STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Southaven	1730 Dorchester Dr Southaven, MS 38671

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 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** 21029 Based on staff interview, facility policy review, facility statement review and record review, the facility failed to implement an elopement/wandering risk plan of care for Resident #1 who had worn a wander guard since his admission on February 12, 2024. Resident #1 had a documented history of wandering and elopement attempts prior to his admission to the facility. Resident #1 was one (1) of four (4) residents identified by the facility, who were at risk for elopement and that wore a wander guard. On 3/31/24 Resident #1 exited the facility unsupervised and undetected by facility staff. It was determined that Resident #1 was missing from the facility for approximately ten to twenty minutes prior to discovery. No facility staff saw resident leave the facility and no facility staff were aware that Resident #1 was missing until approximately 10:40 PM when they received a verbal report from a friend of a staff member that Resident #1 was at an apartment complex parking lot, off the facility grounds, talking to the police. Resident #1 was returned to the facility via personal vehicle by a facility staff at approximately 10:50 PM on 03/31/24. The facility's failure to provide supervision resulted in Resident #1's elopement and has the likelihood to result in serious harm, serious injury, serious impairment, or death for Resident #1 and all other cognitively impaired residents who leave the facility unsupervised. The State Agency (SA) identified an Immediate Jeopardy (IJ) which began on 3/31/24 and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 03/31/24 through 04/01/24, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed on 04/02/24, prior to the SA's entrance on 04/05/24. Findings Include: Record review of a statement on facility letterhead revealed Policy: Care Plans and MDS (Minimum Data Set) will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines. The most recent effective date was August 2019. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's undated policy titled Missing Resident/Elopement revealed Purpose To establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements. Process . If an elopement risk is determined an individual plan is established and intervention is initiated to mitigate that risk. When the nurse identifies the intervention it is documented on the care plan and on the caregiver guide . Record review of the Care Plan for Resident #1 with an initiation date of 2/12/24 revealed Focus: At risk for elopement related to Wandering .Interventions: .Check Placement and function of Wander Guard to Left Ankle every shift .Redirect patient from doors . Record review of the March 2024 Medication Administration Record (MAR) revealed Check Placement of Wander Guard to Left Ankle every shift for Elopement Risk. The MAR documentation revealed there were 11 times on day shift, 10 times on evening shift and seven (7) times on night shift that N was documented, indicating No, that the wander guard for Resident #1 had not been checked. Interview on 04/05/24 at 9:10 AM, with the facility Administrator (ADM) confirmed that Resident #1 had been identified upon his admission as a wanderer and a wander guard alarm was placed on his ankle for security. Interview on 04/05/24 at 9:30 AM with the Assistant Director of Nursing (ADON) who was the interim Director of Nurses (DON), revealed that she understood that the kitchen door was not properly shut which allowed Resident #1 to leave undetected out the back kitchen door on 03/31/24 after 10:30 P.M. The ADON confirmed that Resident #1 was identified and care planned as a wanderer and he wore a wander guard alarm on his ankle. Interview and record review of Resident #1's care plan on 04/09/24 at 8:45 AM with the MDS/ Care Plan nurse (RN #2), revealed that she had completed the MDS and the Care Plan for Resident #1 upon his admission on 02/12/24 and had made care plan revisions on 04/01/24. RN #2 confirmed that she made elopement revisions to the care plan of Resident #1 on 04/01/24 after he had eloped on 03/31/24. Record review of the Admission Record for Resident #1 revealed that he was admitted to the facility on [DATE] with diagnoses that included Senile Degeneration of the brain, Dementia, Muscle Weakness, Unsteadiness on Feet, Abnormalities of Gait or Mobility, Lack of Coordination, and Cognitive Communication Deficit. The facility implemented that following Corrective Action Plan prior to the State