resident #2 arrived from dialysis, "did not receive dialysis today due to condition of access site. Site is to be monitored. Resident has an appointment tomorrow (03/19/24) for a catheter placement". Record review of Nurses Notes for Resident #2, dated 03/22/24 at 6:25 AM, revealed the resident noted in wheelchair with active bleeding noted from right arm from "old dialysis site". Staff applied pressure to site. An ambulance was called and arrived and transported the resident to hospital. Record review of the physician's notes from the hospital revealed Resident #2 was admitted to the hospital on 03/22/24 with principal diagnosis of an Aneurysm of Arteriovenous (AV) Dialysis Fistula requiring four (4) units of blood related to acute blood loss anemia secondary to the ruptured aneurysm of AV dialysis fistula. The note documented the resident's blood pressure was 72/43 due to acute blood loss. An interview with Resident #6 on 04/05/24 at 9:50 AM, revealed he is Resident #2's roommate and also goes to dialysis every Monday, Wednesday and Friday. He revealed he knew Resident #2 had an appointment for a procedure on March 19th (03/19/24) and also had to have surgery on his arm on the following Thursday. He stated, "I	F 600			

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F 600	Continued From page 6 know Resident #2 went to the appointment on Tuesday the 19th, but not sure why he did not go on the following Thursday." Resident #6 also revealed on the morning his roommate went to the hospital, the staff had gotten him up for dialysis and after a little while he looked down at the floor where his roommate was sitting and saw blood dripping on the floor and there was a lot of it and confirmed he called for help and the staff worked on Resident #2 until the ambulance came. Review of section C of the Minimum Data Set (MDS) for Resident #6 with an Assessment Reference Date (ARD) of 01/09/24 revealed the Brief Interview for Mental Status (BIMS) score was a 15 indicating the resident was cognitively intact. An interview with agency LPN #4 on 04/03/24 at 11:00 AM, revealed she was assigned to Resident #2 on 03/18/24, she stated she remembered when he returned from dialysis that he had two appointment cards and paperwork for the appointments on March 19th (03/19/24) and one for March 21st (03/21/24). She revealed she works for a staffing agency and was unaware of the scheduling process, but she gave the information regarding the appointments to the charge nurse on duty and she filled out the appointment forms. An interview with Registered Nurse (RN) #3 on 04/03/24 at 3:00 PM, revealed on the evening of 03/18/24 around 5:30 PM the agency LPN #4 handed her the appointment cards and paperwork sent from dialysis for Resident #2. She revealed she filled out an appointment sheet for 03/19/24 at 12:00 PM and also filled out a form	F 600			

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F 600	Continued From page 7 for 03/21/24 asking the Appointment Scheduler to get the time of the appointment clarified because there was no time listed on the card. She confirmed she did not put a physician's order for the 03/21/24 in the computer because it had to be clarified. She stated she placed the forms and appointment cards in the appointment folder and passed the information to the oncoming nurse to follow-up. She also stated she also copied the appointment cards and placed them in the medical records box. She stated when she returned to work on the 03/19/24, Resident #2 was out of the building for his first appointment scheduled, so she knew that the Appointment Scheduler got the appointment forms. RN #3 confirmed she did not personally follow-up to ensure the appointment time was clarified and scheduled for 03/21/24 for Resident #2 but she checked the appointment folder, and the form was not there. She also stated the dialysis clinic was closed at the time she was given the appointment information for Resident # 2, or she would have gotten the clarification for the order. Review of the March 2024 Order Summary Report for Resident #2 revealed there was no physicians order for the surgical procedure scheduled for 03/21/24. An interview with the Admission Coordinator/ Appointment Scheduler on 04/03/24 at 11:15 AM, revealed she scheduled the transportation for Resident #2 on 3/19/24 because she was notified by the dialysis clinic of the appointment at 12:00 PM on 03/19/24, but stated she was not notified of any appointment on 3/21/24 to repair the right arm. Review of the appointment calendar for 03/21/24 with the Admission Coordinator/ Appointment Scheduler revealed there were no	F 600			

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F 600	Continued From page 8 appointments scheduled for Resident #2 for 03/21/24. She also revealed she did not have any of the appointment forms turned in for March, only the calendar logs that she wrote down for the schedule. She stated that she shreds the appointment forms at the end of each month. She also revealed that Resident #2's niece called her 03/19/24 asking her about Resident #2's surgery for his arm and she informed the niece that she was unaware of any surgery scheduled. The Admission Coordinator/ Appointment Scheduler was asked if she followed up with dialysis clinic regarding the niece's inquiry about his surgery to his right arm and she stated she informed the niece to let her know if she finds out anything. A phone interview with the dialysis clinic Office Coordinator/LPN #1 on 04/03/24 at 12:15 PM, revealed she sent the dialysis communication form and the two appointment cards back to the facility. She also revealed she called the facility on 03/18/24 in the evening and spoke with the Appointment Scheduler and gave specific instructions and times for both of the appointments on 03/19/24 at 12:00 PM and also for 03/21/24 at 11:30 AM. She revealed she informed the the Appointment Scheduler of the importance of Resident #2 not missing either of the appointments. She revealed she was on the speaker phone and had a witness to the phone call, the Administrative Secretary #2, and the dialysis RN #3. She revealed it is customary for the clinic to call the facilities to ensure they received the paperwork sent back to the facility with the residents. A phone interview with Administrative Secretary #2 at dialysis, on 04/03/24 at 12:20 PM, confirmed she was on the call with Office	F 600			

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F 600	Continued From page 9 Coordinator/LPN #1 as a witness to the instructions given to the facility. She confirmed Appointment Scheduler was the staff on the phone at the nursing facility and she was informed of the appointments and times for the appointments 03/19/24 and 03/21/24 and specific instructions for the procedures. Review of the dialysis nurses note dated 03/18/24 by the dialysis Office Coordinator/LPN #1 at 1:43 PM, revealed Resident #2 came to clinic today blood noted on sleeve of shirt. Access was looked at several open areas noted, and small amount of blood noted. Access is pulsatile (pulse detected). The decision was made not to use dialysis access d/t (due to) risk of possible rupture. Informed the surgeon that a significant change in the appearance and size of access from previous visit. An appointment was already made for 03/19/24 at 12:00 PM for catheter placement. Surgery scheduled Thursday 03/21/24 for ligation surgery. The resident's Nephrologist was made aware of condition of access and stated to inform staff and nursing home to call 911 and apply pressure if he bleeds. The Appointment Scheduler at the facility was informed that literature and appointments were sent by the patient. She stated she will let the unit manager be made aware. "I repeated several times how important it is for patient to keep the appointments." Record review of dialysis nurses note dated 03/18/24 at 2:51 PM by the dialysis RN #3 revealed, Asked Secretary to call nursing home and make sure they have arranged for Resident #2 to go to catheter appointment on 03/19/24 at 11:30 at hospital and again at 11:30 AM on 03/21/24 for his appointment with surgeon. I was	F 600			

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F 600	Continued From page 10 standing next to the secretary when she made the call and heard her speaking with the Appointment Scheduler, who confirmed that she knew about both appointments and was making sure Resident #2 was on their schedule to be transported. An interview with RN #2 on 04/03/24 at 1:00 PM, revealed on 03/18/24 she was notified by the Appointment Scheduler that Resident #2 was scheduled to have a surgical procedure to the fistula site and have a catheter inserted to the groin site. She revealed she was informed by the Appointment Scheduler about the concerns from dialysis of potential risk for hemorrhage from the right arm fistula site and that the clinic was sending a tourniquet to apply to arm if bleeding occurs. She revealed she was unaware why Resident #2 did not go to the procedure on the 03/21/24. During an interview with the Administrator on 04/04/24 at 6:45 PM, she revealed the root cause of Resident #2 missing his scheduled appointment on 03/21/24 was related to the failure of staff to follow-up on a scheduled time for the procedure. Review of the Admission Record the facility admitted Resident #2 to the facility on 05/31/23 with diagnoses of End-Stage Renal Disease and Dependence on renal dialysis. Review of the MDS for Resident #2 with an ARD of 03/22/24, revealed Entry/Discharge: Discharge -return anticipated. Removal Plan	F 600			

