STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255268	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Albany Health & Rehab Center	118 South Glenfield Road New Albany, MS 38652

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 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on staff interview, record review, and facility policy review, the facility failed to develop a baseline care plan to include the initial plan of care for delivery of services and to promote continuity of care and communication for facility staff for a newly admitted resident with a known history of eloping from home prior to admission for one (1) of three (3) care plans for residents who were at risk for elopement. Resident #1 Resident #1 left the facility unnoticed and unsupervised at an unknown time on 04/26/24 and was discovered by the local police department at a nearby business approximately 75 yards from the facility. This business notified the police at 5:38 PM and the resident was found by police at 6:01 PM and was returned to the facility. Resident #1 was last observed on 4/26/24 at 4:38 PM in his room, prior to the elopement. Resident #1 was transported back to the facility and was assessed to have no noted injuries or complaints of pain or discomfort. The State Agency (SA) identified an Immediate Jeopardy (IJ) which began on 4/26/24 when Resident #1 eloped from the facility unsupervised and undetected by facility staff. The facility's failure to provide supervision placed Resident #1 and other residents at risk for wandering and elopement, in a situation which was likely to cause serious injury, serious harm, serious impairment, or death. IJ existed at: 42 CFR 483.21(a)(1) Baseline Care Plans -F655, Scope and Severity J Findings Include: (continued on next page)

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.

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

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Baseline Care Plan with an effective date of 9/30/23 revealed Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to prove effective and person-centered care of the resident that meets professional standards of quality care .Policy Explanation and Compliance Guidelines: .2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment hospital transfer information physician orders and discussion with the resident and resident representative, if applicable . b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury. ii. Any identified needs for supervision, behavioral interventions . Record review of Resident #1's medical record revealed there was not a baseline care plan developed to address elopement risk, monitoring or supervision needed for Resident #1. Record review of Resident #1's referral (History and Physical) to the facility dated 4/26/24 revealed the resident had an Altered mental status with recent diagnoses of Dementia and Alzheimer's with worsening Frontotemporal Dementia. Family stated that the resident left his house yesterday and was picked up by the PD (Police Department) three miles away from home and has apparently been having hallucinations. Record review of Resident #1's Elopement Evaluation was completed by Licensed Practical Nurse (LPN) #2 on 4/26/24 at 3:53 PM and revealed that the resident had a history of elopement while at home, wandering behavior with a goal directed pattern, wandering behavior that was likely to affect the safety of or well-being of self/others and had not accepted the situation of being admitted to the facility. An interview on 5/1/24 at 1:27 PM, with the Director of Nurses (DON) confirmed that Resident #1 was known to be an elopement risk when he was admitted on [DATE]. She confirmed that the resident had not had all of his assessments completed or a care plan done when he went missing. An interview on 5/1/24 at 1:34 PM, with Certified Nurse Assistant (CNA) #1 stated that she was Resident #1's CNA when he was admitted to the facility on [DATE]. She revealed that a resident's care plan tells what they need done, but she is not sure she has access to see them, and no one had told her that Resident #1 was an elopement risk. She stated if she had known she would have watched him more frequently. An interview on 5/1/24 at 1:48 PM with LPN #1 confirmed a care plan is supposed to let the staff know what care the resident needs, but she is pretty sure this resident did not have one. An interview on 5/1/24 at 2:48 PM with Registered Nurse (RN) #1 confirmed she was the Unit Manager for the unit where Resident #1 was admitted on [DATE]. She stated that she was not sure if the resident had a care plan completed before he went missing. An interview on 5/1/24 at 3:39 PM, with LPN #3 revealed she was present when Resident #1 was admitted on [DATE] and that the Minimum Data Set (MDS) nurses were not there that day. She confirmed that she did not develop a baseline care plan for the resident. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 5/2/24 at 10:40 AM, with RN #2 and RN #3 revealed they were the MDS nurses and were responsible for putting in the resident's care plans. They both admitted they were not at work on Friday 4/26/24 and therefore was not aware of Resident #1's elopement risk and wandering history. RN #3 revealed that sometimes the nurses would put care plans in if they were not there or were not going to be back to work within 48-72 hours. RN #2 revealed the purpose of the care plan was to let staff know a resident's particular care needs and stated that if she had been at work on Friday 4/26/24 then she might have put the care plan in. An interview on 5/2/24 at 10:55 AM, with LPN #4 revealed she received the admitting orders from the hospital, confirmed with the doctor and then she put them in the computer. She confirmed that was all she did and did nothing about developing a baseline care plan to address his elopement risk and need for immediate and frequent supervision. She stated she did not know the resident was an elopement risk or a wanderer. