| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255125 | A. Building<br>B. Wing | 05/14/2025 |

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| Chadwick Nursing and Rehabilitation Center LLC | 1900 Chadwick Drive<br>Jackson, MS 39204 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283<br><br>Based on observation, interviews, record review, facility policy review, and facility investigation review, the facility failed to provide adequate supervision of 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.<br><br>On 5/09/25, at approximately 7:45 AM, Resident #1 exited the facility while unsupervised wearing a wander alarm device. The resident was out of the facility unsupervised and walked approximately one (1) mile crossing a four-lane highway for approximately two (2) hours before being located and returned to the facility.<br><br>The facility's failure to provide adequate supervision for Resident #1, who was an elopement risk, put this resident and all other residents at risk for wandering and elopement, at risk for serious injury, serious harm, serious impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 5/09/25, when Resident #1 exited the facility and existed at:<br><br>42 CRF(S): 483.25 (d)(1)(2)- Free of Accidents, Hazards/Supervision/Devises (F689).<br><br>The State Agency (SA) notified the Administrator of the IJ on 5/13/25 at 3:00 PM and provided an IJ Template.<br><br>Based on the facility's implementation of corrective actions on 5/9/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 5/10/25, prior to the SA's entrance on 5/13/25.<br><br>Findings include:<br><br>A record review of the facility's policy Missing Resident/Elopements, dated 1/15, revealed . The Unit Charge Nurse/CMT (Certified Medication Technician) is responsible for knowing the location of their residents . Procedure: . 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Charge Nurse/CMT as soon as possible .<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A record review of the facility's investigation summary, dated 5/9/25, revealed Resident #1 was last seen in the dining room at approximately 7:30 AM on 5/9/25 by a staff member. The resident was sitting at a table near the entrance to the kitchen area. At approximately 7:45 AM, a dietary staff member received a phone call from the resident's representative requesting that the staff be reminded of the resident's scheduled physician appointment. When the dietary staff looked back toward the dining room, the resident was no longer there, but his walker remained. Staff began searching the facility, and when the resident could not be located, a facility-wide elopement alert (Dr. Wander) was announced. The investigation indicated that the resident exited the facility through a kitchen door leading to a loading dock. The door was not equipped with a wander guard alert system, unlike all other facility doors. The resident had previously been identified as an elopement risk and was wearing a functioning wander guard bracelet at the time of the incident. Multiple staff members began searching the premises and the surrounding area. The resident was located at 9:20 AM by two staff members approximately one mile from the facility, walking near a busy highway. He was returned to the facility by staff at 9:32 AM and assessed by nursing and administrative personnel. The head-to-toe assessment revealed no signs of injury, distress, or trauma, and the resident was appropriately dressed and alert. According to the facility's documentation, the resident stated he was trying to go home and had exited through the kitchen door. Following the incident, the facility initiated corrective actions including environmental safety reviews, elopement drills, staff in-servicing, and the installation of additional wander guard systems. The resident's care plan was updated, and one-on-one supervision was implemented. A quality assurance meeting was held, and further audits and safety measures were initiated to prevent recurrence.<br><br>A record review of the Admission Record revealed the facility admitted Resident #1 on 04/01/25 with diagnoses including Schizophrenia.<br><br>A record review of the Order Summary Report with active orders as of 05/13/25, revealed Resident #1 had a Physician's Orders, dated 4/4/25, for Wanderguard bracelet daily elopement risk and Wanderguard check bracelet every shift for placement and functioning, replace bracelet if removed or not working properly elopement risk every shift.<br><br>A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) Summary Score of 04, which indicated he was severely cognitively impaired.<br><br>On 05/13/25 at 7:30 AM, an observation of the route from the area Resident #1 was located to the facility, revealed a busy four (4) lane highway with turning lanes and multiple traffic lights noted. There was heavy traffic flow to the facility, which was approximately one (1) mile from the location he was found.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/13/25 at 8:00 AM, during an interview, the Administrator stated that the facility's investigation into the Facility-Reported Incident (FRI) had been completed. She explained that a Quality Assurance and Performance Improvement (QAPI) meeting was held on the day of the elopement, and immediate corrective actions were implemented, including in-service training and a mock elopement drill conducted for each shift. The Administrator stated that based on interviews and the facility's investigation, it was determined that Resident #1 exited through the kitchen hallway via the loading dock door, which is located near the Dietary Manager's office. The resident accessed the area through an unsecured staff door leading into the kitchen. Resident #1 had previously been identified as an elopement risk and was wearing a wander guard device; however, the door used was not equipped with a wander guard sensor, although it did have a keypad lock.