STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015206	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Health & Rehab Center	2326 Morgan Avenue Southwest Decatur, AL 35603

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** 48195 Based on record review, interviews, the facility's VERIFICATION OF INVESTIGATION, a review of the Alabama Department of Public Health Online Incident Reporting System, a review of facility's policies titled Resident Elopement, and Resident-Missing the facility failed to ensure adequate supervision was provided to Resident Identifier (RI) #1 to prevent and identify elopement. On 09/14/2023 around 5:35 PM, RI #1, a resident with cognitive deficits, eloped from the facility. Certified Nursing Assistant (CNA) #5 identified that RI #1 was not in his/her room around 6:00 PM and did not act to locate RI #1, but assumed he/she had discharged home. At 8:47 PM, Licensed Practical Nurse (LPN) #8 identified that RI #1's whereabouts were unknown and initiated action to locate RI #1. At 8:57 PM, RI #1 was found by local law enforcement at a grocery store located 1.9 miles away. The deficient practice affected RI #1, one of three residents reviewed for elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (d) Free of Accident Hazards/Supervision/Devices at a scope and severity of J. On 05/17/2024 at 12:43 PM, the Administrator and the Corporate Nurse were provided a copy of the Immediate Jeopardy Template and notified of the findings of substandard quality of care at the Immediate Jeopardy level in the area of Quality of Care, at F 689-Free of Accident Hazards/Supervision/Devices. The IJ began on 09/14/2023 and continued until 09/18/2023 when the facility implemented corrective actions with ongoing monitoring; thus, immediate jeopardy was cited at Past Non-Compliance. The deficiency was cited as a result of complaint/report number AL00045611. Findings include: A review of facility policy titled Resident Elopement-Risk Of with a revised date of 07/12/2001 revealed: Purpose (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	To identify those residents ar risk for elopement. Policy The facility will have procedures in place to assess each resident for their elopement potential and to minimize the potential for elopement. Procedure . 4. Residents shall be monitored for early warning signs of elopement which include: a. Statements from resident such as I want to go home b. Wandering aimlessly . 10. Staff shall be aware of the facility's list of potential elopement residents. The facility's policy titled Resident-Missing with a revised dated of 07/12/2001 revealed: Purpose To report and investigate all reports of missing residents. Procedure 1. In the event a resident is suspected of being missing from the facility, or for any reason can not be readily located, the Charge Nurse on the wing, which the resident resides, shall be notified immediately. a. The Charge Nurse shall designate an employee to do a complete head count . b. Search the outside areas of the building IMMEDIATELY . RI #1 was admitted to the facility on [DATE] for rehabilitation services and had a diagnoses that included Dementia without behavior, Encephalopathy, and Alcohol abuse. RI # 1's Admission Minimum Data Set (MDS) with an Assessment Reference Date on 08/27/2023 revealed a Brief Interview of Mental Status (BIMS) score of five of 15 which indicated severe cognitive deficits. RI #1's Care Plan included: Care Plan Description Wants to return home .Start Date 8/30/2023 . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility submitted an initial report on 09/15/2023 at 4:39 PM to the Alabama Department of Public Health Online Incident Reporting System. The initial report indicated RI #1 had eloped from the facility on 09/14/2023 at 5:30 PM. The facility's VERIFICATION OF INVESTIGATION signed by the Previous Administrator on 09/21/2023 indicated that . (RI #1) went to a doctor's appointment at 9 am on 9/14/23 . and returned at 3:03 PM. (RI) #1 was eating supper at approximately 4:45 PM in the dining room on the unit. At 5:27 PM per facility cameras, (RI #1) walks out the front door and sits on the porch. At 5:30 PM the patient is seen standing in the parking lot. At 5:35 PM patient is walking in the back parking lot. After this, (RI #1) was not seen on camera. At 8:47 PM, (This is the time he/she was due for his/her medications) the charge nurse (LPN #8) contacts Director of Nursing (DON) and asked if patient discharged early (Patient was supposed to discharge on 9/15/23) . Nurse . was on the phone with RI #1's (spouse) 8:57 pm . police were at (spouse's) house reporting to them that RI #1 was found by . police at the (name of grocery store) . RI #1 was not monitored in the building on 09/14/2023 from 5:31 PM to 8:57 PM . On 05/15/2024 at 3:29 PM an