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE] with no medical diagnoses listed. The facility provided an acceptable Removal Plan on 5/2/24. Review of the facilities Removal Plan revealed the facility took the following actions to remove the IJ: Immediate Actions: 1. Resident #1 was admitted to the facility from acute care hospital on April 26, 2024. He arrived at the facility via this facility's transportation at 3:21 pm. Resident #1 was last seen by a staff member at 4:38 pm when he received his dinner tray. The Police Department received a call of a suspicious person at 5:38 pm. Resident eloped via a window in the room. The facility was made aware of the Immediate Jeopardy on 5/2/2024 at 11:42 am. 2. Resident #1 was placed on one-on-one supervision until transferred to hospital for geriatric psychiatric services on 4/27/2024 at 7:45am. 3. Policy committee reviewed the Elopement and Missing Resident policies on 5/2/2024 at 12:50 pm, no changes were made. 4. Directive Inservice was initiated on 5/2/2024 at 2:00 pm by Licensed Nursing Home Administrator from an outside facility. Content of in-service Elopement and Missing Resident policies. Identifiers and Communication for High-Risk Elopement Residents. Identifiers include Elopement Evaluation User Defined Assessment, resident care profile on the Point Click Care dashboard, the Point of Care, and the Elopement Binders. No staff will be allowed to work until in-serviced. 5. Director of Nursing conducted 100% care plan audit on 5/2/2024 of all residents with elopement risk, 8 total. No issues found. Audit completed at 1:20 pm. 6. The Maintenance Director conducted 100% audit of all resident room windows to ensure they are secure on 5/2/2024, all windows are secure. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. State Department of Health was notified of elopement on 4/26/2024 at 6:51 pm via complaint hotline. Attorney General notified on 5/2/2024 via web portal. Police Department had been notified at 5:38pm by neighboring business and were with resident. 8. Per facility protocol all admissions are assessed for elopement risk, all new admissions will have a baseline care plan within 48 hours of admission, residents who are at high risk for elopement are photographed and added to the elopement binders located at the reception desk and both nursing stations, an order is added for nursing to monitor for elopement, high risk elopement residents are added to the Point of Care for hourly monitoring. A review of high-risk elopement residents is completed weekly during Facility High Risk Meetings to ensure identifiers are present. New Implementations: Elopement risk has been added to the resident care profile on Point Click Care dashboard. Elopement risk has been added to the Point of Care Kardex. The facility has implemented secure conversation via electronic system to be utilized to notify staff of all admissions including those who are high risk for elopement. All new implementations were added on 5/2/2024. 9. Emergency Quality Assurance meeting held via phone conference on 4/26/2024 at 6:30 pm. Physician Assistant, Administrator, Director of Nursing, Staff Coordinator, and Quality Assurance/Infection Preventionist Nurse and Social Services. The unusual occurrence was discussed, all events before, during and after occurrence were reviewed. Committee members placed Resident #1 on one-on-one monitoring until transferred to a hospital. 10. All corrective actions to remove the IJ was completed on 5/2/2024 and the facility alleges the IJ was removed on 5/3/2024. The SA validated the facility's Removal Plan/Corrective Action on 5/6/24: The SA validated through interviews and record review that Resident #1 was admitted to the facility from an acute care hospital on April 26, 2024. He arrived at the facility via this facility's transportation at 3:21 PM. Resident #1 was last seen by a staff member at 4:38 PM when he received his dinner tray. The Police Department received a call of a suspicious person at 5:38 PM. Resident eloped via a window in the room. The facility was made aware of the Immediate Jeopardy on 5/2/2024 at 11:42 AM. The SA validated through interviews and record review that Resident #1 was placed on one-on-one supervision until transferred to hospital for geriatric psychiatric services 4/27/2024 at 7:45 AM. The SA validated through interviews and record review that the policy committee reviewed the Elopement and Missing Resident policies on 5/2/2024 at 12:50 PM, no changes were made. The SA validated through interviews and record review that Directive Inservice was initiated on 5/2/2024 at 2:00 PM by Licensed Nursing Home Administrator from outside facility. Content of in-service Elopement and Missing Resident policies. Identifiers and Communication for High-Risk Elopement Residents. Identifiers include Elopement Evaluation User Defined Assessment, resident care profile on the Point Click Care dashboard, the Point of Care, and the Elopement Binders. No staff will be allowed to work until in-serviced. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SA validated through interview and record review that the Director of Nursing conducted 100% care plan audit on 5/2/2024 of all residents with elopement risk, 8 total. No issues found. Audit completed at 1:20 PM. The SA validated through interview and record review that the Maintenance Director conducted 100% audit of all resident room windows to ensure they are secure on 5/2/2024, all windows are secure. The SA validated through interview and record review that the State Department of Health was notified of the elopement on 4/26/2024 at 6:51 PM via complaint hotline. The Attorney General was notified on 5/2/2024 via web portal. The Police Department had been notified at 5:38 PM by neighboring business and were with the resident. The SA validated through interview and record review that per facility protocol all admissions are assessed for elopement risk, all new admissions will have a baseline care plan within 48 hours of admission, residents who are at high risk for elopement are photographed and added to the elopement binders located at the reception desk and both nursing stations, an order is added for nursing to monitor for elopement, high risk elopement residents are added to the Point of Care for hourly monitoring. A review of high-risk elopement residents is completed weekly during Facility High Risk Meetings to ensure identifiers are present. New Implementations: Elopement risk has been added to the resident care profile on Point Click Care dashboard. Elopement risk has been added to the Point of Care Kardex. The facility has implemented secure conversation via electronic system to be utilized to notify staff of all admissions including those who are high risk for elopement. All new implementations were added on 5/2/2024. The SA validated through interview and record review that there was an emergency Quality Assurance meeting held via phone conference on 4/26/2024 at 6:30 PM. Physician Assistant, Administrator, Director of Nursing, Staff Coordinator, and Quality Assurance/Infection Preventionist Nurse and Social Services. The unusual occurrence was discussed, all events before, during and after occurrence were reviewed. Committee members placed Resident #1 on one-on-one monitoring until transferred to a hospital. The SA validated through observation, interviews, record reviews, and facility policy review that all corrective actions were completed on 5/2/24 and the facility alleged removal of the Immediate Jeopardy (IJ) on 5/3/24.

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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** 44804 Based on observation, staff and family interview, record review and facility policy review the facility failed to supervise and prevent the elopement of a resident who was identified at risk for elopement as evidenced by the resident leaving the facility unnoticed and unsupervised and walking 75 yards to a local business for one (1) of three (3) at risk residents reviewed for elopement. Resident #1 Resident #1 was admitted to the facility on [DATE] at 3:21 PM. Resident #1 left the facility unnoticed and unsupervised at an unknown time on 4/26/24 and was discovered by the local police department at a nearby business. This business notified the police at 5:38 PM and the resident was found by police at 6:01 PM and was returned to the facility. Resident #1 was last observed on 4/26/24 at 4:38 PM in his room, prior to the elopement. Resident #1 was transported back to the facility and was assessed to have no noted injuries or complaints of pain or discomfort. The facility's failure to provide supervision placed Resident #1 and other residents at risk for wandering and elopement, in a situation which was likely to cause serious injury, serious harm, serious impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ), and Substandard Quality of Care (SQC) which began on 4/26/24 when Resident #1 eloped from the facility unsupervised and undetected by facility staff. IJ and SQC existed at: 42 CFR 483.25(d)(1)(2) Accidents -F689, Scope and Severity J Findings Include: Review of the facility policy titled, Elopement with a revision date of 5/1/15 revealed Policy: Residents will be assessed for elopement risk for admission and throughout their stay by the interdisciplinary care planning team .Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Prevention .Residents determined to be at risk for elopement will be monitored by staff for elopement signs and/or attempts, and interventions will be included in their comprehensive plan of care to address the potential for elopement Elopement Prevention Strategies .Room placement for easy observation. React to statements such as, I want to go home .Never assume everyone knows the resident is a wanderer, make it clear to all staff involved in the resident's care, even for a short period of time. Record review of Resident #1's referral (History and Physical) to the facility dated 4/26/24 revealed the resident had an Altered mental status with recent diagnoses of Dementia and Alzheimer's with worsening Frontotemporal Dementia. Family gave most of the history due to the resident was unable to answer questions. Family stated that the resident left his house yesterday and was found by PD (Police Department) three miles away from home and has apparently been having