<br><br>On 05/13/25 at 8:30 AM, during an observation, Resident #1's door to his room was closed. Upon entering, Resident #1 was standing with the assistance of a walker, and a staff member was seated in a chair nearby. Resident #1 appeared well-groomed and was alert and oriented to his name. A functioning wander guard device was noted on his right wrist, with the indicator light visibly flashing.<br><br>On 05/13/25 at 8:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed she had been working on 05/09/25 when Resident #1 eloped from the facility. She explained that during her 7:00 AM morning rounds, she observed Resident #1 walking in the hallway without his walker. LPN #1 redirected the resident to return to his room to retrieve his walker, which he did. She described Resident #1 as pleasantly confused since his admission and stated that he had not yet received his morning medication. LPN #1 recalled that the last time she saw Resident #1, he was turning down Hall #4 toward the dining room. Later that morning, Dietary Aide #1 approached her to say the resident's daughter had called regarding a doctor's appointment, and that his walker was still in the dining room. LPN #1 instructed Certified Nursing Assistant (CNA) #1 to check the resident's room while she retrieved the walker. CNA #1 returned and reported that Resident #1 was not in his room. LPN #1, the CNA, and the dietary aide immediately began searching the facility. Within a few minutes, when they were unable to locate him, LPN #1 announced Dr. Wander over the intercom and notified the Administrator, Director of Nursing (DON), and the Staff Development Nurse. She stated Resident #1 had consistently worn a wander guard on his wrist, which was checked every shift by bringing the resident near the front door to ensure the alarm sounded and this was documented on the Medication Administration Record (MAR). She also noted that Resident #1 had expressed a desire to go home and had been observed multiple times attempting to open exit doors. Following the incident, Resident #1 was moved back to his original room, which is closer to the nurses' station, and he has since been placed on one-on-one supervision.<br><br>On 05/13/25 at 9:30 AM, during an interview with the Director of Nursing (DON), she explained that Dietary Aide #1 was the first staff member to realize Resident #1 was missing. The DON stated that after the resident was returned to the facility, she and the Unit Manager/Registered Nurse (RN) #2 interviewed him. During the interview, Resident #1 reported that he had exited the building through the kitchen door, which led to a hallway connected to the loading dock. He then exited the facility through the door at the end of that hallway.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/13/25 at 10:25 AM, during an interview with Dietary Aide #1, she explained that on 05/09/25 at approximately 7:30 AM, she observed Resident #1 sitting at a table in the dining room. She stated the table was located three (3) tables away from the hallway leading to the dietary manager's office and an exit door. Resident #1 was seated with his walker beside him. As she delivered breakfast trays to Unit B, she turned around and noticed Resident #1 was no longer at the table, but his walker was still present. Dietary Aide #1 reported that she returned to the kitchen, and shortly afterward received a phone call from Resident #1's daughter, asking her to remind the nurse of the resident's scheduled doctor's appointment and ensure a change of clothes was sent with him. She went to notify LPN #1 and noted that Resident #1's walker remained in the dining room. LPN #1 retrieved the walker. Resident #1's breakfast tray had already been placed on the Unit B food cart, and since he had not eaten, staff assumed he had returned to his room. She recalled hearing a CNA inform the nurse that Resident #1 was not in his room. After being informed, she walked through the dining room, then down Unit A and made a full round back to Unit B, but did not see the resident. She notified the nurse and soon after heard the overhead announcement for a Dr. Wander. She then joined the search, looking in resident rooms and throughout the kitchen area. She stated she did not recall seeing the exit door to the loading dock open or ajar but believed it must not have been securely closed.<br><br>On 05/13/25 at 10:50 AM, during an interview with CNA #1, she stated that on 05/09/25 she arrived to work late and did not see Resident #1 upon arrival. She recalled noticing his walker in the dining room, and LPN #1 asked her to check the resident's current room and the room he had recently been moved from, and he was in neither room. She reported back to the nurse that the resident was not in either location. CNA #1 stated that the nurse then began searching for the resident as well. When the resident could not be located, the nurse made a Dr. Wander announcement over the intercom, prompting all staff to assist in the search. CNA #1 explained that she helped search the entire facility, checking every resident room and even the closets. She confirmed that Resident #1 returned to the facility around 9:30 AM and appeared to be unharmed.