STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Nursing and Rehabilitation Center	355 Crossgate Blvd Brandon, MS 39042

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on observation, interviews, and record review the facility failed to protect the residents' right to be free from neglect by not ensuring staff implemented measures to mitigate the risk to prevent elopement for one (1) of six (6) sampled residents, Resident #5. On 5/01/25 at approximately 3:00 PM, the facility failed to prevent Resident #5, a resident who had recently exhibited new exit-seeking behaviors from exiting the facility unnoticed and unsupervised. The facility was unaware of Resident #5's whereabouts for approximately fifteen (15) minutes until a staff member went to his car on break and located her sitting in the passenger seat of his car with the windows up in an unshaded parking space approximately thirty-five yards from the facility entrance at approximately 3:15 PM. The parked car was in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. The facility failure to ensure Resident #5 was adequately supervised to ensure she did not exit the facility unsupervised placed her and other residents with wandering/exit seeking behaviors at risk for serious injury, harm, impairment, and/or death. The State Agency (SA) identified Immediate Jeopardy and Substandard Quality of Care which began on 5/01/25 when Resident #5 exited the facility unnoticed and unsupervised. The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/25 and the IJ removed on 5/11/2025. The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of 42 CFR S483.12(a)(1)Free from Abuse and Neglect (F600), was lowered from a S/S of J to a S/S of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Cross Reference F609, F610, F656, and F689 (continued on next page)

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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility policy titled, ABUSE PREVENTION with Revision Date 1/25 (January 2025), revealed the policy stated, The facility is committed to protecting the residents from abuse .DEFINITIONS . Neglect: A failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain .PREVENTION .3. Identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility. 5. Examples of steps that the facility may put in place immediately to prevent further potential abuse includes, but are not limited to, staffing changes, increased supervision . Review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia and major depressive disorder. Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls. Record review of the Progress Notes for Resident #5 dated 4/25/25 through 5/06/25 revealed that the resident began going to the facility front door with small bags packed with her clothes and reporting family was coming to get her on 4/25/25 after report that she sat up all night with increased confusion. According to Progress Note on 5/01/25 at 1:40 PM (13:40) by Licensed Practical Nurse (LPN) #9, Resident #5 had exit seeking behaviors that included confusion about her brother being outside to get her, constant redirection away from the front entrance and walking with a bag of her belongings and the Nurse Practitioner was notified with new order noted for urinalysis and change to insulin orders with family notified. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by LPN #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility unnoticed by staff and was observed by Certified Nursing Assistant (CNA) #9 sitting in his vehicle when the CNA went on break at approximately 3:00 PM and escorted the resident back into the facility. There was no incident report noted. Progress Note dated 5/03/25 at 10:30 AM documented that Resident #5 was on 1 on 1 observation related to elopement attempts. On 5/08/25 at 1:08 PM during a telephone interview Contact #1 for Resident #5 stated that she was notified by LPN #9 on 5/01/25 at approximately 3:30 PM that Resident #5 had exited the facility and was found sitting in a staff member's car in the facility parking lot. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/08/25 at 2:25 PM during an interview LPN #9 stated that she was familiar with Resident #5 and her care and the resident had exit seeking behaviors which included packing her belongings in bags and going to the front door of the facility and talking about leaving for several days at least since 4/24/25. She stated that she had documented her observations in the Progress Notes but had not updated the resident's care plan and there had been no orders for application of wander management device or other supervision resulting from the behavior until after the resident's elopement on 5/01/25 at approximately 3:00 PM. LPN #9 confirmed she was assigned to the care of Resident #5 on 5/01/25 during the day shift. She stated that at approximately 3:15 PM CNA #9 arrived at the nurses station with Resident #5 who was wearing a short-sleeved shirt, long pants and a pair of shoes. She said CNA #9 reported he had gone to his car and found Resident #5 seated in his front passenger's seat. LPN #9 said she had not known the resident had exited the facility and no one had reported the resident missing. LPN #9 confirmed that the Social Services Director was notified of the incident as well as Contact #1 and the primary healthcare provider for Resident #5 who issued new orders for a wander guard. She confirmed that she did not complete an incident report and had no request to participate in any investigation into the incident. LPN #9 said that she was not aware of any head count of residents, and she had not participated in any elopement drills since the 5/01/25 incident. On 5/08/25 at 3:10 PM an interview with CNA #9 revealed that on 5/01/25 at approximately 3:15 PM he had gone out to his car, which was parked in the first parking spot to the right upon exit from the front door. CNA #9 stated, I looked at my car and saw someone sitting in the passenger seat and thought it wasn't my car, then I realized it was my car, and I opened the drivers' door and asked, 'Mam, you in my car?' and she opened the door and said she thought it was her brother's car. I went around and helped her out and took her inside. CNA #9 reported that the weather was clear, dry and moderate temperature. He said he was not aware of any head count of residents, and he had not participated in any elopement drills since the 5/01/25 incident. On 5/09/25 at 11:00 AM an interview with the Executive Director revealed that at approximately 3:30 PM on 5/01/25 he was notified by the Receptionist that Resident #5 left the facility unnoticed by staff and was outside unsupervised for approximately fifteen minutes and located in a staff members car. On 5/09/25 at 1:36 PM an interview with the facility Receptionist revealed she was familiar with Resident #5 because she had developed the behavior of packing her belongings in bags and coming to the front door prior to the 5/01/25 elopement. She stated that she had redirected Resident #5 several times, including on 5/01/25 with mixed results, explaining that sometimes the resident would return to her unit and sometimes she wasn't easily redirected and that CNAs had to come to the front and escort the resident back to her room. The Receptionist stated that on 5/01/25 around 3:00 PM she had taken a break and asked someone to fill-in for her but that she could not recall whom. She stated that she returned to her desk and shortly thereafter (could not recall time) CNA #9 came in with Resident #5 and said he had found her sitting in his car in the parking lot. She stated that the Executive Director was notified approximately five to ten minutes after CNA #9 and Resident #5 came back into the facility. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/09/25 at 3:00 PM observation revealed the first parking space on the right approximately fifty-five feet from the front entrance. Observation revealed one ambulance and six other vehicles traveling through the parking lot. The sidewalk which led from the facility's front porch/portico area, along the front of the parking spaces led to a busy four lane boulevard with a speed limit of thirty-five miles per hour and no cross walks; observation revealed one hundred twenty-five (125) vehicles traveling on the boulevard between 3:00 PM and 3:05 PM. Record review of the local weather history according to WWW.Wunderground, Copyright The Weather Channel, for the facility for 3:00 PM on 5/01/25 revealed the temperature was eighty-one degrees Fahrenheit, with zero precipitation, eight mile per hour winds and partly cloudy. On 5/12/25 at 4:26 PM during a telephone interview with the former DON revealed that she confirmed that she became aware that Resident #5 had exited the facility unnoticed and unsupervised on 5/01/25 at approximately 3:15 PM when CNA #9 escorted the resident back into the facility. She said there was no head count done to confirm the safety of other residents, and said she was not aware of any elopement drills or initiation of missing resident protocol. She confirmed that the care plan for Resident #5 had not been updated for wandering or exit seeking behaviors prior to the elopement. Removal Plan - IJ The facility was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies. The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689. On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to report the allegation of neglect within the required time frame and complete a thorough investigation. On May 1. 