hallucinations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility investigation dated 4/26/2024 and titled Unusual Occurrence revealed, Resident is a .male with diagnosis of Frontotemporal Dementia .Resident was living at home prior to hospitalization , resident had a history of wandering off from home and his daughter stated she could no longer provide the care he needed. He had left home and walked 3 miles per hospital history and physical .Resident raised the window of the room and knocked out the screen .Staff on the hall going room to room looking for resident . Record review of the Police Department INCIDENT REPORT dated 4/26/24 at 17;38 (5:38 PM) revealed On Friday, April 26, 2024, I (Proper name of officer) responded to a call of a suspicious person outside (Name of local business) .Upon arrival at the business I noticed an elderly man .The male subject gave only a last name but couldn't give me his first name .seemed to be very disoriented . Record review of Resident #1's Elopement Evaluation was completed by Licensed Practical Nurse (LPN) #2 on 4/26/24 at 3:53 PM that indicated the resident had a history of elopement while at home, express the desire to go home, wandering behavior with a goal directed pattern, wandering behavior that was likely to affect the safety of or well-being of self/others and had not accepted the situation of being admitted to the facility. Record review of Resident #1's Order Summary Report with active orders as of 5/1/2024 revealed an order dated 4/26/2024, Monitor for Elopement every shift. Medical diagnoses included Heart Failure and Alzheimer's disease with late onset. (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 5/1/24 at 1:05 PM, with the Administrator revealed that Resident #1 was admitted in the afternoon of 4/26/24 and that she was aware that the resident was an elopement risk based on the referral received from the hospital. She revealed that the resident was upset about being in the facility and was mad at his daughter when he got here. She stated that they took his picture and put it in the elopement binder that is kept at each nurse's station and the front desk. The doors to the outside are code locked and the Unit Manager is supposed to show the residents picture to the staff and educate the staff on the resident who is an elopement risk. She stated that this is their protocol for residents that are an elopement risk. She revealed that the resident did not have a roommate when he was admitted around 3:30 PM and his dinner tray was taken to him in his room around 4:38 PM. She confirmed that this was the last time the staff saw him. She revealed that staff were up and down the hall during that time passing trays and when the aide went back in to get his dinner tray, the resident was not in there, but about 50% of the meal had been eaten. Certified Nurse Assistant (CNA) #1 assumed the resident was in the bathroom, so she went to get some supplies to help clean him up and when she got back, she knocked on the bathroom door. That is when she realized he was not in there. This was around 5:49 PM. CNA #1 immediately notified the medication nurse LPN #1 and they searched other resident rooms then called a code for an elopement resident. When they did this, staff members went through different exit doors and noticed during their walk around the building that the resident's room had the window screen laying on the ground, but his window blinds were down. They had not noticed that the window was open. There was a neighbor standing outside his home next door that pointed in the direction the resident had gone so staff members followed that direction that led to a business down a hill, below the facility that faced a main road. When the staff got to the business, they saw Resident #1 sitting on top of a garbage can and he was talking with a police officer. When the police were interviewed by staff, they revealed that they had received a call about a suspicious person being at the business around 5:38 PM. She revealed she was able to get the timeline for this incident by watching the film from the hall where Resident #1's room was, but the video erases after 5 days. She stated that they determined that the resident got out of his room by raising his window and kicking out the screen and going down the hill to the business. She revealed when they have residents admitted that are an elopement risk, they put the resident's information in the elopement binders with photos and notify everyone. She stated, He was not walking in the hall or exit seeking. She stated that after they got the resident back to the facility, she referred the resident to Geri-psych and staff remained with the resident one on one until he was transferred to Geri-psych the following morning on 4/27/24. She stated that when the resident was admitted that they did not watch him anymore than they do anyone else that is an elopement risk, which is hourly. An interview on 5/1/24 at 1:27 PM, with the Director of Nurses (DON) confirmed that any resident that is an elopement risk gets their information and picture put in the elopement binder, staff are supposed to be made aware, and they do not do any increased assessments on new admits with an elopement risk. She confirmed that the resident was admitted around 3:30 PM on 4/26/24 and was last seen around 4:30 PM on 4/26/24. She stated that the facility does not have an alarm system such as wander guard. (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 5/1/24 at 