STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195596	A. Building B. Wing	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Goss Nursing Home	3300 White Street Monroe, LA 71203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19121 Based on observations, record reviews and interviews the facility failed to provide an environment free of accident hazards for 1 (#1) of 1 (#1) residents identified at high risk for elopement. The facility failed to ensure all exit doors were secured to prevent residents at risk for elopement from exiting the facility unsupervised and failed to provide continued monitoring after resident #1 was returned to the facility. This deficient practice resulted in an Immediate Jeopardy situation on 03/15/2024 at 3:30 p.m. when resident #1 (a cognitively impaired resident identified as an elopement risk) was found a 1/2 block away from the facility. Resident #1 was located 10 minutes after he eloped on 03/15/2024 through an unsecured door and was returned to the facility at 3:45 p.m. Resident #1 was located at 3:40 p.m., by a staff member and found in a ditch, sitting in water, and had a laceration to his left eye and bruise to his left shoulder. Resident #1 was returned to the facility by S7 CNA (Certified Nursing Assistant) and S1Administrator in the nursing home van and then the resident was sent for evaluation to the local hospital by ambulance at 4:00 p.m. S1Administrator was notified of the Immediate Jeopardy on 03/22/2024 at 11:40 a.m. The Immediate Jeopardy was removed on 03/22/2024 at 5:40 p.m., as confirmed by onsite verification through observations, interviews and record reviews that the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: Review of the current facility's Wandering and Elopement policy dated 12/2009 revealed there was no guidance in the policy on placing a resident that had eloped on any type of supervision or monitoring. Review of the medical record for resident #1 revealed an admitted [DATE] with a readmitted [DATE]. Further review revealed diagnosis of myocardial Infarction, alcoholic cardiomyopathy, acute respiratory failure with hypoxia, syphilis, heart failure, alcohol abuse, trichomonas, acute kidney failure, and metabolic encephalopathy. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly Minimum Data Set assessment dated [DATE] revealed resident #1 had severe cognition for daily decisions making and required assistance with one person assist for bed mobility and supervision with one person assist with transfers. Review of the fall risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of resident #1's Elopement Risk Record dated 02/29/2024 revealed no complaints of elopement, but was high risk and the only intervention noted was a bed alarm. Further review revealed the risk record was updated 03/15/2024 to include the incident of the resident leaving the building without staff and interventions were noted as bed alarm, staff aware of residents wander risk and frequent monitoring. Review of resident #1's current care plan revealed he was care planned for elopement with an intervention of monitoring for needs and needs will be met as necessary. Further review revealed on 03/15/2024 care plan updated - resident eloped from the nursing home, with new approaches that included census checks q (every) 30 minutes for whereabouts and elopement attempts. Review of resident #1's record failed to reveal documentation of monitoring the resident's needs and needs being met prior to the elopement prior to 03/15/2024. Review of resident #1's Incident & Accident report dated 03/15/2024 at 3:40p.m. revealed an unwitnessed fall outside the facility, resulting in a gash over the left eye and bruise to the left shoulder. No other injuries noted at this time. Able to move upper and lower extremities. Resident #1 sent by ambulance to the local hospital for evaluation. Resident #1s discharge hospital report dated 03/15/2024 revealed CT (computed tomography) scan done with no injuries found, incision to left upper eye with fibrin sealant. Discharge back to nursing facility and follow up with resident's physician. An interview on 03/21/2024 at 9:55 a.m. with S4LPN (Licensed Practical Nurse) that was taking care of resident #1, confirmed there was no documentation of the monitoring for needs and needs will be met as necessary prior to the 03/15/2024 elopement and for the census checks for the resident's whereabouts every 30 minutes after the elopement on 03/15/2024. An interview on 03/21/2024 at 10:20 a.m. with S9CNA stated resident #1 was checked on by staff every 30 minutes, but they don't document it anywhere. An interview on 03/22/2024 at 9:00 a.m. with S8CNA and S10CNA that was taking care of resident #1, confirmed there was no documentation of monitoring the resident before or after the elopement attempt on 03/15/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 03/21/2024 at 9:50 a.m. with S1Administrator revealed when he was notified resident #1 was not in the facility, he drove the nursing home van down the block and saw the resident sitting on the ground in the water. The Administrator stated he and the other staff member assisted the resident to a standing position and assisted him to the van to be brought back to the nursing home. S1Administrator stated the resident was assessed and found to have a gash above his left eye and bruise to the