

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER West Carroll Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 706 Ross Street Oak Grove, LA 71263	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure 1 (#1) of 5 (#1, #2, #3, #4 and #5) residents who was assessed at risk for elopement, was adequately supervised to prevent her from eloping from the facility.</p> <p>This deficient practice resulted in an Immediate Jeopardy situation on 04/19/2024 at approximately 6:20 p.m. when resident #1 (a severely cognitively impaired resident identified as an elopement risk) was found approximately 300 yards outside of the facility by a staff member. Resident #1 was located 10 minutes after she eloped on 04/19/2024 through a facility door and was returned to the facility at approximately 6:32 p.m.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 04/24/2024. It was determined to be a Past Noncompliance Citation.</p> <p>Findings:</p> <p>Review of the facility's Emergency Procedure for Missing Resident Policy revised August 2018 revealed:</p> <p>Policy Interpretation and Implementation</p> <p>Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety.</p> <p>Review of the medical record revealed resident #1 was admitted to the facility on [DATE] with diagnoses including depressive disorder, macular degeneration, dementia, and hypothyroidism.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed resident #1 had a brief interview for mental status of 3 which indicated that resident #1 had severe cognitive impairment with daily decision making. The assessment also indicated the resident was independent with transfers, and did not require mobility devices.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the current care plan revealed resident #1 was at risk for elopement. The interventions for elopement included: determine the resident's walking pattern, encourage the resident to participate in activities, staff should attempt to keep the resident occupied, assess cognitive abilities. The care plan also noted to monitor the resident for possible risk factors such as history of elopement, wandering, and making statements regarding wanting to go home. Additional interventions were to monitor the resident for potential triggers of elopement such as visual/hearing impairment, hunger, pain or thirst, and educate staff on the resident's potential for elopement.</p> <p>Review of the facility's investigation report revealed on 04/19/2024 at approximately 6:32 p.m. resident #1 was brought back to the facility by a staff member. The resident was found walking approximately 300 yards outside of the facility. Further review of the investigation report documented the facility's camera footage revealed on 04/19/2024 at 6:20 p.m. resident #1 exited the building out of the exit door by the activity room.</p> <p>Review of the Elopement Risk assessment dated [DATE] revealed resident #1 had confusion and was disoriented. The resident had diagnoses of dementia and depression. The resident ambulated independently and verbally expressed the desire to go home during the assessment. Further review of the assessment revealed the facility assessed resident #1 to be at high risk for elopement.</p> <p>Review of the nurse notes dated 04/19/2024 at 6:45 p.m. revealed resident #1 was found about two blocks from the facility by an employee of the nursing facility. The employee brought the resident back to the facility, and a body audit revealed no apparent injuries noted. The resident stated, I just went out the back door. When asked if she put a code in to get out the door she replied, If I did I don't remember it. Resident tearful saying I didn't mean to cause all this trouble. If ya'll would have left me alone I'd be home now.</p> <p>Review of the Resident Incident Report dated 04/19/2024 at 6:45 p.m. revealed resident #1 was found outside, about two blocks from the nursing facility. A staff member found resident #1 and brought the resident back to the facility.</p> <p>During the survey observations of resident #1 revealed she ambulated independently in the hallways.</p> <p>On 04/24/2024 at 10:30 a.m. interview with S3Licensed Practical Nurse (LPN) revealed resident #1 walks by herself in the halls.</p> <p>On 04/24/2024 at 11:00 a.m. interview with S4LPN revealed resident #1 ambulates independently.</p> <p>On 04/24/2024 at 12:50 p.m. interview with S5Certified Nursing Assistant (CNA) revealed resident #1 walks by herself in the halls and the resident goes all over the building.</p> <p>On 04/24/2024 at 1:00 p.m. interview with S6CNA revealed resident #1 walks in the halls independently.</p> <p>On 04/24/2024 at 1:10 p.m. interview with S7CNA revealed she has seen resident #1 walk in the halls by herself.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 04/25/2024 at 1:30 p.m. interview with S2Director of Nursing (DON) revealed resident #1 eloped from the building on 04/19/2024. S2DON revealed she assumed resident #1 entered the code to the locked door and exited the building on 04/19/2024 at approximately 6:20 p.m.</p> <p>On 04/25/2024 at 2:07 p.m. interview with S1Administrator confirmed resident #1 was at risk for elopement. On 04/19/2024 resident #1 eloped from the building, and it was assumed she entered the code and exited the building at approximately 6:20 p.m.</p> <p>On 04/19/2024, the facility implemented the following actions to correct the deficient practice with completion on 04/21/2024:</p> <ol style="list-style-type: none"> 1. Resident #1 was placed on 1:1 supervision until 04/22/2024 at 2:30 p.m. Resident #1 was then monitored every 30 minutes for 24 hours and then placed on hourly monitoring. 2. All other residents were placed on every 30 minute monitoring until 04/21/2024, and then placed on hourly monitoring. 3. A census check for all residents was done immediately. 4. All exit doors were checked immediately for proper functioning. 5. All residents were reassessed for elopement risk on 04/19/2024. 6. All exit door keypad codes were covered with thick paper and tape on 04/19/2024. 7. Extra staff were called to work to monitor the exit doors. 8. On 04/19/2024 the staff were in-serviced regarding: Resident #1 placed on 1:1 monitoring and all other residents were placed on every 30 minute monitoring. The staff were in-serviced on monitoring the exit doors to ensure resident safety and a review of the missing resident protocol was presented. On 04/20/2024 an in-service for missing resident protocol, abuse and neglect policy was presented, and 1:1 care and supervision for the resident who eloped until it is discontinued by the Administrator and/or DON. 9. Staff were educated on residents at risk for elopement. 10. On 04/20/2024 exit doors functioning was checked to ensure proper functioning. 11. An additional camera was installed on the door in which the resident eloped. 12. On 04/22/2024 the plaques above the keypad with the exit code displayed were removed from every exit door and replaced with a small label with the exit code. 13. On 04/22/2024 part of the facility's action list provided by S2DON indicated that the door locks/keypad company would be changing the codes on the exit doors. The door alarm company was in the process of changing all of the door codes upon the surveyor's entrance to the facility on [DATE]. The keypad codes to all exit doors were changed on 04/24/2024. <p>(continued on next page)</p>		

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