2025. at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay. The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1. An interview with Resident (Proper Name) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Corrective Actions: The [NAME] President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented. On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff. On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses. On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge. The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription. Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes thoughts of the leaving the facility. The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who [NAME] the receptionist area was in-serviced on 05/10/25 by the Executive Director. 100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk. An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: [NAME] President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social [NAME] vice Assistants and Medical Director. The IP nurse was present by phone. The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25. On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on record review, policy review and interviews it was determined that the facility failed to ensure that allegations of neglect and incident of elopement were reported to the appropriate agencies, including State Agency, in accordance with State law through established procedures for one (1) of six (6) sampled residents, Resident #5. On 5/01/25 the facility failed to report to the required agencies an allegation of resident neglect related to lack of adequate supervision resulting in the elopement of Resident #5. On 5/01/25 at approximately 3:00 PM, Resident #5, who had recently exhibited new exit-seeking behaviors, exited the facility unnoticed and unsupervised. The facility was unaware of Resident #5's whereabouts for approximately fifteen (15) minutes until a staff member went to his car on break and located her sitting in the passenger seat of his car with the windows up in an unshaded parking space approximately thirty-five yards from the facility entrance at approximately 3:15 PM. The parked car was in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. The facility failure to provide adequate supervision for Resident #5 to ensure she did not exit the facility unsupervised and report the incident to the proper authorities placed her and other residents with wandering/exit seeking behaviors at risk for serious injury, harm, impairment, and/or death. The State Agency (SA) identified Immediate Jeopardy and Substandard Quality of Care which began on 5/01/25 when Resident #5 exited the facility unnoticed and unsupervised. The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/25 and the IJ removed on 5/11/2025. The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of 42 CFR S483.12(c)(1)(4) Reporting of Alleged Violations (F609), was lowered from a S/S of J to a S/S of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference F600, F610, F656, F689 Findings Include: Review of the facility policy titled, ABUSE PREVENTION with Revision Date 1/25 (January 2025), revealed the policy stated, The Executive Director, or designee, shall report any allegations of abuse, neglect, or misappropriation of resident property as well as report any reasonable suspicion of crime in accordance with Section 1150B of the Social Security Act to the Department of Health as required. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility polity titled, MISSING RESIDENT/ELOPEMENTS with Revision Date 8/04, revealed the policy stated, The Charge Nurse will complete a resident Accident/Incident report. The Executive director/Director of Nursing Services will notify the Department of Health per State Regulations. Review of the facility policy titled, Investigation and Reporting of Violation of laws dated 7/2003 (July 2003), revealed the policy stated, all alleged violation of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violations), are reported immediately to the Executive Director of the facility. Such violations will also be reported to the state agencies as required by state and federal law .TRAINING Upon hire each new employee shall be informed of the obligation to report alleged violations . Record review of the accident/incidents log for 1/01/25 through 5/05/25 revealed no documentation of any elopement of any resident. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by Licensed Practical Nurse (LPN) #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility unnoticed by staff and was observed by CNA #9 sitting in his vehicle when the CNA went on break at approximately 3:00 PM and escorted the resident back into the facility. According to the 3:15 PM Progress Note the Unit Manager and Director of Nursing Services (DON) and Social Worker were notified and according to the 3:30 PM Note the Executive Director was made aware of the elopement of Resident #5. There was no incident report noted. An interview on 5/08/25 at 3:10 PM with CNA #9 revealed that on 5/01/25 he was working at the facility and had gone on break at approximately 3:00 PM and at approximately 3:15 PM he had gone out to his car, which was parked in the first parking spot to the right upon exit from the front door. CNA #9 stated, I looked at my car and saw someone sitting in the passenger seat and thought it wasn't my car, then I realized it was my car, and I opened the drivers' door and asked, 'Mam, you in my car?' and she opened the door and said she thought it was her brother's car. I went around and helped her out and took her inside. I told the receptionist and the Executive Director as soon as we got inside. An interview on 5/09/25 at 11:00 AM with the Executive Director revealed that the facility had investigated the 5/01/25 elopement of Resident #5 on 5/08/25. The Executive Director stated that the facility did not report the incident to the State Agency because it was determined that it was not an elopement because the resident told staff that her brother was coming to pick her up. The Executive Director confirmed that the facility procedure was for any person taking a resident out on pass was required to go to the nurses station and sign the resident out in a binder with the date and time unless other arrangements had been made and that on 5/01/25 no one had arrived to take the resident out, signed her out or made any arrangements for her to go out on pass. He stated that it was thought that the resident may have exited the building with a group of Nursing Students at the facility on 5/01/25 for clinical training that had left at approximately 3:00 PM. He confirmed that no report had been made/sent to any agencies, including SA at the time of interview. An interview on 5/09/25 at 1:36 PM with the facility Receptionist revealed she returned to her desk after a break while the reception desk was manned by another staff member, she could not recall whom and shortly thereafter (could not recall time) CNA #9 came in with Resident #5 and said he had found her sitting in his car in the parking lot. She stated that the Executive Director was notified approximately five to ten minutes after CNA #9 and Resident #5 came back into the facility. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/12/25 at 4:26 PM during a telephone interview with the former DON revealed that she confirmed that she had become aware of the elopement of Resident #5 on 5/01/25 when CNA #9 escorted the resident back into the building. She said she had not participated in an investigation into the elopement or reported anything related to the incident to any agencies. Record review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia and major depressive disorder. Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls. Removal Plan - IJ The facility was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies. The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689. On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to report the allegation of neglect within the required time frame and complete a thorough investigation. On May 1. 2025. at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay. The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name Resident #5) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1. An interview with Resident (Proper Name Resident #5) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out. Corrective Actions: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [NAME] President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented. On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff. On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses. On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge. The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription. Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes thoughts of the leaving the facility. The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who [NAME] the receptionist area was in-serviced on 05/10/25 by the Executive Director. 100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk. An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: [NAME] President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social [NAME] vice Assistants and Medical Director. The IP nurse was present by phone. The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25. On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit.