left shoulder and nursing had received an order from the resident's physician to send the resident to the hospital for evaluation. S1Administrator stated he began investigating how the resident eloped from the facility. It was found that the door the resident went out of was normally locked and a code would have to be used to open it, but he stated it must not have closed completely due to when the resident pushed the door opened the alarm did sound. S1Administrator stated he contacted the agency that works on the facilities locked doors and they came to inspect the doors. The agency determined that the door was functioning properly and if it happened again, contact them and they would respond immediately. S1Administrator stated they would have placed a wander guard bracelet on the resident, but the facility did not have any bracelets on hand and he had to order some. S1Administrator stated resident #1 will be monitored by staff every 30 minutes until the wander guard arrives. An interview on 03/21/2024 at 9:55 a.m. with S4LPN that was taking care of resident #1, stated he had never tried to go outside by himself before the incident on 03/15/2024. When asked how he was being monitored after the elopement she stated staff make observations of the resident every 30 minutes, he is taken to the Chapel to eat all meals, and if the resident seems restless they will bring him to the nurse's station to be monitored. When asked where the observations every 30 minutes were documented S4LPN stated they were not documented. An interview on 03/22/2024 at 9:10 a.m. with S2DON (Director of Nurses) stated the facility had not received the wander guard bracelets, but they were ordered. She further stated the resident was being monitored by staff every 30 minutes, but the every 30 minute monitoring had not been documented.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 19121 Based on observations, record review and interviews the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently by failing to have an adequate system in place to ensure 1(#1) of 1 ((#1) residents who was at high risk for elopement was adequately supervised to prevent Resident #1 from eloping from the facility. This deficient practice resulted in an Immediate Jeopardy situation on 03/15/2024 at 3:30 p.m. when resident #1 (a cognitively impaired resident identified as an elopement risk) was found a 1/2 block away from the facility. Resident #1 was located 10 minutes after he eloped on 03/15/2024 through an unsecured door and was returned to the facility at 3:45 p.m. Resident #1 was located at 3:40 p.m., by a staff member and was found in a ditch, sitting in water, and had a laceration to his left eye and bruise to his left shoulder. Resident #1 was returned to the facility by S7 CNA (Certified Nursing Assistant) and S1Administrator in the nursing home van and then the resident was sent for evaluation to the local hospital by ambulance at 4:00 p.m. S1Administrator was notified of the Immediate Jeopardy on 03/22/2024 at 11:40 a.m. The Immediate Jeopardy was removed on 03/22/2024 at 5:40 p.m., as confirmed by onsite verification through observations, interviews and record reviews that the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: Cross Reference F689 Review of the facilities Wandering and Elopement policy dated 12/2009 revealed there was no guidance in the policy on placing a resident that had eloped on any type of supervision or monitoring. Review of the Incident and Accident report dated 03/15/2024 at 3:40 p.m. stated the resident had an unwitnessed fall outside resulting in a gash over his left eye and bruise on his left shoulder. No other injuries noted at this time, the resident was able to move his upper and lower extremities. Further review revealed the resident was sent to the local emergency room for evaluation at 4:00 p.m. on 03/15/2024. An interview on 03/21/2024 at 09:50 a.m. with S1Administrator confirmed he began investigating how the resident eloped from the facility on 03/15/2024. The investigation found that the door the resident went out of was normally locked and a code would have to be used to open it. S1 Administrator stated the door must have not closed completely due to when the resident pushed the door opened the alarm did sound. S1Administrator stated he contacted the agency that maintains the facilities locked doors and they came immediately to inspect the doors. The agency determined that the door was functioning properly and if it happened again, to contact them and they would respond immediately. S1Administrator stated they would have placed a wander guard bracelet on the resident, but the facility did not have any bracelets on hand and he had to order them. S1Administrator stated the facility does not have a system in place to monitor the locked doors to ensure they are in working order. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/22/2024 at 9:10 a.m. with S2DON (Director of Nurses) stated the facility had not received the wander guard bracelets, but they were ordered. She further stated the resident was being monitored by staff every 30 minutes but the monitoring had not been documented. During the survey, there was no documented evidence of monitoring the resident for elopement and monitoring proper working order of the locking of exit doors before or after the elopement incident on 03/15/2024.