<br><br>On 05/13/25 at 11:05 AM, during a phone interview with Resident #1's daughter, she explained that her father had been residing at the facility for approximately one (1) month and had a diagnosis of Dementia. Since his admission, he frequently expressed a desire to go home and often asked how to get there. She stated that on the morning of 05/09/25 at approximately 7:30 AM, she called her friend who works in the facility's kitchen to ask her to remind the nurses and CNAs of her father's scheduled doctor's appointment at 9:00 AM. Her friend agreed to notify the nurse. Within ten (10) minutes of that phone call, Resident #1's daughter received another call informing her that her father was missing from the facility. She arrived around 8:00 AM and began assisting in the search. She also contacted her brother, who began searching the surrounding area. She initially believed her father may have walked up the street and would be found quickly. However, around 9:30 AM, her brother located their father on the opposite side of a busy highway, near a local fast-food restaurant. Resident #1 was walking through a grassy area adjacent to the road. She reported that although she does not know the exact route her father took, he later told her he exited through the kitchen door. She confirmed that her father had consistently verbalized his intent to return home, a behavior consistent with his Dementia diagnosis. Upon his return to the facility, the resident appeared tired but otherwise unharmed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/13/25 at 11:20 AM, during a phone interview with Resident #1's son, he explained that on the morning of 05/09/25, his sister called to inform him that their father had left the facility unsupervised and staff were actively searching for him. He stated that he immediately left work to help locate his father. He looked at several locations he thought he may be and he began asking people in the area if anyone had seen an older man walking alone. One individual suggested he check along the highway and while driving in that area, he spotted his father walking in a grassy area on the opposite side of the busy four-lane highway. He was shocked that his father had managed to cross the highway safely. When he approached him, Resident #1 stated he was just trying to go home and explained that he had exited the facility through the kitchen. Shortly after, two nurses from the facility arrived and one of the nurses spoke with his father, who willingly got into the back seat of the vehicle and was transported back to the facility.<br><br>On 05/13/25 at 11:30 AM, during a follow up interview with the DON, she explained that on the morning of 05/09/25, she was notified that Resident #1 was missing and that a Dr. Wander alert had been initiated prior to 8:00 AM. She arrived at the facility around 8:45 AM and joined the ongoing search for the resident. She confirmed that all other residents were accounted for. The DON stated that she personally inspected all exit doors to ensure they were functioning properly. She also conducted an exterior search of the facility, including walking around the building, stepping into nearby wooded areas while calling the resident's name, and checking the furniture store across the street. She did not observe any signs of a path having been taken. Staff members were provided with a photo of Resident #1 and were assigned to search various locations, including the adjacent hospital emergency room , stores, and surrounding businesses. When he was located and returned, the DON and the Unit Manager/RN conducted a full body audit on the resident. The RN documented the assessment in the resident's progress notes. Resident #1 was noted to be fully dressed in a white T-shirt layered with a long-sleeved shirt, long pants, and laced-up tennis shoes. The resident was wearing a clean brief with no signs of soiling. The DON reported that following the incident, all wander guard devices were inspected, and a review of all residents identified as at risk for elopement was completed with no concerns identified. She confirmed that wander guards are checked daily by the nursing staff and documented on the Medication Administration Record (MAR). In response to the incident, the facility added keypad alarms to all exit doors and conducted a Quality Assurance and Performance Improvement (QAPI) meeting. The DON also stated that elopement education was provided to all staff through in-services, and mock elopement drills were conducted on all shifts. Elopement books are maintained by Social Services and located at both nurses' stations. They contain resident photos, face sheets, and identification details. Social Services coordinated the mock drills, and Staff Development oversaw the in-service training.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/13/25 at 12:10 PM, during an observation and interview with RN #1, she explained that she and the MDS nurse were the staff members who located and returned Resident #1 to the facility on [DATE]. She stated that she arrived at the facility around 8:00 AM that morning and observed staff outside searching for the resident. After learning that Resident #1 had left the building, she began asking staff when he was last seen and what had occurred. She searched throughout the facility again, rechecking previously searched areas, including the kitchen and laundry rooms. RN #1 stated she and other staff also checked outside the building and surrounding wooded areas, but no clear path or trace of the resident was found. With other staff already out in their vehicles searching, she asked the second MDS nurse to accompany her to continue the search. They drove around the nearby apartment complex, streets, and highways. While driving down the major highway, RN #1 spotted Resident #1 walking in a grassy area near a local bank. She and the resident's son arrived at the location around the same time. Resident #1 was alert, oriented to his name, and entered the vehicle willingly. He was well-groomed and reported only that he was tired and trying to get home. