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	08/27/2024

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 - Minimal harm or potential for actual harm 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** 32231 Based on observation, record reviews, and interviews, the facility failed to ensure each resident received adequate supervision to prevent elopement for 1 (#1) of 2 (#1 and #2) sampled residents reviewed for elopement. Findings: Review of the Wandering and Elopement and Implementation dated 03/22/2024 revealed the following: Policy Statement: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation: 1. If identified as at risk for wandering, elopement or other safety issues utilizing the Elopement Risk Form, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of the medical record revealed resident #1 was readmitted to the facility on [DATE] with diagnoses that included myocardial infarction, alcoholic cardiomyopathy, acute respiratory failure with hypoxia, heart failure, acute kidney failure, Stage 3, and metabolic encephalopathy. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed resident #1 had a brief interview for mental status score of 04. A score of 00 - 07 indicated the resident had severely impaired cognitive skills for daily decision making. Review of the August 2024 physician's orders revealed an order dated 05/07/2024 as follows: wanderguard bracelet to ankle. Should be 2 finger widths around ankle. Staff to answer door alarm immediately to ensure resident's safety. Further review revealed the following order dated 03/22/2024: Weekly check wanderguard is working properly on Fridays. Take resident to door and try to open door. Alarm should sound and door should not open. Review of resident #1's Medication Administration Record for August 2024 revealed there was documentation of the weekly wanderguard checks every Friday. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Elopement Risk Record revealed on 05/20/2024 resident #1 was an elopement risk. Further review revealed resident #1 had eloped before, frequent monitoring was done every 30 minutes, and staff aware of resident's wander risk. Review of the incidents and accidents report dated August 2024 revealed resident #1 was found walking in the parking lot on 08/12/2024 at 9:00 p.m. Further review of the report revealed that resident #1 apparently got out of his wheelchair, out of back door, and he had unsteady gait with confusion noted. Review of the Elopement Risk Record revealed on 08/12/2024 resident #1 eloped through exit door at room (referring to resident #1's room). Discovered approximately 100 feet from door outside of building on feet. Brought back into building no injuries noted upon assessment. Dietary notified. Resumed every 30 minute census checks. The note was signed by S2Director of Nursing (DON). Review of the nurse's note dated 08/12/2024 at 9:00 p.m. revealed the following documentation: door alarm sounds off nurse calls to nurse station (referring to the nurse's station that was located on the hall resident #1 was residing on at that time), asks what door alarm is sounding off, nurse at desk gives location. Simultaneously CNA (Certified Nursing Assistant) comes running up hall, was stating Resident #1 is not in his wheelchair! Nurse runs down hall out the door alarming. Resident observed outside, ambulating then stops at end of facility's parking lot. No injuries observed. Resident then escorted back towards door exited. CNA goes around to open door. Resident escorted to room CNA prepares resident for bed. Resident examined for injuries, none observed. Vital signs, blood pressure 109/75, heart rate 86, respirations 18, temperature 98.1. Nurse Practitioner notified, family member notified. Bed alarm activated. Monitoring documented. The note was signed by S3Licensed Practical Nurse (LPN). On 08/21/2024 at approximately 8:35 a.m., an observation revealed resident #1 had a wanderguard intact to his right ankle due to a history of elopement. Further observation revealed S4LPN escorted resident #1 via his wheelchair into the hallway and to the exit door. An observation of the door revealed that it was fully closed and locked with the wanderguard key pad system showing a red light to indicate the door was locked. As S4LPN pushed the resident's wheelchair up to the exit door, the wanderguard system went off and an alarm then sounded to indicate that resident #1 was close to the exit door. During an interview on 08/22/2024 at 9:00 a.m., S1Administrator confirmed the exit door was working correctly prior to resident #1's elopement on 08/12/2024. S1Administrator further revealed it was undetermined as to how resident #1 was able to open the door to exit the building, however the alarm activated upon the opening of the exit door. On 08/22/2024 at 2:48 p.m., S2DON confirmed resident #1 required being monitored every thirty minutes due to his elopement on 08/12/2024 at 9:00 p.m. and to ensure that adequate supervisor was being provided for resident #1's safety.