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F 600	Continued From page 11 On 04/04/2024 at approximately 8:30 AM, the Interim DON contacted Resident #2 general surgeon office to confirm phone for communication that is currently in their file and provide the facility contact information for any further communication. On 04/04/2024 at approximately 9:30 AM, Resident Council Meeting was held with the Activity Director, Assistant Activity Director #1, Assistant Activity Director #2, and Resident Council President, and eighty-two (82) total resident presents to inform them the facility received Immediate Jeopardies. On 04/04/2024 at approximately 10:00 AM, the Staff Development initiated in-servicing with all licensed nurses, transportation, front desk receptionist on communication with appointments to include the process with signing resident in and out of facility, the daily transportation log along with the sign out binder. Inservice also includes adding a step to the appointment communication process with Admission Coordinator to review the communication tab within the electronic records to ensure all appointments are listed. No staff will be allowed to return to work without completing. On 04/04/2024 at approximately 11:25 AM, the Administrator held a one-to-one in-service with Admission Coordinator on the appointment scheduling process to include communication, scheduling and following up on appointments. On 04/04/2024 at approximately 12:30 PM, the Admission Coordinator conducted an audit of current dialysis patients to review for appointments by contacting the dialysis center	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
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F 600	Continued From page 12 and verifying any outside appointment to ensure facility followed up correctly. There are currently twelve (12) dialysis patients. All appointments were followed up. On 04/04/2024 at 12:44 PM, Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/ Infection Preventionist, and Assistant Director of Nursing held a Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence to include audits on elopements, care plans, orientation binder, in-services on appointment process, audits of dialysis residents and contacting dialysis to verify appointments. On 04/04/2024, the Assistant Administrator conducted a one-to-one in-service with Front Desk Receptionist to discuss appointment log, resident leave of absence binder, and how to locate current BIMS for residents. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 04/04/2024 and the Immediate Jeopardy was removed 04/05/2024. State Agency Validation: On 04/05/24, the SA validated through staff interviews, resident interview, record review, sign-in sheets, and in-service reviews that the facility had implemented the following measures to remove the Immediate Jeopardy (IJ): Resident #2	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 13 The SA verified through staff interview and record review, on 04/04/2024 at approximately 8:30 AM, the Interim DON contacted Resident #2 general surgeon office to confirm phone for communication that is currently in their file and provide the facility contact information for any further communication. The SA verified through record review, sign-in sheets, and in-service reviews on 04/04/2024 at approximately 11:25 AM, the Administrator held a one-to-one in-service with Admission Coordinator on the appointment scheduling process to include communication, scheduling and following up on appointments. The SA verified through record review on 04/04/2024 at approximately 12:30 PM, the Admission Coordinator conducted an audit of current dialysis patients to review for appointments by contacting the dialysis center and verifying any outside appointment to ensure facility followed up correctly. There are currently twelve (12) dialysis patients. All appointments were followed up. The SA verified through record review on, 04/02/2024 at approximately 3:30 PM, the Administrator Assistant developed an orientation binder for all agency' staff onboard to be in-serviced on facilities policies and procedures to include wandering, elopement, where to find if a resident is allowed to out leave of absence, and appointment guidelines. The SA verified through resident interview and sign in sheets, on 04/04/2024 at approximately 9:30 AM, Resident Council Meeting was held with the Activity Director, Assistant Activity Director #1,	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 14 Assistant Activity Director #2, and Resident Council President, and eighty-two (82) total resident presents to inform them the facility had Immediate Jeopardies. The SA verified through staff interview, sign-in sheets, and in-service reviews on 04/04/2024 at approximately 10:00 AM, the Staff Development initiated in-servicing with all licensed nurses, transportation, front desk receptionist on communication with appointments to include the process with signing resident in and out of facility, the daily transportation log along with the sign out binder. Inservice also includes adding a step to the appointment communication process with Admission Coordinator to review the communication tab within the electronic records to ensure all appointments are listed. No staff will be allowed to return to work without completing. The SA verified through staff interview and sign-in sheet, on 04/04/2024 at 12:44 PM, Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/ Infection Preventionist, and Assistant Director of Nursing held a Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence to include audits on elopements, care plans, orientation binder, in-services on appointment process, audits of dialysis residents and contacting dialysis to verify appointments. The SA verified through staff interview and record review, on 04/04/2024 at approximately 2:00 PM, Regional Case Mix conducted in-service with Minimum Data Set (MDS) to include implementation, Reviewing, Revising, and	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 15 Resolving person-centered care plans. The SA verified through staff interview, sign-in sheets, and in-service reviews on 04/04/2024, the Assistant Administrator conducted a one-to-one in-service with Front Desk Receptionist to discuss appointment log, resident leave of absence binder, and how to locate current BIMS for residents. On 04/05/24, the SA validated that all corrective actions had been taken by the facility to remove the IJ on 04/04/24 and the IJ was removed on 04/05/24.	F 600			
F 657 SS=J	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		5/2/24	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 16 disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to revise the care plan for a severely cognitively impaired resident who eloped from the facility for one (1) of nine (9) sampled residents. (Resident #1) The SA identified an Immediate Jeopardy (IJ) which began 3/31/24 when the facility allowed Resident #1 to exit the facility unsupervised and was found approximately eight-tenths of a mile from the facility by police. He was away from the facility for 81 minutes. The facility's failure to provide supervision resulted in elopement and places cognitively impaired residents at risk, and in a situation which was likely to cause serious injury, harm, impairment, or death. On 4/3/24 at 5:31 PM, the SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and provided the IJ Template. The facility provided an acceptable Removal Plan on 4/4/24, in which the facility alleged all corrective actions were completed to remove the IJ on 4/4/24. The State Agency (SA) validated the Removal Plan on 4/5/24 and determined the IJ was removed on 4/5/24, prior to exit, and the scope and severity for 42 CFR 483.21 (b)(2) Care Plan Timing and Revision (F657) was lowered from a "J" to a "D", while the facility monitors the	F 657	On 04/01/2024, Resident #1 was assessed by the NP no issues found and care plan was updated by interdisciplinary team to reflect changes in leave of absence status. The facility has determined that each of the 140 residents has the potential to be affected On 4/4/2024 Regional Case Mix conducted in-service with Minimum Data Set (MDS) to include Implementation, Reviewing, Revising, and Resolving person-centered care plans. On 4/4/2024, the Administrator held a one-to-one in-service with the Licensed Social Worker on Leave of Absences Care plans to include who can exit facility, supervision needed and process for a change in BIMS (Brief Interview for Mental Status). On 4/4/2024, An audit was initiated by Social Services Director on leave of absence care plans to ensure resident with impaired cognition receive adequate supervision.