interview was conducted with CNA #10. The CNA said RI #1 was a little confused and walked around the facility but was not a resident who was identified as being at risk for wandering. CNA #10 said she was assigned to RI #1's care on 09/14/2023, but her shift ended before RI #1 returned from his/her appointment. CNA #10 said RI #1 was talking about going home that day and was anticipating discharge. On 05/15/2024 at 4:24 PM an interview was conducted with CNA #11 who said RI #1 would make comments that he/she was ready to go home, and he/she had to go to work. CNA #11 said RI #1 had periods of confusion. CNA #11 said on 09/14/2023 she last saw RI #1 at the nurses' station around dinnertime, around 4:45 to 5:00 PM . CNA #11 said that she redirected RI #1 from the nurses' station to the dining room for dinner. During an interview on 05/16/2024 at 9:16 AM, CNA #5 revealed she was working with RI #1 on 09/13/2023 and 09/14/2023. CNA #5 said on 09/13/2023 RI #1 talked about going home soon. On 09/14/2023 when making her initial rounds between 6:00 PM and 6:30 PM, she went into RI #1's room and she did not see RI #1. It was at that time that CNA #5 went to LPN #8 and made a comment to LPN #8 that RI # 5 must have been discharged because he/she was not in the room. CNA #5 said that around 8:30 PM or 9:00 PM, LPN #8 came to her and said that RI #1 was still in the computer system. It was at this time that the staff began to search for RI #1. During an interview on 05/16/2024 at 5:48 PM, LPN #8 said she was the night shift nurse on 09/14/2023. LPN #8 said when she arrived for the shift, it was busy, and she relieved a travel agency nurse who did not give her a report. LPN #8 said the travel nurse and she should have done a walk through together and she should have received a report from the travel nurse. LPN #8 said that during the evening medication pass she noticed RI #1 was not in his/her room. LPN #8 said he/she did not know how long it had been since RI #1 had last been seen or observed. LPN #8 said RI #1 could have been struck by a vehicle while crossing the busy highway. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/16/2024 at 10:49 AM an interview with the Previous Director of Nursing (PDON) said she was notified that RI #1 was missing by LPN #8 during medication pass. The PDON said that after reviewing the facilities camera footage, it was determined RI #1 was seen exiting the front door. The PDON confirmed RI #1 was last seen during dinner time around 4:45 PM. The PDON said residents should be checked every two hours. The PDON said the nurses and CNAs should have checked on RI #1 during that three-hour time period. The PDON said the concern with RI #1 being found at the grocery store 1.9 miles away from the facility was injury or harm to RI #1 from walking in such a high traffic area. On 05/16/2024 at 3:15 PM the previous Administrator (PADM) was interviewed. The PADM said the frequency in which staff checked on residents depended on the individual resident's acuity, but generally residents should be checked on by staff every 30 minutes to two hours depending on the resident's care needs. He said it was unacceptable for staff not to check on a resident over a three-hour period due to risk of injury and overall safety of the resident. The PADM noted the concern with RI #1 not being supervised by facility staff was the safety of the resident, risk of elopement, and risk of harm or serious injury from crossing a busy six lane highway in the evening hours. On 05/15/2024 at 6:15 PM an interview with RI #1's Responsible Party (RP) was conducted. The RP said RI #1 was admitted for rehabilitation after breaking his back. RI #1 had a doctor's appointment the morning on 09/14/2023. The RP reported the family returned RI #1 to the facility around 2:30 or 3:00 PM that same day. At 9:12 PM that night the RP said local law enforcement informed him/her that RI #1 had been found at a local grocery store. The RP said it was extremely frightening that RI #1 walked all the way to the grocery store on a busy road. ********** Once the facility became aware of RI #1's elopement from the facility on 09/14/2023, the following corrective actions were implemented: 1. The resident was located nearby by local law enforcement and taken to the emergency room for an evaluation upon family request. No injuries noted. The resident discharged home with the RP after the ER visit. This was completed on 09/14/23. 2. A.) A one-time head count to verify all current residents were inside the facility was completed by the charge nurse on duty, on 09/14/2023. All residents were accounted for. B.) All facility exits were verified by the Administrator and DON to be locked and alarms functional. This was completed on 09/14/2023. C.) On 09/15/2023, DON/Social Worker completed a new elopement risk User Defined Assessment for all current residents to identify any resident who may have had a change in condition deeming them at risk for elopement. Any residents found to be newly at risk will have their care plan reviewed and revised as indicated. D.) The front door will be monitored until all reassessments have been completed. This was completed on 09/15/2023. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E.) All staff will be interviewed to ascertain if there are any residents with wandering behavior that may not be documented. If residents are identified with wandering behavior not previously identified, their assessment and care plan will be updated to reflect the wandering. This was completed on 09/15/2023. F.) A discharge communication form will be instituted to reflect scheduled discharges each day indicating discharge date /time to effectively communicate between discharge planner and direct care staff. The discharging nurse will sign acknowledging when discharge occurs. This was initiated on 09/15/2023. 3. A.) Facility front door was locked and/or supervised. This was completed on 09/15/2023. Facility changed the door system to remain locked at all times with keypad code required for entry/exit. Residents and family members notified and educated of change in entry/exit process by resident council meeting and family notifications by phone and written notification. This was completed on 09/18/2023. B.) Staff re-educated by DON/Designee, on 09/15/2023-09/16/2023 regarding reporting of new behaviors such as wandering and elopement policy. Staff also reeducated on steps to take if a resident displays wandering behavior. Charge nurses reeducated regarding documentation of behaviors, specifically wandering with the need to obtain an order for a Wander guard Bracelet if indicated. This was completed on 09/16/2023. C.) 24-hour report/Nurse-to-nurse communication process updated to a more efficient method of communicating changes from shift to shift. A 24-hour notebook will be utilized rather than 24-hour report form. This new process was initiated on 09/15/2023. Staff education was initiated on 09/15/2023. Staff education on the new process for 24-hour report was completed on 09/18/2023. D.) The facility will utilize elopement risk assessment in Electronic Medical Record that scores residents on a scale of 0-10 according to elopement risk level. This was completed on 09/15/2023. E.) Staff educated regarding discharge communication form initiated by discharge planner to communicate with direct care staff the scheduled discharges each day. The discharging nurse will sign acknowledging the discharge is complete and return to the DON. This was completed in person and by telephone on 09/15/2023. 4. A.) Facility doors will be checked daily x 1 week and then weekly x 4 weeks to verify that all doors are secured and functioning properly. This was initiated on 09/15/2023. B.) The facility Interdisciplinary Team (IDT) will review nurse's 24-hour report information and discuss new or worsening behaviors in daily clinical meetings 5 x weekly. If a new behavior is reported or documented, IDT will verify that care plan and orders reflect interventions as indicated. DON/Designee will also interview 5 staff members to verify reporting and documentation of any new wandering behaviors. The interviews will be weekly x 4 weeks, then monthly x 2 months. This was initiated on 09/15/2023. C.) 24-hour report/Nurse-to-nurse communication process monitored daily in clinical meeting 5 x weekly X 4 weeks to verify the 24-hour notebook is being utilized and report is thorough. This was initiated on 09/15/2023. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D.) Elopement risk assessments (that score residents on a scale of 0-10 according to elopement risk level) will be reviewed on all new admissions X 3 months to verify that assessment is complete, interventions in place and care planned if appropriate. This was initiated on 09/15/2023. E.) The facility IDT will review the discharge communication forms from the previous day to verify each discharge occurred as scheduled and will initiate a new discharge communication form listing the discharges scheduled for the day and will provide the form to direct care nurses on each unit. This was initiated on 09/15/2023. F.) An emergency Quality Assessment Program Improvement (QAPI) meeting was conducted on 09/15/2023, attendance included the Medical Director. Date of compliance: 09/18/2023. After review and verification of the information provided in the facility's corrective action plan, in-service/education records, monitoring tools, and facility investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 09/14/2023-09/18/2023, with ongoing monitoring implemented; thus, immediate jeopardy past non-complaint was cited.