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	255106	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Nursing and Rehabilitation Center	355 Crossgate Blvd Brandon, MS 39042

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on record review, policy review and interviews it was determined that the facility failed to initiate a thorough investigation of an allegation of neglect and incident of elopement for one (1) of six (6) sampled residents, Resident #5. On 5/01/25 the facility failed to initiate an investigation of resident neglect related to lack of adequate supervision resulting in the elopement of Resident #5. Resident #5 was out of the facility unsupervised in the parking lot of the facility at shift change and got into a car in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. This car belonged to a staff member who found her in his car around 3:15 PM and escorted her back into the facility. The facility's failure to conduct a thorough investigation of the elopement of Resident #5 on 5/1/25 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/1/25 and existed at 42 CFR S483.12(c)(2)-(4) Investigate/prevent/correct Alleged Violation (F610) S/S of J. The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/25 and the IJ removed on 5/11/2025. The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of 42 CFR S483.12(c)(2)-(4) Investigate/prevent/correct Alleged Violation (F610) was lowered from a S/S of J to a S/S of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference F600, F609, F656, F689 Findings Include: Review of the facility policy titled, Investigation and Reporting of Violation of Laws dated 7/2003, revealed, . INVESTIGATION All investigations shall be conducted by the Executive Director or Director of Nursing Services .The investigation shall include interview of associates, visitors or resident who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions or speculation .kept in the Executive Director's office in an administrative file .'Verification of Investigations' form shall be complete after the investigation is complete and provided to survey agencies when requested . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy review of the facility policy titled, ABUSE PREVENTION with Revision Date 1/25 (January 2025), revealed the policy stated, INVESTIGATION: The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine case and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. The facility shall coordinate its investigation with the Quality Assurance and Performance Improvement Committee . Policy review of the facility policy titled, MISSING RESIDENT/ELOPEMENTS with Revision Date 8/04, revealed the policy stated, The Charge Nurse will complete a resident Accident/Incident report. Record review of the accident/incidents log for 1/01/25 through 5/05/25 revealed no documentation of any elopement of any resident. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by Licensed Practical Nurse (LPN) #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility unnoticed by staff and was observed by Certified Nursing Assistant (CNA) #9 sitting in his vehicle when the CNA went on break at approximately 3:00 PM and escorted the resident back into the facility. According to the 3:15 PM Progress Note the Unit Manager and Director of Nursing Services (DON) and Social Worker were notified and according to the 3:30 PM Note the Executive Director was made aware of the elopement of Resident #5. There was no incident report noted. In an interview on 5/08/25 at 2:25 PM, LPN #9 stated that Resident #5 had exited the facility unnoticed by staff and unsupervised on 5/01/25 at approximately 3:00 PM. At approximately 3:15 PM CNA #9 reported he had gone to his car during his break and found Resident #5 seated in his front passenger's seat. LPN #9 said no missing resident procedure had been initiated. LPN #9 stated that the Unit Manager and Director of Nursing (DON) were on the unit and aware of the incident upon the return of Resident #5. LPN #9 stated she entered a progress note following the incident but did not complete an incident report and had no request to participate in any investigation into the incident. She said she was not aware of any head count of residents. In an interview with CNA #9 on 5/08/25 at 3:10 PM revealed that on 5/01/25 he was working at the facility and had gone on break at approximately 3:00 PM and at approximately 3:15 PM he had gone out to his car, which was parked in the first parking spot to the right upon exit from the front door. CNA #9 stated, I looked at my car and saw someone sitting in the passenger seat and thought it wasn't my car, then I realized it was my car, and I opened the drivers' door and asked, 'Mam, you in my car?' and she opened the door and said she thought it was her brother's car. I went around and helped her out and took her inside. I told the receptionist and the Executive Director soon as we got inside. In an interview with LPN #8 on 5/08/25 at 3:34 PM revealed she worked the 3:00 PM till 11:00 PM shift on 5/01/25 and was assigned to the care of Resident #5. She confirmed that Resident #5 was escorted back into the facility by CNA #9 at approximately 3:15 PM, who reported he had found her sitting in his car in the facility parking lot. LPN #8 stated that she had entered a Progress Note but had not completed an incident report or participated in any investigation. She confirmed that no one had reported Resident #5 as a missing resident and no missing resident code was initiated. She said she was not aware of any head count of residents. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LPN #7 on 5/08/25 at 3:50 PM revealed she was the assigned Unit Manager for Resident #5 on 5/01/25 on Unit 1. She stated she was made aware by LPN #9 that Resident #5 had left the building unnoticed and unsupervised shortly after 3:15 PM on 5/01/25. She said she had not been involved in a head count of residents following the elopement of Resident #5 on 5/01/25 or any investigation into how the resident exited the facility. She said that she recalled staff supposing that Resident #1 may have exited the building with some Nursing Students that had left the facility around 3:00 PM. In an interview with the Executive Director on 5/09/25 at 11:00 AM revealed that the facility had investigated the 5/01/25 elopement of Resident #5 on 5/08/25. The Executive Director stated that the facility did not report the incident to the State Agency because it was determined that it was not an elopement because the resident told staff that her brother was coming to pick her up. He confirmed that no report had been made/sent to any agencies, including SA. In an interview with the facility Receptionist on 5/09/25 at 1:36 PM revealed she stated that the Executive Director was notified of the elopement approximately five to ten minutes after CNA #9 and Resident #5 came back into the facility. In a telephone interview with the Nursing Instructor at the local community college, on 5/09/25 at 2:45 PM revealed that no one had contacted her concerning the elopement of any resident from the facility on 5/01/25. In a telephone interview with the former DON on 5/12/25 at 4:26 PM revealed that she confirmed that she had become aware of the elopement of Resident #5 on 5/01/25 when CNA #9 escorted the resident back into the building. She said she had not participated in an investigation into the elopement. Record review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia and major depressive disorder. Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls. Removal Plan - IJ The facility was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies. The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to report the allegation of neglect within the required time frame and complete a thorough investigation. On May 1. 2025. at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay. The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name Resident #5) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1. An interview with Resident (Proper Name Resident #5) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out. Corrective Actions: The [NAME] President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented. On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff. On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses. On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge. The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes thoughts of the leaving the facility. The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who [NAME] the receptionist area was in-serviced on 05/10/25 by the Executive Director. 