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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255110	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS Care Center of Alcorn County, Inc-Snf	3701 Joanne Drive Corinth, MS 38834

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on observation, interviews, record reviews, facility policy reviews, and the facility's investigation, the facility failed to provide adequate supervision to prevent Resident #1, who was identified as a wandering risk, from exiting the facility unnoticed and unsupervised for one (1) of three (3) residents reviewed. Resident #1. The facility failed to provide supervision to prevent an elopement for Resident #1, who was a wandering risk. The resident left the facility unnoticed and unsupervised on 3/4/25 at 5:09 AM and was discovered asleep in the back seat of someone's car at their place of residency which was approximately eight (8) miles from the facility on 3/4/25 at approximately 9:30 AM after the resident rode home with them from their place of employment. During the investigation, the State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 3/4/25 and existed at 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity J. This situation placed Resident #1 and other residents at risk for wandering and elopement, at risk for serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 3/5/25 at 2:00 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 3/4/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 3/5/25, prior to the SA's entrance on 3/5/25. Findings Include: A review of the facility's policy Elopements and Wandering Residents revealed This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . Policy Explanation and Compliance Guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Incident Description and Reportable Summary revealed that on 3/4/25 at 7:35 AM while delivering breakfast trays Resident #1 was found not to be in his room. A Code W (missing resident) was initiated, and staff began searching for the resident. The local Police Department, Attorney General, Nurse Practitioner, and Resident #1's Responsible Party were notified. Resident #1 exited the facility at 5:09 AM through the front door. Resident #1's shoes were found across the street in a local crisis center parking lot. Review of security footage from the local crisis center revealed Resident #1 in the crisis center parking lot from 5:12 AM until 6:55 AM when he entered an employee's car. The crisis center employee was unaware that the resident was in their car and drove home. The crisis center notified their employee who looked in the car, saw Resident #1 sleeping and notified the local Police Department. The resident was transported to the local hospital by emergency services and returned to the facility on [DATE] at 11:16 AM, with no injuries. Review of the facility camera footage for 3/4/25, with the Administrator present on 3/5/25 at 12:00 PM revealed Resident #1 exited the front door of the facility at 5:09:10 AM on 3/4/25. Further observation of the video footage revealed a staff member, identified as Licensed Practical Nurse #1 (LPN), by the Administrator, walking toward the front door of the building at 5:09:49 looking at her phone. She is seen entering the door code, looking back down at her phone, turning and walking away. This is approximately 39 seconds after Resident #1 exited the building. Telephone interview on 3/5/25 at 12:38 PM with Certified Nursing Assistant #1 (CNA), who was assigned to Resident #1 on the 11 PM to 7 AM shift stated that she had gotten the resident up just before 5:00 AM and assisted him to get dressed and took him to the 200-hall sitting area. She stated that the resident sat down in the recliner. She stated that this is his routine every morning and he usually sits in the recliner until breakfast and will sometimes nap. She stated that was the last time she saw the resident before the end of her shift. She stated that he was not displaying agitation or anxiety, he was not having increased wandering nor was he exit seeking. She stated that the resident does wander around the inside of the facility, but he has never gone into anyone else's room or attempted to exit the building. She stated that the resident was wearing a long sleeve gray shirt, heavy plaid pants and gray shoes. She stated that she starts her rounds in the hall furthest away from the front door so if the alarm was sounding, she would not have been able to hear it. A telephone interview with LPN #1 on 3/5/25 at 1:34 PM, she stated that she last saw Resident #1 around 5:00 AM on 3/4/25, when he walked past the nurse's station while she was preparing medication for another resident. She stated that he usually sits in the recliner in the 200 Hall lounge area until breakfast. She stated that sometimes when the resident is near the front door the alarm would go off, but she initially stated that she did not hear any alarms sounding. Upon further interview with LPN #1 she was notified, by the SA, of the video showing her walk to the front door a few seconds after Resident #1 exited the building and entering a code on the door alarm. When asked about this she stated she guessed the alarm was going off and thought a phlebotomist set it off