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 17 effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Resident #1 Cross reference F 689 Review of facility policy titled "Care Plans, Comprehensive Person-Centered," reviewed January 2023, revealed, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Care plans are revised as information about the residents and the residents' conditions change. Record review of Resident #1's Care Plan, with latest revision 11/02/23, revealed the resident likes to leave/sign out Leave of Absence (LOA) for personal outings. The Care Plan goal read, "I will exhibit understanding and recognition of risk vs benefits while signed out LOA through next review date." A record review of the facility investigation revealed on 3/31/24 at approximately 8:30 PM, the Director of Nursing (DON) contacted the Administrator and stated the police had Resident #1 on (Formal Name of street in the community). The Administrator contacted the Interim DON, who was at the facility, to verify that Resident #1 was not in the facility. She confirmed that he was not. The facility driver was contacted and dispatched to pick up Resident #1 who remained	F 657	Beginning 4/8/24, Social Services will monitor all residents that are able to sign out of the facility weekly for twelve (12) weeks ensuring any changes in Brief Interview of Mental Status is reviewed and properly care planned. A report beginning on 05/01/24 will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The MDS Director is responsible for monitoring and compliance.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 18 under the supervision of the police officer until pick up. Resident #1 returned to the facility at 9:29 PM. Resident #1 was assessed by Interim DON with no injuries noted. An updated wander assessment was completed by the Administrator and Interim DON to reflect new behavior. The Administrator verified that the wander guard was working and placed the bracelet on the left wrist of Resident #1. Upon staff interviews and review of camera footage, the facility noted Resident #1 exiting the facility at 7:25 PM when an agency Licensed Practical Nurse (LPN) opened the door for him. When questioned by the Administrator, the LPN stated that she thought he was going to sit on the front porch. Resident #1 was admitted on 2/7/20 the facility with diagnoses including Epilepsy and Dependence on a wheelchair. In an interview with Licensed Practical Nurse #2 (LPN) at 8:35 AM on 4/3/24, she verified that in the past Resident #1 did go on Leave of Absence (LOA) outside the facility without supervision, but the facility staff no longer allowed him to go out unsupervised due to his confusion. LPN #2 was unsure when the facility stopped letting him go on leave of absence (LOA) by himself, but verified it was prior to 3/31/24. On 4/3/24 at 1:30 PM, during an interview with the Assistant Director of Nursing (ADON), she verified that Resident #1's most recent Brief Interview for Mental Status (BIMS) score on 2/22/24 was a five (5), indicating severe cognitive impairment and that he was not safe to go LOA by himself. During an interview with the Social Worker (SW) on 4/3/24 at 1:46 PM, she stated that once Resident #1's cognition declined, and his BIMS	F 657			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 19 was less than 12 he was no longer safe to go LOA by himself . The SW verified that the resident's BIMS was five (5) on 2/22/24, indicating severe cognitive impairment. The SW verified Resident #1's care plan did not reflect that he could not go LOA by himself. She stated that based on Resident #1's care plan, staff could allow Resident #1 LOA by himself. She agreed that his care plan should have been updated to reflect that he was no longer safe to go LOA by himself when his BIMS score fell below 12 and verified that it was not updated until 4/1/24 after the resident left the building unsupervised. In an interview with Interim Director of Nursing (DON) on 4/4/24 at 9:45 AM, she agreed Resident #1's care plan should have been updated at the time he was determined to no longer be safe to go LOA unsupervised. Record review of the Admission Record for Resident #1 revealed that the facility admitted the resident on 11/8/21 with a diagnosis of Epilepsy. Removal Plan On 3/31/2024 at approximately 9:35 PM the interim Director of Nursing (DON) and Licensed Practical Nurse (LPN) #1 conducted a head-to-toe body assessment on Resident #1 to review for any skin abnormalities or concerns. Resident #1 had no negative skin issues or concerns. On 3/31/2024 at about 10:30 PM, the Interim DON oversaw verification of all residents in facility	F 657			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 20 using census with only one resident out of the facility and currently in the hospital. The census in the facility was 140. On 3/31/2024 at approximately 10:30 PM, staff present in the facility during the time of Resident #1 exit received immediate in-service by the Interim DON and Administrator on the procedures with residents signing out to exit facility to include verification of BIMS (Brief Interview for Mental Status). On 3/31/2024 at approximately 1030 PM, the Interim DON and Administrator initiated servicing with all staff present on Abuse, Neglect, Resident Rights, Vulnerable Adult, and Wandering. Staff Development will continue In-Servicing. No staff will be allowed to return to work without completing. On 3/31/2024 at approximately 10:40 PM, Resident #1 wandering evaluation was reviewed by Interim Director of Nursing and indicated low risk for wandering. Resident #1 wandering evaluation was updated by the Interim DON and Administrator on 3/31/2024. On 3/31/2024 at approximately 10:40 PM, the wander guard bracelet was verified to work properly by checking function with door alarm by Administrator, and then placed on Resident #1's left wrist. On 3/31/2024, the facility camera was reviewed by the Administrator to determine the timeline of events leading up to Resident #1 exit of facility. On 3/31/24 at 10:45 PM, the Administrator interviewed staff present of Resident #1 leaving	F 657			

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F 657	Continued From page 21 the facility unattended. The agency LPN who held the door open stated that she was not aware he could not leave the facility. On 3/31/2024 at approximately 11:05 PM, the Mississippi State Department of Health was notified of Resident #1 elopement. On 3/31/2024 at approximately 11:09 PM, the Nurse Practitioner (NP) was notified by the Administrator of Resident #1 elopement and return to facility. On 3/31/2024, licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs. On 4/01/2024 approximately 12:30 AM, the LPN #1 initiated facility-based incident reporting on Resident #1. On 4/01/2024 approximately 10:00 AM, the Corporate Clinical Specialist (CCS) initiated an audit of the wander risk evaluations on all 140 active residents. Results indicated twelve (12) residents requiring updates to the wander system. All updates were corrected on 4/1/2024. On 4/1/2024 at approximately 10:30 AM, the Social Services Director updated the wander and elopement binders to ensure all are reflective of results. On 4/01/2024 at approximately 11:00 AM, the Maintenance Supervisor checked all wander guards to verify all were in correct working order with no issues found.			F 657			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 22 On 4/1/2024 at approximately 11:19 AM, the NP placed orders for Resident to obtain Urinalysis, Comprehensive Metabolic Panel, and Complete Blood Count. On 4/01/2024 at approximately 1:46 PM, the Administrator performed an elopement drill to review and educate day shift on policies and procedures on elopement. On 4/01/2024 at approximately 2:00 PM, Social Services completed a BIMS on Resident #1 which resulted in moderate cogitative impairment of a 9. On 4/1/2024 at approximately 2:00 PM, a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction. On 4/01/2024 at approximately 3:11 PM, Resident # 1 was assessed by the NP no issues found and care plan was updated by interdisciplinary team to reflect changes in leave of absence status. On 4/01/2024 at approximately 11 P.M., the Registered Nurse Supervisor #1 performed an elopement drill to review and educate night shift on policies and procedures on elopement. On 4/2/2024 at about 11:30 PM, the Interim DON and Administrator Assistant performed an elopement Drill and educated staff on day shift. On 4/2/2024 at approximately 3:30 PM, the Administrator Assistant developed an orientation	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER YAZOO CITY REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 925 CALHOUN AVENUE YAZOO CITY, MS 39194		