Agency (SA) entering the facility on 04/05/24: (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/31/24 at approximately 10:50 PM Resident #1 was assisted back to the facility via facility staff personal vehicle. Resident #1 was thoroughly assessed head to toe by RN #1 and no adverse injuries/incidents were found. RN #1 contacted the RR; the Medical Director (MD); the facility Administrator; the facility ADON; and placed Res #1 on one to one (1:1) close observation by facility staff. The elopement risk assessment was updated for Resident #1 and the care plan was revised. The elopement book kept at the nursing station was reviewed and updated. Facility staff conducted room to room audits of all residents in the building to ensure safety. The facility conducted a Quality Assurance (QA) meeting with the Medical Director (MD) in attendance via telephone on 04/01/24 at 8:00 A.M. An elopement drills were conducted on 3/31/24 and 4/01/24 and every day since the incident of 03/31/24 on all three (3) shifts. All residents with wander guard bracelets were checked for functionality and positioning on each shift. The ADM and the ADON began in-services on 04/01/24 of all staff on elopement protocol; wander guard monitoring; and Abuse and Neglect. All doors and windows were checked for for proper functioning and operation. ADM began an investigation to determine how Res #1 eloped. ADM called the incident in to the Mississippi State Department of Health (MSDH) office 04/01/2024 at 6:00 P.M. Resident #1 was placed on 1:1 close observation on 03/31/24 immediately upon his return to the facility at 10:50 PM on 03/31/24 and remained on 1:1 by staff until his transfer on 04/02/24 at 12:00 noon. There was a staff member placed at the front door to monitor the entrance and exits of the building and the staff would remain at the front door 24/7 until the new wander guard alarm system was installed on 04/01/24. No staff were allowed to work until they were in-serviced on elopements; Abuse/Neglect; and monitoring of wander guard systems. Immediate Actions: At 10:50 PM on 03/31/24 the RN#1 notified the ADM; the ADON; the Maintenance Director; the RR and the MD; and the Nurse Practitioner; via telephone of the elopement of Res #1. At 10:50 PM on 03/031/24 the facility staff conducted a 100% head count of all residents to ensure they were all accounted for. All residents were found to be in the facility. Upon return to the facility RN #1 assessed Res #1 from head to toe and found no injuries or incidents. Beginning at 10:50 PM on 03/31/24 all doors were monitored by staff 24/7 until the wander guard system was found fully functioning and new punch pad systems were installed on the kitchen doors. On 03/31/24 at 10:50 PM four (4) residents with risks of elopement were reevaluated and updated to ensure all residents at risk for elopement had appropriate interventions in place. No negative findings were identified on 3/31/24. On 03/31/24 at 10:50 PM RN #1 and the ADM began officially investigating and obtaining statements for the Elopement of Res #1. On 03/31/24 at 10:30 PM staff In-services were begun by RN#1 and the ADM; and the ADON, to include all staff on Elopement Protocols, Wander Guard checks; and Abuse/Neglect with no staff allowed to work until in-services were completed. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/01/24 at 8:00 AM a QA meeting was held via telephone with the MD. The DON; the Maintenance Director; the Dietary Director; ADM; MDS/Care Plan Nurses x 3 were present; along with the Social Worker; and QA/Infection Control Nurse. All members of the QA committee were in attendance via telephone. On 03/31/24 the Maintenance Director checked the functioning of the wander guard alarm/security system and found that the alarm was functioning properly and the alarm was sounding. It was discovered that Resident #1 exited the facility through the kitchen doors, which had not been properly shut and did not contain an alarm, causing Resident #1 to leave the facility unsupervised and undetected. The vendor came to the facility on [DATE] and installed new punch pads and alarms and locks to the kitchen doors x 3. The doors were also monitored by a staff member 24/7 until the wander guard system was installed on the kitchen doors. On 04/01/24 at 6:00 PM the ADM contacted the SA and the MS Attorney General's Office (AGO) to report the elopement of Resident #1. All corrective actions were completed on 04/01/24 and the facility alleged removal of the immediate Jeopardy (IJ) on 04/02/24. Validation: The State Agency (SA) completed the validation for the facility's Past Non Compliance (PNC) Corrective Action