1:34 PM, with CNA #1 revealed she works the 7 AM-7 PM shift and was the only aide working on the unit where Resident #1 was admitted on the afternoon of 4/26/24. She revealed that no one told her that the resident was an elopement risk, but that they usually do. She knew the resident must have dementia because he had told her that he knocked out a famous boxer. She confirmed that she took the resident his dinner tray about 4:30 PM and the resident stated that he didn't want to be there and was not going to be there long. She confirmed that when she went back to pick up the dinner tray around 5:50 PM, she saw that he had eaten about half of his meal and thought he was in the bathroom. She left to go get a brief and when she came back, he still was not in the room, so she knocked on the bathroom door and that is when she realized he was not in there. She notified LPN #1, who was her manager that day, and they started looking up and down the hall and in other resident rooms for him. When they did not find him, they called a Code and that is when the staff started looking outside and someone saw the screen to his window lying on the ground. She stated that she did not notice that his window was up because his window blinds were still down. She said that a neighbor next door to the facility yelled and pointed out that the resident had gone in the direction of the business down below the hill from the facility and that is when I saw cop cars there. She stated she went down the hill and found the resident there talking with the police and she informed them that he was a resident at the facility, so they drove them back to the facility. She said when they got back to the facility they put the resident on 1:1 observation. She stated she is aware of the elopement binder and residents are normally put on our smart charting to chart about every shift if they are an elopement risk, but they never told me he was. (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 5/1/24 at 1:48 PM, with LPN #1 confirmed that she was the medication nurse on the unit that Resident #1 was admitted to on the afternoon of 4/26/24 around 3:30 PM. She stated that Registered Nurse (RN) #1 was the Unit manager and had told her that the resident was very confused and had been found wandering in another state. She revealed that when the resident got to the facility he was confused and thought they had been in the military together. She stated his blood pressure (BP) was a little high so as soon as his BP meds were due, I gave them to him and that was around the time he got his dinner tray. She stated that when she gave him his medicine the resident stated, Those are the last pills I'm taking from you and started talking about us being in the military again. She confirmed that the resident had not been walking the halls or trying to exit seek. She admitted to going into the therapy department after administering medications to talk to the therapist, which is across the hall from the nurse's station. At some point, CNA #1 came and told me that she could not find the resident. She confirmed that they checked all rooms and then called a Code. Staff went out the back and the front and that is when we saw his screen from his room window lying on the ground. She confirmed that the staff could not tell that the residents window was up because the blinds were still down. She stated that as far as she knows the windows do not lock in the rooms, so a resident could just raise the window and get out. She confirmed that the resident was found at a car detailing business below the facility. She confirmed that the business was on the main road that runs through the town, so it is a busy road. She revealed the resident was in a room at the back of the building, not visible from the nurse's station, did not have a roommate, was wearing a shirt and pants with tennis shoes and the weather was good, it had not rained for a few days' prior. She confirmed that when they got him back into the facility, he did not have any injuries, did not say much, and was put on 1:1 observation until he went to Geri-psych the next day. She confirmed that the CNA's are supposed to check hourly in their smart charting on the computer and the LPN's check every shift for those residents that are an elopement risk but was not sure if she had documented on the resident before he went missing. She stated, I want to say they had made his picture and put it in the elopement binder, but I am not sure. She revealed that the CNA's would find out a resident is an elopement risk by either getting a report from me or the Unit Manager. She stated that she thought she told CNA #1 that he was a wanderer but was not sure and confirmed that CNA #1 was the only aide working on the unit where the resident was admitted . She admitted that she did not tell anyone that the resident had stated that those would be the last pills he would be taking from her. Record review of Resident #1's April 2024 Electronic Medication Administration Record (EMAR) indicated that the LPN had not documented on the resident during the 12 hour day shift on 4/26/24. An observation and interview on 5/1/24 at 2:05 PM, with the Administrator confirmed Resident #1's had been in a room at the back of the building, approximately 100 feet from the nurses station. The window in the room was approximately 4 feet wide by 4 feet tall and would raise approximately 2-3 feet, with one lock and no window stopper. There was a fenced area