100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk. An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: [NAME] President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social [NAME] vice Assistants and Medical Director. The IP nurse was present by phone. The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25. On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on interviews, policy review and record review it was determined that the facility failed to develop a comprehensive care plan for one (2) of six (6) sampled residents, Resident #5 and Resident #6 On 5/01/25, Resident #5 with documented new wandering and exit seeking behaviors for at least a week eloped from the facility unnoticed and was outside unsupervised for approximately fifteen minutes. Documentation of the resident's change of behavior, including wandering had been reported to her primary healthcare provider with new orders noted for urinalysis to check for urinary tract infection, but the facility failed to identify exit seeking and elopement risk or develop her care plan to provide adequate supervision to prevent elopement. While Resident #5 was out of the facility unsupervised in the parking lot of the facility at shift change she got into a person's car unknown to her in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. The facility's failure to identify the need for development of an elopement risk care plan contributed to lack of adequate supervision to prevent Resident #5's elopement and placed all residents who developed wandering/exit seeking behaviors at risk for serious injury, impairment, and/or death. During the investigation of the complaint, the SA identified an Immediate Jeopardy (IJ) which began on 5/1/25 and existed at 42 CFR S483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656) S/S of J. The SA notified the facility's Administrator of the IJ on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/25 and the IJ removed on 5/11/2025. The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of 42 CFR S483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656), was lowered from a S/S of J to a S/S of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Cross Reference F600, F609, F610, F689 Findings: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility policy titled, COMPREHENSIVE PERSON-CENTERED CARE PLANS with Revision Date 1/25 (January 2025) revealed the policy stated, Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team (IDT) will provide care. RESPONSIBILITY: All members of the Interdisciplinary Team monitored by the Executive Director .The Interdisciplinary Team along with the resident and/or Resident Representative will identify problems, needs, strengths, life history, preferences, and goals. For each problem, need, or strength a resident-centered goal id developed. Goals should be measurable .staff approaches to be developed for each problem/strength/need .The comprehensive Person-Centered Care Plan can be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS quarterly, significant change and annual assessments per the RAI manual .Upon change in condition, the Comprehensive Person-Centered Care Plan or Baseline Care Plan will be updated or an Instant Care Plan will be initiated if applicable. An Instant Care Plan can be completed with a change in resident condition if there is no care plan available or until the Comprehensive Person-Centered Care Pan is updated. Policy review of the facility policy titled, Investigation and Reporting of Violation of laws dated 7/2003, revealed the policy stated, The Director of nursing Services or his/her designee shall initiate a care plan to reflect the resident's condition and measures to be taken to prevent recurrence, where appropriate. Resident 5: On 5/08/25 record review of the comprehensive care plan for Resident #5 and the resident's physical (paper) chart revealed she had a care plan initiated on 11/04/24 for at risk for impaired cognitive function/and impaired thought processes. There were no care plans in place for risk for elopement, wandering or other related behaviors. Review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia, and major depressive disorder. Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Progress Notes for Resident #5 dated 4/25/25 through 5/06/25 revealed that the resident began going to the facility front door with small bags packed with her clothes and reporting family was coming to get her on 4/25/25 after report that she sat up all night with increased confusion. According to Progress Note on 5/01/25 at 1:40 PM (13:40) by Licensed Practical Nurse (LPN) #9, Resident #5 had exit seeking behaviors that included confusion about her brother being outside to get her, constant redirection away from the front entrance and walking with a bag of her belongings and the Nurse Practitioner was notified with new order noted for urinalysis and change to insulin orders with family notified. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by LPN #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility unnoticed by staff and was observed by CNA #9 sitting in his vehicle when the CNA went on break at approximately 3:00 PM and escorted the resident back into the facility. Progress Note dated 5/03/25 at 10:30 AM documented that Resident #5 had been placed on one-on-one observation related to elopement attempts on 5/01/25; these interventions were not reflected in the resident's care plan. During an interview on 5/08/25 at 2:25 PM, LPN #9 stated that she was assigned to the care of Resident #5 on 5/01/25 during the day shift and that Resident #5 had exit seeking behaviors which included packing her belongings in bags, going to the front door of the facility and talking about leaving for several days, at least since 4/24/25. LPN #9 confirmed that on 5/01/25 the Social Services Director was notified of the incident as well as Contact #1 and the primary healthcare provider for Resident #5 who issued new orders for wander guard safe wandering device with monitoring of placement and functioning each shift. She stated that she had documented her observations, the incident and new orders in the Progress Notes but had not updated the resident's care plan. During an interview LPN #7 on 5/08/25 at 3:50 PM, the assigned Unit Manager for Resident #5 on 5/01/25 on Unit 1 revealed she had not updated the resident's care plan due to change in behavior/development of wandering/exit seeking behaviors prior to or on 5/01/25. She confirmed that the DON had assessed the resident upon return to the unit and obtained orders for and applied a Wander Guard wander management device to the resident's left ankle and initiated one-on-one supervision for seventy-two hours. On 5/09/25 at 11:00 AM an interview with the Executive Director revealed that the facility had investigated the 5/01/25 elopement of Resident #5 on 5/08/25 and included care plan update in follow up actions to be taken. During an interview on 5/12/25 at 11:26 AM with the Social Services Director (SSD) revealed she was made aware through visual observation and interaction with Resident #5 on 5/01/25 that the resident made multiple, repeated trips to the front hall of the facility on 5/01/25 throughout the day and packing her belongings, but had not identified exit seeking behavior but could clearly see that the resident had increased anxiety. She stated that Resident #5's behavioral changes were discussed on 4/25/25 during a Behavioral Meeting with the resident's primary healthcare provider notified of behavioral changes that at the time were not identified as elopement risk. She stated that on 5/01/25 she updated the Elopement Binders which were supposed to be located at each of the facility's four (4) nurses' stations and added Resident #5 but had not updated the resident's care plan with approaches related to wandering or elopement risk. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/12/25 at 12:25 PM an interview with the MDS Coordinator revealed that the interdisciplinary team (IDT) was responsible for updates to the residents' care plans. She stated that the SSD was responsible for updating the social services care plan, including elopement risk. She stated that she was not aware of the elopement of Resident #5 until 5/09/25. She stated that the development and implementation of care plans was very important, and the purpose of care plans was to let staff know how to care for residents. She stated that it was very important to update care plans as needed related to changes in resident needs, including behaviors, for the protection and to ensure the needs of the residents were met. During a telephone interview with the former DON on 5/12/25 at 4:26 PM revealed that she became aware that Resident #5 had left the facility unnoticed and unsupervised on 5/01/25 at approximately 3:15 PM when CNA #9 escorted the resident back into the facility. She confirmed that the care plan for Resident #5 had not been updated for wandering or exit seeking behaviors prior to the elopement. On 5/12/25 at 5:07 PM an interview with the DON revealed she confirmed that identifying problems and needs of residents and updating their person-centered care plans was very important for the purpose of providing instructions to staff for care. She confirmed that any member of the interdisciplinary team could update any resident's care plan as needed. Removal Plan - IJ The facility was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies. The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689. On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to report the allegation of neglect within the required time frame and complete a thorough investigation. On May 1. 2025. at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay. The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name Resident #5) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1. An interview with Resident (Proper Name Resident #5) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Corrective Actions: The [NAME] President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented. On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff. On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses. On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge. The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription. Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes thoughts of the leaving the facility. The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who [NAME] the receptionist area was in-serviced on 05/10/25 by the Executive Director. 100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk. An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: [NAME] President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social [NAME] vice Assistants and Medical Director. The IP nurse was present by phone. The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25. On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit. Resident # 6: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #6 admission record revealed an admssion date of 8/29/2023 with documented medical conditions including obstructive uropathy (blocked urine flow) that required a left nephrostomy tube for urinary drainage. The hospital discharge summary and admission nursing assessment noted the presence of the nephrostomy tube. At the time of admission, staff initiated a baseline care plan for the resident ' s immediate needs; however, there was no inclusion of the nephrostomy tube care in the initial care planning documents. The admission orders did not explicitly state the care instructions for the nephrostomy tube (e.g., flush frequency or dressing change schedule), and the facility did not reach out to the physician or specialist for guidance on nephrostomy care upon admission. Record review of Resident #6 ' s comprehensive care plan, as of 5/08/25, revealed no care plan focus or goals addressing the nephrostomy tube or related care needs. The care plan contained sections for other issues (such as nutrition, mobility, and medications), but no entry was found for Urinary Device, Nephrostomy, or similar terms. There were no interventions listed for tasks like nephrostomy site care, flushing the tube, monitoring output, or infection prevention. This indicated that since admission (over 8 months), the facility failed to develop or update the care plan to include the resident ' s nephrostomy tube management. On 5/08/25 at 1:00 PM, an interview was conducted with the facility ' s MDS Coordinator. The MDS Coordinator confirmed that Resident #6 ' s MDS assessments identified the presence of a nephrostomy tube. She explained that when such a device is noted, it should trigger a care plan update to address that device and its care needs. Upon reviewing the file, the MDS Coordinator acknowledged that no care plan was ever created for the nephrostomy tube. She stated, This looks like an oversight - we should have completed a Care Area Assessment and developed a care plan back when [Resident #6] was admitted with the nephrostomy. The MDS Coordinator agreed that the care plan should include specifics like who will do the flushing, how often to change dressings, what to monitor, and physician involvement. 5/08/2025 - Nursing Staff Interview (LPN #5): In an interview on 5/08/25 (approximately 2:15 PM), LPN #5 was asked about care planning for Resident #6 ' s nephrostomy tube. LPN #5 indicated that she had never seen a care plan instruction for the nephrostomy tube. She stated, Usually the care plan or Kardex will tell us if we need to do special care. For [Resident #6], I didn ' t see anything about the nephrostomy. As a result, LPN #5 said she relied on general practice and common sense for the resident ' s care, such as keeping the area clean if she noticed any issue, but there was no formal guidance. She acknowledged that without a written care plan or orders, important care steps (like routine flushing) were missed, and said We should have had something in writing so everyone knows what to do. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/09/25 at 10:30 AM, the Director of Nursing (DON) was interviewed about the facility's care planning for Resident #6. The DON confirmed that no comprehensive care plan existed for the nephrostomy tube care. She stated that all significant medical devices or care needs must be reflected in the care plan, and a nephrostomy tube is definitely something that should be in the care plan with clear instructions. The DON explained that the care plan should have included interventions such as checking the nephrostomy site, changing dressings [at a specified frequency], flushing the tube [with specified solution and frequency], monitoring urine output and characteristics, and noting signs of infection. Additionally, the care plan should assign these tasks to nursing staff and include coordination (for example, consulting the urologist or Medical Director for orders or follow-up). The DON admitted that we missed it - the team did not create that section of the care plan upon admission or thereafter. She also acknowledged that no one contacted the physician/urology provider specifically regarding a care regimen for the nephrostomy tube, which should have been done. The DON agreed that this was a failure in the care planning process and could lead to staff confusion or neglect of critical care tasks. On 5/09/25 at 11:30 AM, the Medical Director was interviewed about Resident #6 ' s care coordination. He stated that he expects the facility to develop a care plan for any resident with specialized medical needs, such as a nephrostomy tube, and to communicate with him or the appropriate specialist to obtain necessary orders and guidance. The Medical Director said he had not been contacted about a care plan or specific orders for Resident #6 ' s nephrostomy tube since the resident ' s admission. He expressed that if he had been consulted, he would have recommended a standard protocol (e.g., weekly flushing with normal saline, weekly dressing changes, and prn as needed, with monitoring for signs of infection). The Medical Director remarked, Without a care plan in place, the staff might not know to do those things, and the resident could suffer as a result. He agreed that the lack of a nephrostomy care plan meant important preventive care was overlooked, placing Resident #6 at risk for infection or other complications.