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F 657	Continued From page 23 binder for all agency' staff onboard to be in-se Nice on facilities policies and procedures to include wandering, elopement, where to find if a resident is allowed to out leave of absence, and appointment guidelines. On 4/03/2024 at approximately 11:00 AM, NP reviewed results of labs ordered and placed an order for Levaquin 750 milligrams one by mouth at bedtime for 7 days related to Urinary Tract Infection to start on 4/3/2024 at 9:00 PM. Starting 4/3/2024, a current BIMS list will be in the leave of absence binder updated weekly or as needed by Social Services. All residents with BIMS under 12 will not be allowed to leave the facility without supervision. On 4/3/2024 at 5:50 PM., The final letter of investigation was sent to the Mississippi State Department of Health. On 4/3/2024 at 5:54 PM, the Attorney General was notified regarding the results of the Investigation. On 4/03/2024 at approximately 7:00 PM, the Administrator performed an elopement drill to review and educate evening shift on policies and procedures on elopement. On 4/4/2024 at approximately 8:30 AM, the Interim DON contacted Resident #2 general surgeon office to confirm phone for communication that is currently in their file and provide the facility contact information for any further communication. On 4/04/2024 at approximately 9:30 AM,	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 24 Resident Council Meeting was held with the Activity Director, Assistant Activity Director #1, Assistant Activity Director #2, and Resident Council President, and eighty-two (82) total resident presents to inform them the facility IJs. On 4/4/2024, an in-service was initiated by Staff Development Coordinator on leave of absence process and how to locate residents BIMS. No staff will be allowed to return to work without signing. On 4/4/2024 at approximately 11:00 AM, the Administrator held a one-to-one in-service with the Licensed Social Worker on Leave of Absences Care plans to include who can exit facility, supervision needed and process for a change in BIMS (Brief Interview for Mental Status). On 4/4/2024 at 12:44 PM, Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/ Infection Preventionist, and Assistant Director of Nursing held a Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence to include audits on elopements, care plans, orientation binder, in-services on appointment process, audits of dialysis residents and contacting dialysis to verify appointments. On 4/4/2024 at approximately 2:00 PM, Regional Case Mix conducted in-service with Minimum Data Set (MDS) to include implementation, Reviewing, Revising, and Resolving person-centered care plans.			F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 25 On 4/4/2024 at approximately 11:00 AM, An audit was initiated by Social Services Director on leave of absence care plans to ensure resident with impaired cognition receive adequate supervision. On 4/4/2024, the Assistant Administrator conducted a one-to-one in-service with Front Desk Receptionist to discuss appointment log, resident leave of absence binder, and how to locate current BIMS for residents. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 4/04/2024 and the Immediate Jeopardy was removed. Validation: On 4/05/24, the SA validated through staff interviews, resident interview, record review, sign-in sheets, and in-service reviews that the facility had implemented the following measures to remove the Immediate Jeopardy (IJ): The SA verified through record review, that interim Director of Nursing (DON) and Licensed Practical Nurse (LPN) #1 conducted a head-to-toe body assessment on Resident #1 to review for any skin abnormalities or concerns on 3/31/24 at 9:35 PM. Resident #1 had no negative skin issues or concern. The SA verified through record review, the Interim DON oversaw verification of all residents in facility using census with only one resident out of the facility and currently in the hospital. The census in the facility was 140 on 3/31/24 at 10:30 PM.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 26 The SA verified through staff interview, sign-in sheets, and in-service reviews, on 3/31/2024 at approximately 10:30 PM, staff present in the facility during the time of Resident #1 exit received immediate in-service by the Interim DON and Administrator on the procedures with residents signing out to exit facility to include verification of BIMS (Brief Interview for Mental Status). The SA verified through staff interview, sign-in sheets, and in-service reviews, on 3/31/2024 at approximately 10:30 PM the Interim DON and Administrator initiated servicing with all staff present on Abuse, Neglect, Resident Rights, Vulnerable Adult, and Wandering. Staff Development will continue In-Servicing. No staff will be allowed to return to work without completing. The SA verified through staff interview and record review, on 3/31/2024 at approximately 10:30 PM Resident #1 wandering evaluation was reviewed by Interim Director of Nursing and indicated low risk for wandering. Resident #1 wandering evaluation was updated by the Interim DON and Administrator on 3/31/2024. The SA verified through staff interview and record review, the wander guard bracelet was verified to work properly by checking function with door alarm by Administrator, and then placed on Resident #1's left wrist on 3/31/24 at 10:40 PM. The SA verified through staff interview and record review, on 3/31/24 at 10:45 PM, the facility camera was reviewed by the Administrator to determine the timeline of events leading up to Resident #1 exit of facility.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 657	Continued From page 27 The SA verified through staff interview, staff interview and record review, on 3/31/24 at 10:45 PM the Administrator interviewed staff present of Resident #1 leaving the facility unattended. The agency LPN who held the door open stated that she was not aware he could not leave the facility. The SA verified through staff interview and record review, on 3/31/24 at 11:05 PM the SA was notified of Resident #1 elopement. The SA verified through record review, on 3/31/2024 at approximately 11:09 PM, the Nurse Practitioner (NP) was notified by the Administrator of Resident #1 elopement and return to facility. The SA verified through staff interview and record review, on 3/31/2024, licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs. The SA verified through record review, on 4/01/2024 approximately 12:30 AM, the LPN #1 initiated facility-based incident reporting on Resident #1. The SA verified through record review, on 4/01/2024 approximately 10:00 AM, the Corporate Clinical Specialist (CCS) initiated an audit of the wander risk evaluations on all 140 active residents. Results indicated twelve (12) residents requiring updates to the wander system. All updates were corrected on 4/1/24. The SA verified through staff interview and record review, on 4/1/2024 at approximately 10:30 AM,	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 657	Continued From page 28 the Social Services Director updated the wander and elopement binders to ensure all are reflective of results. The SA validated through staff interview and record review that on 4/01/2024 at approximately 11:00 AM, the Maintenance Supervisor checked all wander guards to verify all were in correct working order with no issues found. The SA verified through record review, on 4/1/2024 at approximately 11:19 AM, the NP placed orders for Resident to obtain Urinalysis, Comprehensive Metabolic Panel, and Complete Blood Count. The SA verified through staff interview, record review, and sign-in sheets, on 4/01/2024 at approximately 1:46 PM, the Administrator performed an elopement drill to review and educate day shift on policies and procedures on elopement. The SA verified through record review, on 4/01/2024 at approximately 2:00 PM, Social Services completed a BIMS on Resident #1 which resulted in moderate cogitative impairment of a 9. The SA verified through staff interview, sign-in sheets, and record review, on 4/1/2024 at approximately 2:00 PM, a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 29 The SA verified through staff interview and record review, on 4/01/2024 at approximately 3:11 PM, Resident # 1 was assessed by the NP no issues found and care plan was updated by interdisciplinary team to reflect changes in leave of absence status. The SA verified through staff interview, and sign-in sheets, on 4/01/2024 at approximately 11 P.M., the Registered Nurse Supervisor #1 performed an elopement drill to review and educate night shift on policies and procedures on elopement. The SA verified through staff interview and sign-in sheets, on 4/2/2024 at about 11:30 PM, the Interim DON and Administrator Assistant performed an elopement Drill and educated staff on day shift. The SA verified through record review on 4/03/2024 at approximately 11:00 AM, NP reviewed results of labs ordered and placed an order for Levaquin 750 milligrams one by mouth at bedtime for 7 days related to Urinary Tract Infection to start on 4/3/2024 at 9:00 PM. The SA verified through staff interview and record review, starting 4/3/2024, a current BIMS list will be in the leave of absence binder updated weekly or as needed by Social Services. All residents with BIMS under 12 will not be allowed to leave the facility without supervision. The SA verified through record review, on 4/3/2024 at 5:50 PM, the final letter of investigation was sent to the SA. The SA verified through record review, on	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 30 4/3/2024 at 5:54 PM, the Attorney General was notified regarding the results of the investigation. The SA validated through interview and record, on 4/03/2024 at approximately 7:00 PM, the Administrator performed an elopement drill to review and educate evening shift on policies and procedures on elopement. The SA verified through staff interview, sign-in sheets, and in-service reviews, on 4/4/2024, an in-service was initiated by Staff Development Coordinator on leave of absence process and how to locate residents BIMS. No staff will be allowed to return to work without signing. The SA verified through record review on 4/4/2024 at approximately 11:00 AM, an audit was initiated by Social Services Director on leave of absence care plans to ensure resident with impaired cognition receive adequate supervision. The SA verified through staff interview, sign-in sheets, and in-service reviews and record review on 4/4/2024 at approximately 11:00 AM, the Administrator held a one-to-one in-service with the Licensed Social Worker on Leave of