that had an opening at one end that led to both the parking lot on the east side of the building and the back grassed area behind the facility. The parking lot had approximately 5 cars parked at this time and the grassed area behind the facility was a sloped hill leading to a wooded area along the property line that is approximately 6-10 feet drop with randomly cleared areas. Those cleared areas led to the business where the resident was found sitting on the main road that runs through the town. The approximate length from the facility to the business where the resident was found is 75 yards. The Administrator revealed that one of the residents told her on 4/29/24 that she hoped the maintenance man was ok from when he rolled down the hill on Friday. She stated that she can't swear that was Resident #1 that she was referring to, but she knows it was not the maintenance man. She confirmed that the resident did not have any scratches or injuries when they got him back to the facility. (continued on next page)

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	255268	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Albany Health & Rehab Center	118 South Glenfield Road New Albany, MS 38652

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 5/1/24 at 2:39 PM, with LPN #2 revealed she is the assistant Unit Manager for the unit where Resident #1 was admitted on [DATE] at 3:21 PM. She admitted that she called the hospital and got a report on the resident before he was admitted and was told that the resident had walked across six (6) counties prior to coming to the facility. She stated that after she got the report from the hospital, she told the Unit Manager/Registered Nurse (RN) #1 that the resident was a wanderer but does not recall if she gave all of the details about him walking across 6 counties. She revealed that when the resident was admitted to the facility, that his daughter confirmed that he had walked across 6 counties to another state that was approximately 93 miles from his home and that is what put him in the hospital. She confirmed that the resident was extremely confused and agitated when he was admitted and kept stating that we did not tell him where he was going and that he wanted to go to his home. She admitted that LPN #1 was notified that the resident was a wanderer but that she did not tell the CNA's and did not tell them the report of the resident walking across 6 counties, because she thought they knew. An interview on 5/1/24 at 2:48 PM, with RN #1 confirmed she was the Unit Manager for the unit that Resident #1 was admitted to. She revealed she was present when Resident #1 was admitted to the facility, and she knew that report from the hospital was that he was a wanderer. RN #1 revealed that the resident got an elopement assessment, and they followed protocol by monitoring every 2 hours with rounds, LPN's document, the facility doors stay locked. She revealed that she was not sure she had ever seen the elopement binder and stated she had been at the facility for about 6 months, and she is sure they have probably shown it to her before. She stated that she normally gives reports to the LPNs with the CNA's present, and she thinks she told them that the resident was an elopement risk and that his daughter said he liked to walk. She revealed that she did not know that the resident had told other staff members that he did not want to be there. An interview on 5/1/24 at 2:55 PM, with Resident #1's Resident Representative confirmed that the resident had wandered away from his home several times and that she just could not keep him at home. She stated that the resident had worsened in the last few weeks and had walked away from home so far that he had to be picked up by police and was seeing children in the trees. She stated he ended up in the hospital and we just did not know what we were going to do with him, so we were so thankful when this facility agreed to take him. She stated that she told staff at the facility about his wandering away from home so much and so far, including the nurses and the Social Worker. She revealed that the Social Worker had called her Friday 4/26/24 and told her that he had got out of the facility, but they had got him back and he did not have any injuries. She stated that the Social Worker called her back later and told her that staff were going to sit with the resident 1:1 and had been referred to Geri-psych for the next day and I agreed. She said that the Social Worker had called her Monday 4/29/24 and told her she was not sure if he could come back to the facility and stated she did not know what they were going to do. (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 5/1/24 at 3:17 PM, with Social Services confirmed that she got a referral for Resident #1 from the hospital, and she gave it to the DON and the Administrator and was made aware by the DON that the resident had gotten out of his house and wandered off, but they approved his admission. She stated that when the resident was admitted he was very upset about being at the facility and was mad at his daughter. She admitted that she found out more information from his daughter about him getting out of the house and wandering off when he was admitted to the facility on [DATE] at 3:21 PM. She revealed that she immediately went and told the Administrator and the DON, and they started getting his information in the elopement binder. She revealed that she had just left the facility when