when she came in. She stated she looked out the door but did not see anyone. (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 with the Administrator (ADM) on 3/5/25 at 1:45 PM, he verified that the Resident #1 was noted missing 3/4/25 at 7:35 AM, and Code W, which is the code for a missing resident, was initiated. All other residents were accounted for; staff began looking for Resident #1. He stated upon review of the camera footage Resident #1 was seen exiting the front door of the building 3/4/25 at 5:09 AM, and LPN #1 was seen entering the alarm code on the front door at 5:09 AM. He stated that he believes when the phlebotomist came into the facility, prior to the resident's exit, the door did not latch when it closed, and the resident was able to push it open and exit the building. He verified upon review of camera footage from the crisis center across the street from the facility, Resident #1 was seen sitting on the bumper of a vehicle from 5:16 AM until 6:55 AM when he found the door unlocked and got into the vehicle. A crisis center employee who owned the vehicle went home after work not realizing the resident was in the car. The employee was contacted and asked to check her vehicle, and the resident was noted to be asleep in the back of the car. The local police department was notified, and Emergency Medical Services (EMS) transported the resident to the local emergency room (ER) for evaluation then the resident returned to the facility around 11:16 AM. He stated that the resident was placed on increased monitoring and the locksmith was called to evaluate the door closure. He stated the door closure was not malfunctioning, but that it was replaced with a more heavy-duty closure. The facility notified Resident #1's responsible party (RP) and nurse practitioner as well as the State Agency (SA) and Attorney General's Office (AGO). The Administrator stated the facility began to have additional elopement drills and all employees were in-serviced on elopement, supervision of residents and care plans. The Administrator provided the SA with copies of the statements received regarding the investigation and the sign-in page of the Quality Assurance Performance Improvement (QAPI) meeting that was held on the afternoon of the incident to discuss the incident and steps needed to prevent this from happening again. The facility conducted an investigation and submitted it to the SA and AGO. Following their investigation, they determined there were no signs of abuse or neglect. Through a root cause analysis by the Director of Nursing (DON) and Administrator, it was determined that the resident exited the building through the front door when the door did not latch properly after the phlebotomist entered and the nurse did not respond appropriately to the alarm when the resident exited the building. During an interview with the DON on 3/4/25 at 1:50 PM, she confirmed that Resident #1 did wander but did not have exit seeking behavior or verbalizations of wanted to leave. She verified that it was his usual routine to get up early and sit in the recliner in the 200 Hall area until breakfast. She stated upon return to the facility a body audit was conducted, and Resident #1 was noted to have no injuries. Resident #1 was placed on increased visual monitoring for 24 hours and then continued every hour visual monitoring. She stated that his elopement assessment and care plan were updated on 3/4/25. She stated that his wander guard was present and functional upon return to the facility and that placement and function are checked every shift. The DON also stated that all residents in the facility were assessed for elopement and their care plans were updated as needed. She stated that all residents at risk for elopement will be visually monitored every hour. She revealed LPN #1 was suspended pending termination on 3/4/25 when the facility camera footage revealed that she entered the alarm code without investigating the cause of the alarm. An interview with the Locksmith on 3/5/25 at 2:30 PM, he stated that the closure on the door was worn but not in disrepair. He verified that he replaced the closure with a stronger closure system. Record review of the door check form for March 2025, with the Administrator, on 3/5/25 at 2:35 PM, revealed all doors were checked for functionality in the morning and at 3:00 PM daily. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/5/25 at 3:00 PM, during an observation walk-through of the route from the facility to crisis center across the street where Resident #1 was seen to get into an employee's vehicle and the distance was determined to be 400 feet across a commercial road. During the observation, there was 1 car on the road and 1 streetlight in place. A record review of the weather report from the website https://www.localconditions.com/weather-corinth-mississippi/38834/past.php revealed that it was 52 degrees on 3/4/35 at 5:00 AM. Wind speed 13.2 miles per hour with gusts of 22.1 miles per hour. Record review of the Elopement Risk Evaluation for Resident #1, dated 2/13/25 revealed Resident wanders, no other risks for elopement. Elopement Risk Score 0. Record review of the Admission Record revealed that the facility admitted Resident #1 on 2/12/24 with diagnoses including Diabetes Mellitus, Cognitive Communication Deficit, and Difficulty Walking. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating that the resident is rarely/never understood. The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 3/5/25. Immediate action started on 3/4/25 at 7:35 AM. On 3/4/25 at 7:35 AM, resident #1 was noticed to be missing when his dining room tray was delivered to the hall by Certified Nursing Assistant (CNA). On 3/4/25 at 7:37 AM, a Code W was initiated by Unit Manager, Registered Nurse (RN). All staff searching for resident and one hundred percent audit was completed to ensure all other residents were present. On 3/4/25 at 7:41 AM, Assistant Director of Nursing (ADON) notified Director of Nursing (DON). On 3/4/25 at 7:59 AM, Director of Nursing (DON) notified Administrator. On 3/4/25 at 7:54 AM, Local Police Department, Local Fire and Rescue, and Attorney General Investigation Team were notified resident missing by Quality Assurance Licensed Practical Nurse (LPN). On 3/4/25 7:56 AM, Resident #1 House shoe was located by Housekeeper #1 in parking lot of local crisis center. On 3/4/25 at approximately 8:05 AM, Resident Responsible Party and Resident Physician Family Nurse Practitioner (FNP) notified by Assistant Director of Nursing (ADON). On 3/4/25 at 8:15 AM, Review of security cameras by Minimum Data Set (MDS) Registered Nurse (RN) saw Resident #1 exiting facility via front door at 5:09 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/4/25 at 8:20 AM, Janitor #1 was assigned to monitor the front door and the Maintenance Supervisor contacted Locksmith to evaluate door closure mechanism. On 3/4/25 at 09:22 AM, Facility was notified by the Dietary Manager while watching security footage at the Crisis Center that the resident was seen getting into the back of an employee vehicle. Crisis Center then notified the employee to have someone check in the car and notify police. Resident was asleep in the back seat. On 3/4/25 at 9:30 AM, Local police department went to the crisis center ' s staff member ' s residence and called Emergency Medical Services (EMS) for transport to Local Hospital for evaluation. Resident #1 was evaluated and noted to have no injury or signs of distress. On 3/4/25 at 10:03 AM, Resident #1 arrived at local emergency room and Infection Control, Registered Nurse (RN) was sent to supervise Resident #1 until return to facility. On 3/4/25 at 11:00 AM, Locksmith present and working on front door to replace door closures. On 3/4/25 at 11:16 AM, Resident #1 returned to facility, Body Audit completed revealing no injuries. Visual checks initiated every 15 minutes for total of four (4) hours, every 30 minutes for total of 4 hours, and every 1 hour for eight (8) hours to total 24 hours. Resident #1 will be monitored every hour indefinitely. On 3/4/26 at 11:17 AM, Resident #1 Wander Guard Bracelet was checked and was determined to be functioning. All residents with Wander Guards were checked and found to be functional. They will be checked each shift by nurse for functional status. On 3/4/25 at 11:19 AM, Resident Elopement Assessment and Care Plan were updated to include actual elopement on Resident #1 On 3/4/25 at 11:20 AM, DON, Assistant DON, Minimum Data Set Registered Nurse (RN), and Admissions Registered Nurse (RN) did one hundred percent Elopement Assessment on all residents. Care Plans for residents with Elopement Risk were updated to include visual checks every hour. Visual Monitoring will be monitored by the nurse each shift, any discrepancies will be reported to the Quality Assurance Nurse who will report findings to the Quality Assurance Committee monthly for three (3) months, then quarterly. On 3/4/25 at 1:00 PM, an Ad Hoc Emergency Quality Assurance and Improvement Committee meeting was held related to resident elopement to conduct a root cause analysis and Policy and Procedure for changes. Attendees were the Nursing Home Administrator, Director of Nursing, Infection Preventionist, Social Services, Quality Assurance Coordinator, Maintenance Supervisor, Housekeeping Supervisor, Dietary Supervisor, Nurse Practitioner attended by phone for the Medical Director who is off on medical leave. No policy and procedure changes were made at this time. On 3/4/25 at 2:00 PM, Director of Nursing, Quality Assurance Nurse, and Staff Development Nurse initiated in-services for all staff related to Elopement and Wandering Prevention, Response to Alarms, and following Care Plans. No employee will be allowed to return to work without training. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/4/25 at 4:00 PM, an Elopement Drill was completed and will continue to be conducted daily for 3 days on each shift, then weekly for three (3) weeks, then monthly. Social Services will report findings to the Quality Assurance Committee monthly. On 3/4/25 at 4:11 PM License Practical Nurse (LPN) #1 was suspended pending termination. All corrective actions were completed on 3/4/25 and facility alleges the IJ was removed on 3/5/25. The State Agency validated the facility's Corrective Action Plan on-site during the Complaint Investigation by record review and interviews on 3/5/25 and 3/6/25. The SA determined all corrective actions were completed on 3/4/25 and the IJ was removed on 3/5/25.