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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** 42807 Based on observation, interviews, record review and facility policy review, the facility failed to provide adequate supervision and a secure environment to prevent the elopement of one (1) of six (6) sampled residents, Resident #5. On 5/01/25 at approximately 3:00 PM Resident #5 who had documented new wandering and exit seeking behaviors for at least a week exited the facility unnoticed and was outside unsupervised for approximately fifteen minutes until a staff member located the resident sitting in his unlocked car in an unshaded parking space approximately thirty-five feet from the facility entrance with windows up. The car was in front of a sidewalk that led to a busy four-lane boulevard with no barrier or crosswalk. Documentation of the resident's change of behavior, including wandering had been reported to her primary healthcare provider with new orders noted for a urinalysis to check for urinary tract infection, but the facility failed to identify exit seeking and elopement risk or provide adequate supervision to prevent elopement. The resident was admitted on [DATE] with diagnoses of bipolar disorder, anxiety, schizophrenia and history of fall and was assessed by the facility as at risk for falls and requiring supervision for walking. The facility's failure to provide adequate supervision to prevent the elopement of Resident #5 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/1/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity of J. The SA notified the facility's Administrator of the IJ and SQC on 5/09/2025 at 3:10 PM and provided the Administrator with the IJ templates. The facility submitted an acceptable Removal Plan on 5/12/2025, in which they alleged all corrective actions to remove the IJ were completed on 5/10/2025 and the IJ removed on 5/11/2025. The SA validated the Removal Plan on 5/12/2025 and determined the IJ was removed on 5/11/2025, prior to exit. Therefore, the scope and severity of 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity (S/S) of J was lowered from a S/S of J to a S/S of D while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings: Cross Reference F600, F609, F610, F656 Record review of the facility policy titled, MISSING RESIDENT/ELOPEMENTS with Revision Date 8/04 revealed the policy stated, The Unit charge Nurse is responsible for knowing the location of their residents . RESPONSIBILITY: The Charge Nurses and all other staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Admission Record for Resident #5 revealed the facility admitted the resident on 5/23/23 and the resident had diagnoses of bipolar disorder, anxiety disorder, schizophrenia, repeated falls and major depressive disorder. Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 for Resident #5 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. No mood or behavioral issues were noted, including wandering or exit seeking behaviors, during the lookback period. The MDS documented she had no restraints or wander/elopement alarms in use and was able to walk with supervision only for one hundred fifty (150) feet and was at risk for falls. Record review of the Progress Notes for Resident #5 dated 4/25/25 through 5/06/25 revealed that the resident began going to the facility front door with small bags packed with her clothes and reporting family was coming to get her on 4/25/25 after report that she sat up all night with increased confusion. According to Progress Note on 5/01/25 at 1:40 PM (13:40) by LPN #9, Resident #5 had exit seeking behaviors that included confusion about her brother being outside to get her, constant redirection away from the front entrance and walking with a bag of her belongings and the Nurse Practitioner was notified with new order noted for urinalysis and change to insulin orders with family notified. The Progress Notes dated 5/01/25 at 3:15 PM (15:15) by LPN #8 and at 3:30 PM by LPN #9 documented that the resident exited the facility unnoticed by staff and was observed by C.N.A. #9 sitting in his vehicle when the C.N.A. went on break at approximately 3:00 PM and escorted the resident back into the facility. There was no incident report noted. Progress Note dated 5/03/25 at 10:30 AM documented that Resident #5 was placed on one-on-one observation related to elopement attempts. Telephone interview on 5/08/25 at 1:08 PM Contact #1 for Resident #5 stated that she was notified by LPN #9 on 5/01/25 at approximately 1:30 PM that the resident had new orders for a urinalysis due to new behaviors that included wandering and making statements about leaving and again at 3:30 PM LPN #9 notified her that Resident #5 had exited the facility and was found sitting in a staff member's car in the facility parking lot. Interview on 5/08/25 at 2:25 PM LPN #9 stated that she was familiar with Resident #5 and her care and the resident had exit seeking behaviors which included packing her belongings in bags and going to the front door of the facility and talking about leaving for several days at least since 4/24/25. She stated that she had documented her observations in the Progress Notes but had not updated the resident's care plan and there had been no orders for application of wander management device or other supervision resulting from the behavior until after the resident's elopement on 5/01/25 at approximately 3:00 PM. LPN #9 confirmed she was assigned to the care of Resident #5 on 5/01/25 during the day shift. She stated that at approximately 3:15 PM C.N.A. #9 arrived at the nurses station with Resident #5 who was wearing a short-sleeved shirt, long pants and a pair of shoes. She said C.N.A. #9 reported he had gone to his car and found Resident #5 seated in his front passenger's seat. LPN #9 said she had not known the resident had exited the facility and no one had reported the resident missing. LPN #9 confirmed that the Social Services Director was notified of the incident as well as Contact #1 and the primary healthcare provider for Resident #5 who issued new orders for wander guard. She confirmed that she did not complete an incident report and had no request to participate in any investigation into the incident. LPN #9 said that she was not aware of any head count of residents, and she had not participated in any elopement drills since the 5/01/25 incident. She confirmed that the Elopement Binder was missing from the Nurses Station. She confirmed upon review that there was not a Release During Pass form for Resident #5 in the Out on Pass binder at the Unit #1 Nurses' station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/08/25 at 3:00 PM observation and record review revealed the absence of an Elopement Binder at the Unit 1 nurses' station. Resident #5's Release During Pass form was not found in the Out on Pass form was not found in the Unit 1 binder. SA located the form in the binder at the Unit 4 nurses' station with documentation of the last time Resident #5 being signed out on 12/20/24 at 11:16 AM. Interview with CNA #9 on 5/08/25 at 3:10 PM revealed that on 5/01/25 at approximately 3:15 PM he had gone out to his car, which was parked in the first parking spot to the right upon exit from the front door. CNA #9 stated, I looked at my car and saw someone sitting in the passenger seat and thought it wasn't my car, then I realized it was my car, and I opened the drivers' door and asked, 'Mam, you in my car?' and she opened the door and said she thought it was her brother's car. I went around and helped her out and took her inside. CNA #9 reported that the weather was clear, dry and moderate temperature. He said he was not aware of any head count of residents, and he had not participated in any elopement drills since the 5/01/25 incident. Interview with LPN #7 on 5/08/25 at 3:50 PM (the assigned Unit Manager for Resident #5 on 5/01/25 on Unit 1) stated that the procedure for a resident to leave for out on pass was that the person picking the resident up and taking responsibility for the resident had to report to the resident's nurses station and sign them out with date, time, address and telephone number, name and signature prior to exiting the building with the resident. LPN #7 said she worked at least five days a week and had never known the family or any person to sign Resident #5 out on pass. LPN #7 confirmed that Resident #5 had not had any order or application of any wander alarm device and that she had not updated the resident's care plan due to change in behavior/development of wandering/exit seeking behaviors, and that she had not been involved in a head count of residents following the elopement of Resident #5 on 5/01/25 or any investigation into how the resident exited the facility or any elopement drills since. She confirmed that the DON had assessed the resident upon return to the unit and obtained orders for and applied a Wander Guard wander management device to the resident's left ankle and initiated one-on-one supervision for seventy-two hours. Interview with the Executive Director on 5/09/25 at 11:00 AM revealed that the facility had investigated the 5/01/25 elopement of Resident #5 on 5/08/25. The Executive Director stated that the facility did not report the incident to the State Agency because it was determined that it was not an elopement because the resident told staff that her brother was coming to pick her up. The Executive Director confirmed that the facility procedure was for any person taking a resident out on pass was required to go to the nurses' station and sign the resident out in a binder with the date and time. He said he had not been aware that Resident #5 had new wandering/exit-seeking behaviors. He stated that the facility did not have operational security cameras. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Social Services Director (SSD) on 5/12/25 at 11:26 AM revealed she was made aware through visual observation and interaction with Resident #5 on 5/01/25 that the resident was anxious, made multiple, repeated trips to the front hall of the facility on 5/01/25 throughout the day and packing her belongings, but had not identified exit seeking behavior. She revealed she could clearly see that the resident had increased anxiety. She stated that Resident #5's behavioral changes were discussed on 4/25/25 during a Behavioral Meeting with the resident's primary healthcare provider notified of behavioral changes that at the time were not identified as elopement risk. She stated that on 5/01/25 she updated the Elopement Binders which were supposed to be located at each of the facility's four (4) nurses' stations and added Resident #5 but had not updated the resident's care plan with 'Focus' for elopement risk. She confirmed that there was 18 Residents identified as having wandering behaviors and at risk for elopement. She stated that a Trauma Screen was conducted for Resident #5 on 5/10/25. Interview with the facility Receptionist on 5/09/25 at 1:36 PM revealed she manned the desk at the front entrance and had a button she pressed which released the lock on the front door to allow entrance/exit. She stated that all the other doors required, and the front door could also be opened with numeric code entered into wall-mounted keypad on the inside or outside of the doors. She stated that she was familiar with Resident #5 because the resident had developed the behavior of packing her belongings in bags and coming to the front door prior to the 5/01/25 elopement. She said that Resident #5 had come to the front entrance at least three (3) separate times on 5/01/25 talking about going out, she said that she had to call the nurses station and a C.NA came and got the resident at least twice and escorted her back to her unit. The Receptionist stated that around 3:00 PM she had taken a break and asked someone to fill in for her but that she could not recall whom. She stated that she returned to her desk and shortly thereafter (could not recall time) and CNA #9 came in with Resident #5 and said he had found her sitting in his car in the parking lot. She stated that she notified the Executive Director approximately five to ten minutes later. She stated that the Executive Director checked the entrance door for proper locking on 5/01/25 following the return of Resident #5 and the locks were working correctly. On 5/09/25 at 3:00 PM observation revealed the first parking space on the right approximately fifty-five feet from the front entrance. Observation revealed one ambulance and six other vehicles traveling through the parking lot. The sidewalk which led from the facility's front porch/portico area, along the front of the parking spaces led to a busy four lane boulevard with a speed limit of thirty-five miles per hour and no cross walks; observation revealed one hundred twenty-five (125) vehicles traveling on the boulevard between 3:00 PM and 3:05 PM. Record review of the local weather history according to WWW.Wunderground, Copyright The Weather Channel, for the facility for 3:00 PM on 5/01/25 revealed the temperature was eighty-one degrees Fahrenheit, with zero precipitation, eight mile per hour winds and partly cloudy. Interview with the former DON on 5/12/25 at 4:26 PM by telephone revealed that she confirmed that she became aware that Resident #5 had exited the facility unnoticed and unsupervised on 5/01/25 at approximately 3:15 PM when C.N.A. #9 escorted the resident back into the facility. She said there was no head count done to confirm the safety of other residents, and said she was not aware of any missing resident protocol. She confirmed that the care plan for Resident #5 had not been updated for wandering or exit seeking behaviors prior to the elopement. Removal Plan - IJ (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 was informed by state agency on 05/09/2025 at 5:30 PM of 5 immediate jeopardies. The state agency provided the facility with IJ template for F656, F600, F609, F610 and F689. On 05/01/2025, Resident #1 exited the facility unaccompanied and unnoticed and sitting in a staff member's car with no supervision until the resident was found by staff approximately 15 minutes later. The facility failed to implement a care plan with interventions when Resident #1 exhibited behavioral changes that included wandering and exit seeking and a history of altered mental status. The facility also failed to report the allegation of neglect within the required time frame and complete a thorough investigation. On May 1. 2025 at approximately 2:45-3 :00 PM, a CNA walked to his car on his break and noticed a resident sitting in his passenger seat. The CNA immediately told the resident that she has to come back inside. Calmly and without hesitation, the resident stated "okay. The CNA walked the resident back inside the building, notified the front desk, and walked the resident to the sitting area on the unit The CNA also let Resident (Proper Name Resident #5) nurse know what happened. The front desk notified the Administrator and the DNS. The Resident was assisted to her room by the evening shift Charge Nurse. A skin assessment was completed by the DNS with no negative findings. Vital signs were obtained. Nurse Practitioner and Sister of Resident# 1 was notified. New orders received by the Nurse Practitioner to included to apply wanderguard signaling device and consult psych services. Resident was also seen by the Physician on 05/01/25 and new orders were received for UA with C&S and Novolog sliding scale change. Resident was also seen by the Psych NP on 05/02/25 and placed 1: 1. An interview with Resident (Proper Name Resident #5) on 05/01/25 who stated that she was going outside to wait on her brother, noticed a car that looked like her brother's and got in on the passenger side to wait until he signed her out. She stated that she exited the facility with other people and that her brother normally comes to take her out. Corrective Actions: The [NAME] President in-serviced the Social Services Department on 05/10/25 on ensuring that care plans and interventions are implemented for Residents with behavioral changes that verbalizing to leave the facility, exit seeking, wandering and packing belongs should be immediately assessed and elopement precautions implemented. On 05/10/25 The Executive Director notified the Mississippi Department of Health of the incident regarding Resident # 1 exiting the facility unaccompanied and unnoticed by staff. On 05/10/25 an audit was completed for all 18 Residents who were determined to be at risk for elopement risk to ensure accuracy of the care plan and appropriate interventions by the Director of Nurses. On 05/10/25 a sign was placed on all exit doors reminding staff and visitors to be cautious when entering and exiting the facility in an effort to prevent Residents from leaving the facility without staff knowledge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Nursing and Rehabilitation Center	355 Crossgate Blvd Brandon, MS 39042