Plan on 04/09/24. The SA validated through interviews and record reviews that at 10:50 PM on 03/31/24 RN #1 notified the ADM, the ADON, Maintenance Director, the RR and the MD via telephone of the elopement of Resident #1. The SA validated through interviews and record reviews that at 10:50 PM on 03/31/24 the facility staff conducted a 100% head count of all residents to ensure they were all accounted for. All residents were found to be in the facility. The SA validated through interviews and record reviews that upon return to the facility RN #1 assessed Resident #1 from head to toe and found no injuries or incidents. The SA validated through observations, record reviews, and interviews that beginning at 10:50 PM on 03/31/24 all doors were monitored by staff 24/7 until the wander guard system was found fully functioning on all doors including the kitchen doors. The SA validated through observations, record reviews and interviews that on 03/31/24 at 10:50 PM four (4) residents with risks of elopement were re-evaluated and updated to ensure all residents for risk for elopement had appropriate interventions in place. No negative findings were identified on 03/31/24. The SA validated through record reviews and interviews that on 03/31/24 at 10:50 PM RN #1 and the ADM began officially investigating and obtaining statements of the Elopement of Resident #1. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SA validated through interviews and record reviews that on 03/31/24 at 11:30 PM staff in-services were initiated by RN #1, the ADON and the ADM to include all staff on Elopement Protocols, Wander Guard checks and Abuse/Neglect with no staff allowed to work until in-services were completed. The SA validated through interviews and record reviews that on 04/01/24 at 8:00 AM a Quality Assurance (QA) meeting was held via telephone with the MD. The ADON, ADM, MDS/Care Plan Nurses x 3, Maintenance Director, Dietary Manager; Social Worker, and the QA/Infection Control Nurse were present. All members of the QA committee were in attendance via telephone. The SA validated through interviews, and record reviews, and review of vendor receipts that on 04/01/24 the Maintenance Director staff checked the functioning of the wander guard alarm system and found that there were three doors in the kitchen area that had not been properly shut and locked. It was discovered that the kitchen doors were not shut properly and the alarm did not sound when Resident #1 exited the facility through the kitchen unsupervised and undetected. The vendor came to the facility on [DATE] and installed new punch pad locks to the kitchen doors. The doors were monitored by a staff 24/7 until the wander guard system was installed on the kitchen doors. The SA validated through interviews and record reviews that on 04/01/24 at 6:00 P.M. the ADM contacted the SA and the MS Attorney General's Office (AGO) to report the elopement of Resident #1. The SA validated through observations, record reviews, and interviews that all corrective actions were completed on 04/01/24 and the facility alleged removal of the Immediate Jeopardy (IJ) on 04/02/24.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on observation, staff and family interviews, record review and facility policy review the facility failed to provide adequate supervision to prevent Resident #1, who was identified as an elopement and wandering risk, from exiting the facility unnoticed and unsupervised for one (1) of four (4) residents reviewed. Resident #1 On 3/31/24 Resident #1 exited the facility unsupervised and undetected by facility staff. It was determined that Resident #1 was missing from the facility for approximately ten to twenty minutes prior to discovery. No facility staff saw resident leave the facility and no facility staff were aware that Resident #1 was missing until approximately 10:40 PM when they received a verbal report from a friend of a staff member that Resident #1 was at an apartment complex parking lot, off the facility grounds, talking to the police. Resident #1 was returned to the facility via personal vehicle by a facility staff at approximately 10:50 PM on 03/31/24. The facility's failure to provide supervision resulted in Resident #1's elopement and has the likelihood to result in serious harm, serious injury, serious impairment, or death for Resident #1 and all other cognitively impaired residents who leave the facility unsupervised. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/31/24 and provided the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 03/31/24 through 04/01/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 04/02/24, prior to the SA's entrance on 04/05/24. Findings Include: Record review of a statement on facility letterhead, dated 4/5/2024 and signed by the Administrator revealed Supervision (Name of facility) provides supervision based on care plans, individual needs, and Resident Rights. The statement was signed by the facility administrator. Record review of the facility's undated policy titled Missing Resident/Elopement revealed Purpose To establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements. Process . If an elopement risk is determined an individual plan is established and intervention is initiated to mitigate that risk. When the nurse identifies the intervention it is documented on the care plan and on the caregiver guide . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 04/05/24 at 9:10 AM with the facility Administrator (ADM) revealed that Resident #1 was currently transferred to a Behavioral Health hospital for evaluation of his emotional and mental status as well as for his behaviors and medications. The ADM confirmed that on 03/31/24 after 10:30 PM Resident #1 left the facility without the knowledge of the staff. A visitor to the facility verbally reported that a male that appeared to be a facility Resident was seen at an apartment complex talking to the police. The facility staff immediately began searching for Resident #1 and ran to the apartment complex where the police were talking to a man. Upon arriving at the apartment complex it was determined that Resident #1 had walked to the parking lot of the apartment complex located below a hillside from the facility. The staff placed Resident #1 in a staff member's vehicle and brought Resident #1 back to the facility for evaluation. The staff began assessing Resident #1 at approximately 10:50 PM upon arrival back to the facility. Resident #1 was found not to be injured and in no distress. The Resident Representative (RR) and the Nurse Practitioner for Resident #1 were contacted and told of the elopement of Resident #1. The ADM confirmed that Resident #1 had been identified upon his admission as a wanderer and a wander guard alarm was placed on his ankle for security. The ADM stated that she observed on the facility security camera that Resident #1 had left out of the kitchen's back door that had not been properly closed shut and locked. Therefore, the wander guard alarm had not sounded and no staff saw Resident #1 leave the building because the kitchen had no wander guard alarm system and there was no staff assigned to that area that late at night. An observation and interview on 04/05/24 at 9:20 A.M. with Dietary Worker #1 revealed that a push pad lock and/or keypad lock was not on the kitchen doors on 3/31/24 when Resident #1 exited the facility. The Dietary Worker #1 confirmed that a keypad lock had been placed on the three (3) doors in the kitchen on 04/01/24. During an interview on 04/05/24 at 9:30 AM, with the Assistant Director of Nursing (ADON) who was the interim Director of Nurses (DON), revealed that she understood that the kitchen door was not properly shut which allowed Resident #1 to leave undetected out the back kitchen door on 03/31/24 after 10:30 P.M. The ADON confirmed that Resident #1 was identified and care planned as a wanderer and he wore a wander guard alarm on his ankle. During an interview on 04/08/24 at 3:15 PM with Certified Nursing Assistant (CNA) #3 revealed that she worked 3:00 PM - 11:00 PM on 03/31/24. She stated that as soon as she was told that Resident #1 was missing from the facility, she began to look inside and outside of the facility for Resident #1. She stated that a visitor reported that they thought they saw a Resident talking to the police in the parking lot of the apartment complex that was located down a hill from the facility. She immediately went outside and saw a man in a white T-shirt standing in the parking lot of the apartment complex talking to police. CNA #3 and two (2) other staff ran down the hill and found Resident #1. They told the police that he was a resident of the facility and the police released Resident #1. CNA #3 and CNA #4 along with the Registered Nurse (RN) Supervisor (RN #1) placed Resident #1 in their personal vehicle and returned him to the facility. Resident #1 remained calm and did not reveal any distress. Resident #1 told the facility staff that he would go where he wanted to and do what he wanted to because he was a grown man. CNA #3 stated that Resident #1 was a known wanderer and that he would often wander in and out of other Residents rooms and all about the facility hallways. CNA #3 stated that Resident #1 wore a wander guard alarm on his ankle