Absences Care plans to include who can exit facility, supervision needed and process for a change in BIMS (Brief Interview for Mental Status). The SA verified through record review on, 4/2/2024 at approximately 3:30 PM, the Administrator Assistant developed an orientation binder for all agency' staff onboard to be in-serviced on facilities policies and procedures to include wandering, elopement, where to find if a resident is allowed to out leave of absence, and	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 31 appointment guidelines. The SA verified through resident interview and sign in sheets, on 4/04/2024 at approximately 9:30 AM, Resident Council Meeting was held with the Activity Director, Assistant Activity Director #1, Assistant Activity Director #2, and Resident Council President, and eighty-two (82) total resident presents to inform them the facility received IJs. The SA verified through staff interview, sign-in sheets, and in-service reviews on 4/04/2024 at approximately 10:00 AM, the Staff Development initiated in-servicing with all licensed nurses, transportation, front desk receptionist on communication with appointments to include the process with signing resident in and out of facility, the daily transportation log along with the sign out binder. Inservice also includes adding a step to the appointment communication process with Admission Coordinator to review the communication tab within the electronic records to ensure all appointments are listed. No staff have been allowed to return to work without completing. The SA verified through staff interview and sign-in sheet, on 4/4/2024 at 12:44 PM, Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/ Infection Preventionist, and Assistant Director of Nursing held a Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence to include audits on elopements, care plans, orientation binder, in-services on appointment process, audits of dialysis residents and contacting dialysis to verify appointments.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 32 The SA verified through staff interview and record review, on 4/4/2024 at approximately 2:00 PM, Regional Case Mix conducted in-service with Minimum Data Set (MDS) to include implementation, Reviewing, Revising, and Resolving person-centered care plans. The SA verified through staff interview, sign-in sheets, and in-service reviews on 4/4/2024, the Assistant Administrator conducted a one-to-one in-service with Front Desk Receptionist to discuss appointment log, resident leave of absence binder, and how to locate current BIMS for residents. On 4/05/24, the SA validated that all corrective actions had been taken by the facility to remove the IJ on 4/04/24 and the IJ was removed on 4/05/24.	F 657			
F 689 SS=J	Surveyor: Bumpous, Shelbie 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:	F 689			5/2/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 33 Based on staff and resident interviews, record review and facility policy review, the facility failed to provide supervision to prevent the elopement of a resident who was severely cognitively impaired for one (1) of five (5) residents reviewed. Resident #1. The facility failed to provide supervision to prevent the elopement of Resident #1, who was severely cognitively impaired and left the facility unattended. This failure allowed Resident #1 to be away from the facility unnoticed and unsupervised on 3/31/24 from 7:25 PM until 8:41 PM, when the facility was alerted that the resident was seen in the community, approximately eight-tenths (0.8) of a mile from the facility. This was approximately 81 minutes after Resident #1 was last observed in the facility. The facility's failure to provide supervision resulted in Resident #1's elopement and has the likelihood to result in serious harm, serious injury, serious impairment, or death for Resident #1 and all other cognitively impaired residents who leave the facility unsupervised. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/31/24 when a severely cognitively impaired resident left the facility unsupervised. The facility Administrator was notified of the IJ by the SA on 4/3/24 at 5:31 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 4/4/24, in which the facility alleged all corrective actions were completed to remove the IJ. The SA validated the Removal Plan and determined the IJ was removed on 4/5/24, prior to	F 689	On 03/31/2024, the Interim Director of Nursing (DON) and Licensed Practical Nurse (LPN) #1 conducted a head-to-toe body assessment on Resident #1 to review for any skin abnormalities or concerns. Resident #1 had no negative skin issues or concerns. The Interim DON oversaw verification of all residents in facility using census with only one resident out of the facility and currently in the hospital. The census in the facility was 140. Resident #1 wandering evaluation was reviewed by Interim Director of Nursing and indicated low risk for wandering. Resident #1 wandering evaluation was updated by the Interim DON and Administrator. The wander guard bracelet was verified to work properly by checking function with door alarm by Administrator, and then placed on Resident #1's left wrist. The facility camera was reviewed by the Administrator to determine the timeline of events leading up to Resident #1 exit of facility. The Administrator interviewed staff present of Resident #1 leaving the facility unattended. The agency LPN who held the door open stated that she was not aware he could not leave the facility. The Nurse Practitioner (NP) was notified by the Administrator of Resident #1 elopement and returned to facility. Licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 34 exit, and the scope and severity for 42 CFR(s) 483.25(d)(1)(2) Free of Accidents Hazard/supervision/devices (F689) was lowered from a "J" to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of a statement, on facility letterhead, dated 4/4/24, and signed by the Administrator, revealed that the facility does not have a policy related to resident leave of absence. Review of the facility's policy titled, "Wanderer Management, Monitoring System & Resident Elopement Protocol" revealed, " Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible..." Record review of the "Brief Interview for Mental Status" (BIMS), dated 2/22/24 revealed Resident #1 had a score of five (5) indicating severe cognitive impairment. During an interview with Licensed Practical Nurse #2 (LPN) at 8:35 AM on 4/3/24, she stated that in the past Resident #1 did leave the building by himself, but they no longer let him do that due to his confusion. She could not remember when they stopped letting him go on leave of absence (LOA) by himself, but verified it was prior to 3/31/24. She stated she did not know how the facility communicated that a resident was not supposed to go LOA by themselves.	F 689	The facility has determined that each of the 140 residents has the potential to be affected. On 04/01/2024, the Corporate Clinical Specialist (CCS) initiated an audit of the wander risk evaluations on all 140 active residents. Results indicated twelve (12) residents requiring updates to the wander system. All updates were corrected on 4/1/2024. On 4/1/2024, the Social Services Director updated the wander and elopement binders to ensure all are reflective of results. On 3/31/2024, staff present in the facility during the time of Resident #1 exit received immediate in-service by the Interim DON and Administrator on the procedures with residents signing out to exit facility to include verification of BIMS (Brief Interview for Mental Status). On 03/31/2024, the Interim DON and Administrator initiated in-servicing with all staff present on Abuse, Neglect, Resident Rights, Vulnerable Adult, and Wandering. Staff Development will continue In-Servicing. Beginning on 4/8/24 Social Services will review five residents on the sign out log per week for twelve weeks ensuring that proper sign in/out procedures are being followed that the Brief Interview for Mental Status (BIMS) is up to date. A report beginning on 05/01/2024 will be submitted		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/05/2024
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F 689	Continued From page 35 In an interview with Resident #1 on 4/3/24 at 9:30 AM, he stated he remembered going outside on 3/31/24. He stated he just wanted to get some air. He denied having the exit code and stated he just went out the door. Resident #1 would not answer any further questions. In an interview with the Interim DON on 4/3/24 at 12:01 PM, she stated she arrived at the facility on 3/31/24 at 7:30 PM but did not see Resident #1 outside. She stated that around 8:30 PM the floor nurse asked her if she had seen Resident #1. She stated she went downstairs but the resident was not there. She stated that around 8:41 PM she received a call from the Administrator notifying her that the police had located the resident in the community. She stated that the resident was returned to the facility at 9:30 PM. She performed an assessment at that time and the resident had no injuries. She stated that the resident was wearing long jean pants, long sleeve pullover sweatshirt, tennis shoes and a cap. During a telephone interview with Police Officer #1 on 4/3/24 at 1:06 PM, he verified that on 3/31/24 he received a call from dispatch that a man in a wheelchair was seen in the middle of the street near (Proper Name of apartment complex). He said when he arrived the person was already gone. Officer #1 stated at that time he received a second call that a man in a wheelchair was seen at the intersection of (Proper Name of streets)where he located the resident. He stated the facility sent someone to pick the resident up. In an interview with the Administrator on 4/3/24 at 1:16 PM, she stated that she watched the surveillance camera footage for 3/31/24 and she	F 689	to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Social Service Director is responsible for monitoring and compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 36 saw that an agency nurse let Resident #1 outside at 7:25 PM. During an interview with LPN #1 on 4/3/24 at 1:24 PM, she verified that at 7:20 PM on 3/31/24 the resident was downstairs by the elevator, she asked him where he was going, and he stated "nowhere" so she went back upstairs. LPN # 1 stated around 8:30 PM she arrived at Resident #1's room, and he was not in the room. She notified the DON that she had not seen the resident since she was downstairs at 7:20 PM. She stated the DON went downstairs to look for the resident and at around 9:15 PM the DON told her that the resident had been found in the community by the police. During an interview with the Assistant Director of Nursing (ADON) on 4/3/24 at 1:30 PM, she verified that Resident #1's last BIMS score on 2/22/24 was a 5, indicating severe cognitive impairment and that he was not safe to go LOA by himself. She agreed that the facility did not have anything in place to ensure effective communication that the resident was not safe to go LOA by himself, but that they should have something in place. During an interview with the Social Worker (SW) on 4/3/24 at 1:46 PM, she stated that once Resident #1's cognition declined, and his BIMS was less than 12 he was no longer safe to go LOA by himself. She stated that residents must have a BIMS of 12 or higher to go LOA by themselves because of potential problems. She verified that Resident #1's BIMS on 2/22/24 was 5, indicating severe cognitive impairment and he was no longer safe to go outside the facility by himself.	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 37 In an interview with Registered Nurse# 1 (RN) on 4/3/24 at 3:10 PM, she stated that due to Resident #1's increased confusion he was not safe to go LOA by himself. She stated that this information is communicated verbally during the report, and there is no written communication provided. In an interview with Certified Nursing Assistant (CNA) #1 on 4/3/24 at 3:15 PM, she stated that she does not know which residents can or cannot go LOA by themselves. During a telephone interview conducted with the Administrator on 4/3/24 at 3:27 PM, she stated she was notified Resident #1 was not in the facility on 3/31/24 at 8:30 PM, when the DON called informing her that he was seen by a witness in the community. She stated that she then contacted the facility and notified them of the resident's whereabouts and called the van driver to pick the resident up. During a telephone interview with the Van Driver on 4/3/24 at 3:46 PM, he verified the location in the community where he picked up Resident #1 on 3/31/24 at approximately 9:20 PM. During a telephone interview with LPN #3 on 4/5/24 at 11:00 AM, she verified on 3/31/24 Resident #1 was at the front door of the facility attempting to exit. She stated that she really did not know who the resident was. She stated that she thought he was just going to sit on the porch. LPN #3 stated that she was not aware that Resident #1 was not allowed to go out by himself. She stated there was no communication in place that informed her what residents could or could	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 38 not leave the building unattended. Record review of "Past Weather in (Name of City)" dated 3/31/24 revealed that sunset was at 7:22 PM and it was 55 degrees Fahrenheit (F) from 7:30 PM to 9:30 PM with no precipitation. Record review of "Google Maps" revealed that the address where Resident #1 was located was eight-tenths (0.8) of a mile from the facility. Record review of the Admission Record for Resident #1 revealed that the facility admitted the resident on 11/8/21 with diagnoses including Epilepsy. A record review of the facility investigation revealed Resident #1 was admitted on 2/7/20 the Facility with diagnoses including Epilepsy and Dependence on a wheelchair. On 3/31/24 at approximately 8:30 PM, Director of Nursing (DON) contacted the Administrator and stated the police had Resident #1 on (Formal Name of street in the community). The Administrator contacted the Interim DON ,who was at the facility, to verify that Resident #1 was not in the facility. She confirmed that he was not. The facility driver was contacted and dispatched to pick up Resident #1 who remained under the supervision of the police officer until pick up. Resident #1 returned to the facility at 9:29 PM. Resident #1 was given a head-to-toe assessment by Interim DON with no injuries noted. An updated wander assessment was completed by Administrator and Interim DON to reflect new behavior. The Administrator verified that the wander guard was working and placed the bracelet on the left wrist of Resident #1. Upon staff interviews and review of camera footage,			F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 39 Resident #1 noted exiting the facility at 7:25 PM when the agency Licensed Practical Nurse (LPN) opened the door for him. When questioned by the Administrator she stated that she thought he was going to sit on the front porch. The Administrator educated LPN on the fact that residents are required to sign out even if they are sitting on the porch. Resident #1 is his own responsible party. The Medical Director and Nurse Practitioner were also notified. Prior to this incident Resident #1 was not deemed a wander risk due to no previous exit seeking behavior and a previous wander assessment completed on 2/1/24 placed him at low risk for wandering. Resident #1's care plan was reviewed and updated by the interdisciplinary team to include new wander behaviors. The Wander Binder was updated to reveal new behavior. In services began on 3/31/24 on Abuse and Neglect, Resident's Rights, MS (Mississippi) Vulnerable Adult Act, and Elopement. A binder was started and placed at each nurse's station for Orientation Procedure. An Ad hoc Quality Assurance (QA) meeting was held on 4/1/2024 with the Medical Director, Interdisciplinary team to discuss events along with plan of correction. Social Services to follow up as needed for any physical, mental, or psychosocial needs. The labs obtained revealed the resident has a Urinary Tract Infection (UTI) and his treatment has been started. The resident remains his own Responsible Party but due to his variations in health status, and for process improvement the staff was in serviced to ensure BIMS (Brief Interview for Mental Status) verification is obtained along with the resident signing out prior to exit from facility. In conclusion, abuse and/or neglect by the facility could not be substantiated. Observation based on the reported sightings of	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 40 the resident on 3/31/24 there were three (3) possible routes Resident #1 could have taken when he left the facility. On 4/3/24 at 6:00 PM, the SA retraced the possible routes that Resident #1 could have taken revealed that all routes were dimly lit with ditches and large culverts on the sides of the roads, as well as railroad tracks on all three (3) routes. All routes were eight-tenths (0.8) of a mile from the facility. Record review of the "Incident Report" from local police department revealed "On 3-31-24, I (Proper Name of officer) was dispatched at 8:12 PM to look for a subject in front of (Proper Name of apartment complex) in a wheelchair in the middle of the roadway. I arrived on the scene at 8:16 PM. Upon my arrival, I did not see anyone in a wheelchair in the roadway. I rode around the apartment complex and still didn't see a subject in a wheelchair. I went back in service at 8:20 PM. I received another call at 8:27 PM about a male subject in the roadway on (Proper name of Street) near (Proper Name of street). I arrived on the scene at 8:28 PM. I came into contact with (Proper Name of Witness) she was following the male subject in her car so no one would run over him. We came to a stop near (Proper Name of Street). I came into contact with the male subject (Proper name of Resident #1) who was in a wheelchair. I asked if he was ok. He advised that he was ok and that he was just going home. There was a lady who lived next to where we were she called (Proper name of Facility) and talked to the director. I advised that I was calling Emergency Medical Services (EMS) to transport (Proper Name of Resident #1) back to the facility. The director advised that they were going to send a van to pick up (Proper Name of Resident #1)."	