she got a call that the resident was out of the building. She stated that when they found the resident and got him back to the facility that she called the resident's daughter and told her what had happened. She also informed her that the resident had been referred to Geri-Psych for the next day, that staff would be 1:1 with him until he was transferred, and she agreed. She stated that she had told the family that the resident needs a lock down unit. She revealed she still did not know if they were going to take him back, because she has not been told by the Administrator. She stated, He wouldn't be safe here. An observation on 5/2/24 at 10:10 AM, of the room windows for the nine residents listed in the elopement binder revealed that all windows were approximately 4 feet wide by 4 feet tall and some had window stoppers which were L brackets screwed into the window frame that would prevent the window from being raised up all the way. This observation revealed that four (4) of the resident's windows had no window locks or window stoppers. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE] with no medical diagnoses listed. Review of the past weather report for the town where the facility is located revealed that on 4/26/24 the high temperature was 82 with a low of 73 and no rain. This report revealed there had been no rain for 5 days prior to 4/26/24. The facility provided an acceptable Removal Plan on 5/2/24. Review of the facilities Removal Plan revealed the facility took the following actions to remove the IJ: Immediate Actions: 1. Resident #1 was admitted to the facility from acute care hospital on April 26, 2024. He arrived at the facility via this facility's transportation at 3:21 PM. Resident #1 was last seen by a staff member at 4:38 PM when he received his dinner tray. The Police Department received a call of a suspicious person at 5:38 pm. Resident eloped via a window in the room. The facility was made aware of the Immediate Jeopardy on 5/2/2024 at 11:42 AM. 2. Resident #1 was placed on one-on-one supervision until transferred to hospital for geriatric psychiatric services 4/27/2024 at 7:45 AM. 3. Policy committee reviewed the Elopement and Missing Resident policies on 5/2/2024 at 12:50 PM, no changes were made. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SA validated through interviews and record review that the policy committee reviewed the Elopement and Missing Resident policies on 5/2/2024 at 12:50 PM, no changes were made. The SA validated through interviews and record review that Directive Inservice was initiated on 5/2/2024 at 2:00 PM by Licensed Nursing Home Administrator from outside facility. Content of in-service Elopement and Missing Resident policies. Identifiers and Communication for High-Risk Elopement Residents. Identifiers include Elopement Evaluation User Defined Assessment, resident care profile on the Point Click Care dashboard, the Point of Care, and the Elopement Binders. No staff will be allowed to work until in-serviced. The SA validated through interview and record review that the Director of Nursing conducted 100% care plan audit on 5/2/2024 of all residents with elopement risk, 8 total. No issues found. Audit completed at 1:20 PM. The SA validated through interview and record review that the Maintenance Director conducted 100% audit of all resident room windows to ensure they are secure on 5/2/2024, all windows are secure. The SA validated through interview and record review that the State Department of Health was notified of the elopement on 4/26/2024 at 6:51 PM via complaint hotline. The Attorney General was notified on 5/2/2024 via web portal. The Police Department had been notified at 5:38 PM by neighboring business and were with the resident. The SA validated through interview and record review that per facility protocol all admissions are assessed for elopement risk, all new admissions will have a baseline care plan within 48 hours of admission, residents who are at high risk for elopement are photographed and added to the elopement binders located at the reception desk and both nursing stations, an order is added for nursing to monitor for elopement, high risk elopement residents are added to the Point of Care for hourly monitoring. A review of high-risk elopement residents is completed weekly during Facility High Risk Meetings to ensure identifiers are present. New Implementations: Elopement risk has been added to the resident care profile on Point Click Care dashboard. Elopement risk has been added to the Point of Care Kardex. The facility has implemented secure conversation via electronic system to be utilized to notify staff of all admissions including those who are high risk for elopement. All new implementations were added on 5/2/2024. The SA validated through interview and record review that there was an emergency Quality Assurance meeting held via phone conference on 4/26/2024 at 6:30 PM. Physician Assistant, Administrator, Director of Nursing, Staff Coordinator, and Quality Assurance/Infection Preventionist Nurse and Social Services. The unusual occurrence was discussed, all events before, during and after occurrence were reviewed. Committee members placed Resident #1 on one-on-one monitoring until transferred to a hospital. The SA validated through observation, interviews, record reviews, and facility policy review that all corrective actions were completed on 5/2/24 and the facility alleged removal of the Immediate Jeopardy (IJ) on 5/3/24.