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Executive Director and Director of Nurses reinterviewed Resident# 1 on 05/10/25. Resident# 1 confirmed that she exited the facility from the front door by following other people out. Resident #1 could not recall how many people she followed or give a decription. Letters were mailed to family members on 05/10/25 by Social Services as a reminder to use precautions when entering and the facility in an effort to prevent Residents from exiting the facility unaccompanied or unnoticed by staff. The letter also requested that family members notify the staff of the facility if a Resident verbalizes thoughts of the leaving the facility. The Receptionist who vacated the front desk on 05/01/25 was in-serviced on 05/10/25 by the Executive Director to ensure that coverage is requested by another staff member prior to leaving the front desk. In addition to all routine staff who [NAME] the receptionist area was in-serviced on 05/10/25 by the Executive Director. 100% audit of elopement binders were conducted on 05/10/25 by the Social Service Department to ensure the binders information was reflective of all Residents who are deemed as elopement risk. An Emergency Quality Assurance Committee was held on 05/10/25 with the following staff in attendance: [NAME] President, Executive Director, Regional Director of Clincial Services, Director of Nurses (2) Assistant Executive Directors, Social Service Director, (2) Social [NAME] vice Assistants and Medical Director. The IP nurse was present by phone. The facility completed all actions to remove the Immediate Jeopardies on 5/10/25 and alleges the IJ was removed on 5/11/25. On 5/12/25, SA validations were made onsite during the complaint investigation through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/11/25, prior to exit.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47873 Based on interviews, record review and facility policy review, the facility failed to provide appropriate care and services for Resident #6's nephrostomy tube. Specifically, the facility did not perform or document any nephrostomy tube dressing changes or flushes since admission, creating a potential for infection due to improper device care. This deficient practice affected Resident #6, one (1) of two (2) nephrostomy appliances in the building. Findings include: Record review of facility policy Weekly Skin Audit Policy: A Skin audit will be documented on residents weekly. Any identified skin conditions will be documented and treatment initiated. Responsibility director of nursing, licensed nurses, medical records. Procedure: 1. Every resident will have a head-to-toe skin evaluation performed and documented on a weekly basis, the evaluation will be documented electronically or on a weekly scan audit form. 5. Treatment will be initiated per the physician's orders. Record review of the Mississippi Attorney General Nurse Review revealed a complaint received on 08/05/2024. The complainant, from (Proper Name of Local Hospital), reported that Resident # 6 was transferred from (Proper Name/Address of Facility). The allegation stated that upon presentation to the emergency room , the attending physician noted that the resident's urostomy dressing had not been changed in 14 days. No specific date of the incident was provided in the complaint. Based upon review of the documents submitted, the allegations of criminal abuse or neglect could not be substantiated. However, the review indicated concerns regarding the quality of care Resident # 6 received. It was recommended that the matter be reported to the Mississippi State Department of Health for further investigation. Record review of Resident #6 admission record revealed was admitted to the facility on [DATE] with multiple diagnoses, including a urinary obstruction that required a nephrostomy tube (a tube inserted into the kidney to drain urine). The hospital discharge records and admission notes indicated the presence of a nephrostomy tube. No physician orders for specific nephrostomy tube care (such as flushing the tube or changing the dressing) were noted upon admission, and no initial care plan addressing the nephrostomy tube was developed at that time. Record review of Resident #6's clinical record from admission through the survey date (May 2025) revealed no documentation of any nephrostomy tube dressing changes or flushes. There were no nursing notes or treatment records indicating that the nephrostomy site dressing had been changed or that the tube had been flushed to maintain patency. On 5/08/25 at approximately 11:30 AM, an interview was conducted with an RN (Registered Nurse) responsible for Resident #6's unit. The RN stated that she had not changed the nephrostomy tube dressing or flushed the tube since the resident's admission. She explained that I didn't have any specific orders or schedule for the nephrostomy tube care, and she assumed that perhaps the wound care nurse or urology provider was managing it. The RN confirmed that no documentation existed in the resident's chart for any dressing change or flush and acknowledged it should have been done; we normally would at least change the dressing weekly. She expressed concern that not performing these care routines could lead to infection or tube blockage. (continued on next page)

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	255106	A. Building B. Wing	05/12/2025

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/25 at 2:15 PM, Licensed Practical Nurse (LPN) #5 was interviewed. LPN #5 had frequently cared for Resident #6. She stated that she was not aware of any care plan instructions or physician orders regarding the nephrostomy tube. She confirmed that during her shifts she only monitored the site visually and would address it if it looked red or leaking, but otherwise did not perform routine maintenance. LPN #5 agreed that routine care (like dressing changes and flushes) should be in place to prevent complications and acknowledged that no such guidance or documentation was present for Resident #6. On 5/09/25 at 10:00 AM, an interview was conducted with the Director of Nursing (DON) regarding Resident #6's nephrostomy care. The DON stated that it is the facility's expectation and standard practice that any resident with an invasive device (such as a nephrostomy tube) has appropriate physician orders and nursing care routines. This includes regular dressing changes (at least weekly or more often if soiled) and periodic flushing of the tube as per physician orders or protocol, with each instance documented in the treatment record. Upon reviewing Resident #6's chart, the DON confirmed the lack of orders and documentation for nephrostomy care. She acknowledged that we should have been flushing that tube and changing the dressing on a schedule and documenting it every time. The DON described this as a failure in care and stated that staff should have contacted the physician or urology specialist upon admission to obtain orders for care if none were given. She agreed that not providing these services posed an infection control risk to the resident. On 5/09/25 at 11:00 AM, the facility's Medical Director was interviewed about Resident #6's nephrostomy tube management. He stated that a nephrostomy tube requires routine care and monitoring to prevent complications. The Medical Director expected the nursing staff to notify him or the consulting urologist if specific orders were needed for maintaining the tube. He expressed concern upon learning that no flushing or dressing changes had been done. The Medical Director said, According to standard care practices, a nephrostomy tube dressing should be changed regularly (e.g., at least weekly or when soiled) and the tube flushed as ordered to prevent blockage and infection. The absence of documentation suggested that these care tasks were not being performed or not recorded. He confirmed that the facility failed to follow professional standards of practice in this case, as nursing staff should proactively ensure all devices are cared for even if initial orders are missed.