since his admission to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 04/08/24 at 3:30 PM with RN #1 Supervisor, revealed that she was told at approximately 10:40 PM that Resident #1 was missing from the facility and the staff had not seen Resident #1 since 10:30 PM. RN #1 stated that a friend of a staff member reported that he had seen a Resident in the parking lot of a nearby apartment complex talking to police. RN #1 and 2 other staff members took off running down the hill to the apartment complex to look for Resident #1. He was in the parking lot of the apartment complex talking to the police, and RN #1 told the police that he was a resident of the facility and that she would take him back to the facility for evaluation where she was the Nurse Supervisor. Resident #1 got into RN #1's vehicle and came back with her for evaluation without any incidents. RN #1 stated that Resident #1 was thoroughly assessed, and no injuries or distress were found. RN #1 stated that the Director of Maintenance found that the kitchen doors were not properly closed and had not been locked and Resident #1 had left the facility out the kitchen door. During an interview on 04/08/24 at 3:50 PM, with the Maintenance Director revealed he had been called to the facility at approximately 11:00 PM and immediately went to the facility and began assessing how Resident #1 left the facility without staff knowledge. The Maintenance Director stated he found that the door to the kitchen had not been properly shut and was not locked. He immediately reported his findings to the facility Administrator and to the RN Supervisor. He made sure the facility was secure, the wander guard alarm system was properly working and safe before he left the facility the night of 03/31/24. During an interview on 04/08/24 at 4:10 PM, CNA #4 revealed that he worked 3:00 PM - 11:00 PM on 3/31/24. He was assigned to the care of Resident #1. CNA #4 stated that he saw Resident #1 walking in the hallway at approximately 10:30 PM and had redirected him to his room. CNA #4 stated that walking and wandering about the facility was a regular occurrence for Resident #1. Resident #1 usually wandered about the facility, and he wore a wander guard alarm around his ankle because he had a tendency to wander. At approximately 10:40 PM, CNA #4 received word that Resident #1 was missing from the facility and the entire staff began looking for Resident #1. CNA #4 stated that he, CNA #3 and the RN Supervisor found Resident #1 approximately 200 yards off the facility grounds, down a hillside from the facility at an apartment complex. CNA #4 stated that Resident #1 told the staff that he would go where he pleased because he was a grown man and could take care of himself. Interview on 04/08/24 at 5:15 PM, with the Resident Representative (RR) of Resident #1 revealed Resident #1 had been living with family prior to his admission to the facility and he had made numerous attempts to elope and to wander away without supervision. The RR stated that the reason for Resident #1's admission to the facility was due to his wandering and resistance to care. He reported that the family was up-front with the facility about Resident #1's tendency to wander. He stated the family was unable to provide the level of supervision in their home that Resident #1 required. The RR stated that on 03/31/24 very late at night, a message had been left on his voicemail that Resident #1 had eloped. The RR stated that on 04/01/24 he came to the facility first thing in the morning to inquire as to what had happened and he agreed to have Resident #1 evaluated by the Behavioral Hospital unit. An interview on 04/09/24 at 10:00 AM with the ADM, revealed Resident #1 was admitted to a Behavioral Health facility for evaluation and that he would return to the facility. The ADM stated that on the night that Resident #1 eloped he was wearing a white T-shirt, tennis shoes, and gray sweatpants. The weather was clear and mild, and the temperature was in the low 60's. The elopement occurred on 3/31/24 at approximately 10:40 PM (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 04/09/24 at approximately 10:30 AM, by the SA revealed that the distance off the facility grounds to the apartment complex parking lot was approximately 200 yards from the facility and down a steep hillside. Record review of the Admission Record for Resident #1 revealed that he was admitted to the facility on [DATE] with diagnoses that included Senile Degeneration of the brain, Dementia, Muscle Weakness, Unsteadiness on Feet, Abnormalities of Gait or Mobility, Lack of Coordination, and Cognitive Communication Deficit. Record review of the Elopement Risk Evaluation dated 02/14/2024 revealed that Resident #1 was an elopement risk and had a history of wandering or elopement prior to his admission to the facility. The Narrative revealed Patient is a new admission. Patient states he need to get out of here to go home. Record review of the Elopement Risk Evaluation dated 04/03/2024 revealed Narrative: Resident continues to walk from East to [NAME] in the center. He continues to talk about his vehicle and he needs to find it. Wander Guard in place. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/19/24 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 8, which implicated that Resident #1 had moderate cognitive impairment. Record review of the Progress Note for Resident #1 written by the facility Nurse Practitioner (NP) dated 04/01/2024 at 22:59 (10:59 PM) revealed Patient is seen today for f/u (follow-up) on nurse report of elopement. He is laying in bed calm and cooperative with examination. No injuries noted. He denies having any pain. No grimacing noted during exam. He continue to be confused. Respond inappropriately to all orientation question except name. He is a/o x 1(alert and oriented times one). Staff is concurrently working to find appropriate facility for Resident. Family has been notified of current poc (plan of care). The facility implemented that following Corrective Action Plan prior to the State Agency (SA) entering the building on 04/05/24: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/31/24 at approximately 10:50 PM Resident #1 was assisted back to the facility via facility staff personal vehicle. Resident #1 was thoroughly assessed head to toe by RN #1 and no adverse injuries/incidents were found. RN #1 contacted the RR; the Medical Director (MD); the facility Administrator; the facility ADON; and placed Res #1 on one to one (1:1) close observation by facility staff. The elopement risk assessment was updated for Resident #1 and the care plan was revised. The elopement book kept at the nursing station was reviewed and updated. Facility staff conducted room to room audits of all residents in the building to ensure safety. The facility conducted a Quality Assurance (QA) meeting with the Medical Director (MD) in attendance via telephone on 04/01/24 at 8:00 A.M. An elopement drills were conducted on 3/31/24 and 4/01/24 and every day since the incident of 03/31/24 on all three (3) shifts. All residents with wander guard bracelets were checked for functionality and positioning on each shift. The ADM and the ADON began in-services on 04/01/24 of all staff on elopement protocol; wander guard monitoring; and Abuse and Neglect. All doors and windows were checked for for proper functioning and operation. ADM began an investigation to determine how Res #1 eloped. ADM called the incident in to the Mississippi State Department of Health (MSDH) office 04/01/2024 at 6:00 P.M. Resident #1 was placed on 1:1 close observation on 03/31/24 immediately upon his return to the facility at 10:50 PM on 03/31/24 and remained on 1:1 by staff until his transfer on 04/02/24 at 12:00 noon. There was a staff member placed at the front door to monitor the entrance and exits of the building and the staff would remain at the front door 24/7 until the new wander guard alarm system was installed on 04/01/24. No staff were allowed to work until they were in-serviced on elopements; Abuse/Neglect; and monitoring of wander guard systems. Immediate Actions: At 10:50 PM on 03/31/24 the RN#1 notified the ADM; the ADON; the Maintenance Director; the RR and the MD; and the Nurse Practitioner; via telephone of the elopement of Res #1. At 10:50 PM on 03/031/24 the facility staff conducted a 100% head count of all residents to ensure they were all accounted for. All residents were found to be in the facility. Upon return to the facility RN #1 assessed Res #1 from head to toe and found no injuries or incidents. Beginning at 10:50 PM on 03/31/24 all doors were monitored by staff 24/7 until the wander guard system was found fully functioning and new punch pad systems were installed on the kitchen doors. On 03/31/24 at 10:50 PM four (4) residents with risks of elopement were reevaluated and updated to ensure all residents at risk for elopement had appropriate interventions in place. No negative findings were identified on 3/31/24. On 03/31/24 at 10:50 P.M. RN #1 and the ADM began officially investigating and obtaining statements for the Elopement of Res #1. On 03/31/24 at 10:30 PM staff In-services were begun by RN#1 and the ADM; and the ADON, to include all staff on Elopement Protocols, Wander Guard checks; and Abuse/Neglect with no staff allowed to work until in-services were completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Southaven	1730 Dorchester Dr Southaven, MS 38671