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 41 Record review of a facility "Behavior Note" dated 3/31/2024 at 9:30 PM, revealed "This nurse got off the elevator to go get supplies at 7:20 PM on another unit. This nurse passed the resident sitting in wheelchair downstairs in hallway by the social worker's office door and asked, "Where are you going"? Resident answered, "No where". This nurse said "OK" and proceeded to go get supplies on Annex unit. This nurse then went back up to her unit on the 2nd floor and started the med pass. When this nurse reached the resident room around 8:30 PM the resident was not in his room. DON was on the unit and this nurse asked if she had seen the resident. This nurse stated that the resident was downstairs earlier and is usually back in bed by now. DON (Formal Name of DON) stated that she would go look for the resident. DON returned at 9:15 PM and notified this nurse that the resident had left the building and was located near the police station. DON stated facility transportation was on the way to pick up the resident. Resident returned to unit per wheelchair around 9:30 PM with DON. Resident was assisted into bed and a head-to-toe assessment was performed by DON and this nurse. ... When asked why he left the building resident stated, "I was going to my cousin house across the street to get my truck". Confusion noted. Resident received a wander guard for elopement monitoring to left wrist and placed on q (every) 15 minute checks for elopement risk while in bed. Administrator present in building." Facility Removal Plan On 3/31/2024 at approximately 9:35 PM the interim Director of Nursing (DON) and Licensed Practical Nurse (LPN) #1 conducted a head-to-toe body assessment on Resident #1 to	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 42 review for any skin abnormalities or concerns. Resident #1 had no negative skin issues or concerns. On 3/31/2024 at about 10:30 PM, the Interim DON oversaw verification of all residents in facility using census with only one resident out of the facility and currently in the hospital. The census in the facility was 140. On 3/31/2024 at approximately 10:30 PM, staff present in the facility during the time of Resident #1 exit received immediate in-service by the Interim DON and Administrator on the procedures with residents signing out to exit facility to include verification of BIMS (Brief Interview for Mental Status). On 3/31/2024 at approximately 1030 PM, the Interim DON and Administrator initiated servicing with all staff present on Abuse, Neglect, Resident Rights, Vulnerable Adult, and Wandering. Staff Development will continue In-Servicing. No staff will be allowed to return to work without completing. On 3/31/2024 at approximately 10:40 PM, Resident #1 wandering evaluation was reviewed by Interim Director of Nursing and indicated low risk for wandering. Resident #1 wandering evaluation was updated by the Interim DON and Administrator on 3/31/2024. On 3/31/2024 at approximately 10:40 PM, the wander guard bracelet was verified to work properly by checking function with door alarm by Administrator, and then placed on Resident #1's left wrist.	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 43 On 3/31/2024, the facility camera was reviewed by the Administrator to determine the timeline of events leading up to Resident #1 exit of facility. On 3/31/24 at 10:45 PM, the Administrator interviewed staff present of Resident #1 leaving the facility unattended. The agency LPN who held the door open stated that she was not aware he could not leave the facility. On 3/31/2024 at approximately 11:05 PM, the Mississippi State Department of Health was notified of Resident #1 elopement. On 3/31/2024 at approximately 11:09 PM, the Nurse Practitioner (NP) was notified by the Administrator of Resident #1 elopement and return to facility. On 3/31/2024, licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs. On 4/01/2024 approximately 12:30 AM, the LPN #1 initiated facility-based incident reporting on Resident #1. On 4/01/2024 approximately 10:00 AM, the Corporate Clinical Specialist (CCS) initiated an audit of the wander risk evaluations on all 140 active residents. Results indicated twelve (12) residents requiring updates to the wander system. All updates were corrected on 4/1/2024. On 4/1/2024 at approximately 10:30 AM, the Social Services Director updated the wander and elopement binders to ensure all are reflective of results.			F 689			

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F 689	Continued From page 44 On 4/01/2024 at approximately 11:00 AM, the Maintenance Supervisor checked all wander guards to verify all were in correct working order with no issues found. On 4/1/2024 at approximately 11:19 AM, the NP placed orders for Resident to obtain Urinalysis, Comprehensive Metabolic Panel, and Complete Blood Count. On 4/01/2024 at approximately 1:46 PM, the Administrator performed an elopement drill to review and educate day shift on policies and procedures on elopement. On 4/01/2024 at approximately 2:00 PM, Social Services completed a BIMS on Resident #1 which resulted in moderate cogitative impairment of a 9. On 4/1/2024 at approximately 2:00 PM, a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction. On 4/01/2024 at approximately 3:11 PM, Resident # 1 was assessed by the NP no issues found and care plan was updated by interdisciplinary team to reflect changes in leave of absence status. On 4/01/2024 at approximately 11 P.M., the Registered Nurse Supervisor #1 performed an elopement drill to review and educate night shift on policies and procedures on elopement.	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 45 On 4/2/2024 at about 11:30 PM, the Interim DON and Administrator Assistant performed an elopement Drill and educated staff on day shift. On 4/2/2024 at approximately 3:30 PM, the Administrator Assistant developed an orientation binder for all agency' staff onboard to be inserviced on facility's policies and procedures to include wandering, elopement, where to find if a resident is allowed to out leave of absence, and appointment guidelines. On 4/03/2024 at approximately 11:00 AM, NP reviewed results of labs ordered and placed an order for Levaquin 750 milligrams one by mouth at bedtime for 7 days related to Urinary Tract Infection to start on 4/3/2024 at 9:00 PM. Starting 4/3/2024, a current BIMS list will be in the leave of absence binder updated weekly or as needed by Social Services. All residents with BIMS under 12 will not be allowed to leave the facility without supervision. On 4/3/2024 at 5:50 PM., The final letter of investigation was sent to the Mississippi State Department of Health. On 4/3/2024 at 5:54 PM, the Attorney General was notified regarding the results of the Investigation. On 4/03/2024 at approximately 7:00 PM, the Administrator performed an elopement drill to review and educate evening shift on policies and procedures on elopement. On 4/4/2024 at approximately 8:30 AM, the Interim DON contacted Resident #2 general	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/05/2024
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F 689	Continued From page 46 surgeon office to confirm phone for communication that is currently in their file and provide the facility contact information for any further communication. On 4/04/2024 at approximately 9:30 AM, Resident Council Meeting was held with the Activity Director, Assistant Activity Director #1, Assistant Activity Director #2, and Resident Council President, and eighty-two (82) total resident presents to inform them the facility received Immediate Jeopardies. On 4/4/2024, an in-service was initiated by Staff Development Coordinator on leave of absence process and how to locate residents BIMS. No staff will be allowed to return to work without signing. On 4/4/2024 at approximately 11:00 AM, the Administrator held a one-to-one in-service with the Licensed Social Worker on Leave of Absences Care plans to include who can exit facility, supervision needed and process for a change in BIMS (Brief Interview for Mental Status). On 4/4/2024 at 12:44 PM, Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/ Infection Preventionist, and Assistant Director of Nursing held a Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence to include audits on elopements, care plans, orientation binder, in-services on appointment process, audits of dialysis residents and contacting dialysis to verify appointments.	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 47 On 4/4/2024 at approximately 2:00 PM, Regional Case Mix conducted in-service with Minimum Data Set (MDS) to include implementation, Reviewing, Revising, and Resolving person-centered care plans. On 4/4/2024 at approximately 11:00 AM, An audit was initiated by Social Services Director on leave of absence care plans to ensure resident with impaired cognition receive adequate supervision. On 4/4/2024, the Assistant Administrator conducted a one-to-one in-service with Front Desk Receptionist to discuss appointment log, resident leave of absence binder, and how to locate current BIMS for residents. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 4/04/2024 and the Immediate Jeopardy was removed 4/05/2024. Validation: On 4/05/24, the SA validated through staff interviews, resident interview, record review, sign-in sheets, and in-service reviews that the facility had implemented the following measures to remove the Immediate Jeopardy (IJ): Resident # 1 The SA verified through record review, that interim Director of Nursing (DON) and Licensed Practical Nurse (LPN) #1 conducted a head-to-toe body assessment on Resident #1 to review for any skin abnormalities or concerns on 3/31/24 at 9:35 PM. Resident #1 had no negative	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 48 skin issues or concern. The SA verified through record review, the Interim DON oversaw verification of all residents in facility using census with only one resident out of the facility and currently in the hospital. The census in the facility was 140 on 3/31/24 at 10:30 PM. The SA verified through staff interview, sign-in sheets, and in-service reviews, on 3/31/2024 at approximately 10:30 PM, staff present in the facility during the time of Resident #1 exit received immediate in-service by the Interim DON and Administrator on the procedures with residents signing out to exit facility to include verification of BIMS (Brief Interview for Mental Status). The SA verified through staff interview, sign-in sheets, and in-service reviews, on 3/31/2024 at approximately 10:30 PM the Interim DON and Administrator initiated servicing with all staff present on Abuse, Neglect, Resident Rights, Vulnerable Adult, and Wandering. No staff have been allowed to return to work without completing. The SA verified through staff interview and record review, on 3/31/2024 Resident #1's wandering evaluation was reviewed by Interim Director of Nursing and indicated low risk for wandering. Resident #1 wandering evaluation was updated by the Interim DON and Administrator on 3/31/2024. The SA verified through staff interview and record review, the wander guard bracelet was verified to work properly by checking function with door alarm by Administrator, and then placed on	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/11/2024
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 49 Resident #1's left wrist. The SA verified through staff interview, staff interview and record review, on 3/31/24 at 10:45 PM the Administrator interviewed staff present of Resident #1 leaving the facility unattended. The agency LPN who held the door open stated that she was not aware he could not leave the facility. The SA verified through staff interview and record review, on 3/31/24 at 11:05 PM the SA was notified of Resident #1 elopement. The SA verified through record review, on 3/31/2024 at approximately 11:09 PM, the Nurse Practitioner (NP) was notified by the Administrator of Resident #1 elopement and return to facility. The SA verified through staff interview and record review, on 3/31/2024, licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs. The SA verified through record review, on 4/01/2024 approximately 12:30 AM, the LPN #1 initiated facility-based incident reporting on Resident #1. The SA verified through record review, on 4/01/2024 approximately 10:00 AM, the Corporate Clinical Specialist (CCS) initiated an audit of the wander risk evaluations on all 140 active residents. Results indicated twelve (12) residents requiring updates to the wander system. All updates were corrected on 4/1/24. The SA verified through staff interview and record	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 50 review, on 4/1/2024 at approximately 10:30 AM, the Social Services Director updated the wander and elopement binders to ensure all are reflective of results. The SA validated through staff interview and record review that on 4/01/2024 at approximately 11:00 AM, the Maintenance Supervisor checked all wander guards to verify all were in correct working order with no issues found. The SA verified through record review, on 4/1/2024 at approximately 11:19 AM, the NP placed orders for Resident to obtain Urinalysis, Comprehensive Metabolic Panel, and Complete Blood Count. The SA verified through staff interview, record review, and sign-in sheets, on 4/01/2024 at approximately 1:46 PM, the Administrator performed an elopement drill to review and educate day shift on policies and procedures on elopement. The SA verified through record review, on 4/01/2024 at approximately 2:00 PM, Social Services completed a BIMS on Resident #1 which resulted in moderate cogitative impairment of a 9. The SA verified through staff interview, sign-in sheets, and record review, on 4/1/2024 at approximately 2:00 PM, a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction.	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 51 The SA verified through staff interview and record review, on 4/01/2024 at approximately 3:11 PM, Resident # 1 was assessed by the NP no issues found and care plan was updated by interdisciplinary team to reflect changes in leave of absence status. The SA verified through staff interview, and sign-in sheets, on 4/01/2024 at approximately 11 P.M., the Registered Nurse Supervisor #1 performed an elopement drill to review and educate night shift on policies and procedures on elopement. The SA verified through staff interview and sign-in sheets, on 4/2/2024 at about 11:30 PM, the Interim DON and Administrator Assistant performed an elopement Drill and educated staff on day shift. The SA verified through record review on 4/03/2024 at approximately 11:00 AM, NP reviewed results of labs ordered and placed an order for Levaquin 750 milligrams one by mouth at bedtime for 7 days related to Urinary Tract Infection to start on 4/3/2024 at 9:00 PM. The SA verified through staff interview and record review, starting 4/3/2024, a current BIMS list will be in the leave of absence binder updated weekly or as needed by Social Services. All residents with BIMS under 12 will not be allowed to leave the facility without supervision. The SA verified through record review, on 4/3/2024 at 5:50 PM, the final letter of investigation was sent to the SA.	F 689			

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F 689	Continued From page 52 The SA verified through record review, on 4/3/2024 at 5:54 PM, the Attorney General was notified regarding the results of the investigation. The SA validated through interview and record, on 4/03/2024 at approximately 7:00 PM, the Administrator performed an elopement drill to review and educate evening shift on policies and procedures on elopement. The SA verified through staff interview, sign-in sheets, and in-service reviews, on 4/4/2024, an in-service was initiated by Staff Development Coordinator on leave of absence process and how to locate residents BIMS. No staff will be allowed to return to work without signing. The SA verified through record review on 4/4/2024 at approximately 11:00 AM, an audit was initiated by Social Services Director on leave of absence care plans to ensure resident with impaired cognition receive adequate supervision. The SA verified through staff interview, sign-in sheets, and in-service reviews and record review on 4/4/2024 at approximately 11:00 AM, the Administrator held a one-to-one in-service with the Licensed Social Worker on Leave of Absences Care plans to include who can exit facility, supervision needed and process for a change in BIMS (Brief Interview for Mental Status). The SA verified through record review on, 4/2/2024 at approximately 3:30 PM, the Administrator Assistant developed an orientation binder for all agency' staff onboard to be in-serviced on facilities policies and procedures to include wandering, elopement, where to find if a	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 53 resident is allowed to out leave of absence, and appointment guidelines. The SA verified through resident interview and sign in sheets, on 4/04/2024 at approximately 9:30 AM, Resident Council Meeting was held with the Activity Director, Assistant Activity Director #1, Assistant Activity Director #2, and Resident Council President, and eighty-two (82) total resident presents to inform them the facility received IJs. The SA verified through staff interview, sign-in sheets, and in-service reviews on 4/04/2024 at approximately 10:00 AM, the Staff Development initiated in-servicing with all licensed nurses, transportation, front desk receptionist on communication with appointments to include the process with signing resident in and out of facility, the daily transportation log along with the sign out binder. Inservice also includes adding a step to the appointment communication process with Admission Coordinator to review the communication tab within the electronic records to ensure all appointments are listed. No staff will be allowed to return to work without completing. The SA verified through staff interview and sign-in sheet, on 4/4/2024 at 12:44 PM, Medical Director, Administrator, Assistant Administrator, Interim Director of Nursing/ Infection Preventionist, and Assistant Director of Nursing held a Quality Assurance Performance Improvement Meeting to include notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence to include audits on elopements, care plans, orientation binder, in-services on appointment process, audits of dialysis residents and contacting dialysis to verify appointments.	F 689			

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F 689	Continued From page 54 The SA verified through staff interview and record review, on 4/4/2024 at approximately 2:00 PM, Regional Case Mix conducted in-service with Minimum Data Set (MDS) to include implementation, Reviewing, Revising, and Resolving person-centered care plans. The SA verified through staff interview, sign-in sheets, and in-service reviews on 4/4/2024, the Assistant Administrator conducted a one-to-one in-service with Front Desk Receptionist to discuss appointment log, resident leave of absence binder, and how to locate current BIMS for residents. On 4/05/24, the SA validated that all corrective actions had been taken by the facility to remove the IJ on 4/04/24 and the IJ was removed on 4/05/24.	F 689			