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/01/24 at 8:00 A.M. a QA meeting was held via telephone with the MD. The DON; the Maintenance Director; the Dietary Director; ADM; MDS/Care Plan Nurses x 3 were present; along with the Social Worker; and QA/Infection Control Nurse. All members of the QA committee were in attendance via telephone. On 03/31/24 the Maintenance Director checked the functioning of the wander guard alarm/security system and found that the alarm was functioning properly and the alarm was sounding. It was discovered that Resident #1 exited the facility through the kitchen doors, which had not been properly shut and did not contain an alarm, causing Resident #1 to leave the facility unsupervised and undetected. The vendor came to the facility on [DATE] and installed new punch pads and alarms and locks to the kitchen doors x 3. The doors were also monitored by a staff member 24/7 until the wander guard system was installed on the kitchen doors. On 04/01/24 at 6:00 P.M. the ADM contacted the SA and the MS Attorney General's Office (AGO) to report the elopement of Resident #1. All corrective actions were completed on 04/01/24 and the facility alleged removal of the immediate Jeopardy (IJ) on 4/02/24. Validation: The State Agency (SA) completed the validation for the facility's Past Non Compliance (PNC) Corrective Action Plan on 04/09/24. The SA validated through interviews and record reviews that at 10:50 PM on 03/31/24 RN #1 notified the ADM, the ADON, Maintenance Director, the RR and the MD via telephone of the elopement of Resident #1. The SA validated through interviews and record reviews that at 10:50 PM on 03/31/24 the facility staff conducted a 100% head count of all residents to ensure they were all accounted for. All residents were found to be in the facility. The SA validated through interviews and record reviews that upon return to the facility RN #1 assessed Resident #1 from head to toe and found no injuries or incidents. The SA validated through observations, record reviews, and interviews that beginning at 10:50 PM on 03/31/24 all doors were monitored by staff 24/7 until the wander guard system was found fully functioning on all doors including the kitchen doors. The SA validated through observations, record reviews and interviews that on 03/31/24 at 10:50 PM four (4) residents with risks of elopement were re-evaluated and updated to ensure all residents for risk for elopement had appropriate interventions in place. No negative findings were identified on 03/31/24. The SA validated through record reviews and interviews that on 03/31/24 at 10:50 PM RN #1 and the ADM began officially investigating and obtaining statements of the Elopement of Resident #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SA validated through interviews and record reviews that on 03/31/24 at 11:30 PM staff in-services were initiated by RN #1, the ADON and the ADM to include all staff on Elopement Protocols, Wander Guard checks and Abuse/Neglect with no staff allowed to work until in-services were completed. The SA validated through interviews and record reviews that on 04/01/24 at 8:00 AM a Quality Assurance (QA) meeting was held via telephone with the MD. The ADON, ADM, MDS/Care Plan Nurses x 3, Maintenance Director, Dietary Manager; Social Worker, and the QA/Infection Control Nurse were present. All members of the QA committee were in attendance via telephone. The SA validated through interviews, and record reviews, and review of vendor receipts that on 04/01/24 the Maintenance Director staff checked the functioning of the wander guard alarm system and found that there were three doors in the kitchen area that had not been properly shut and locked. It was discovered that the kitchen doors were not shut properly and the alarm did not sound when Resident #1 exited the facility through the kitchen unsupervised and undetected. The vendor came to the facility on [DATE] and installed new punch pad locks to the kitchen doors. The doors were monitored by a staff 24/7 until the wander guard system was installed on the kitchen doors. The SA validated through interviews and record reviews that on 04/01/24 at 6:00 P.M. the ADM contacted the SA and the MS Attorney General's Office (AGO) to report the elopement of Resident #1. The SA validated through observations, record reviews, and interviews that all corrective actions were completed on 04/01/24 and the facility alleged removal of the Immediate Jeopardy (IJ) on 04/02/24.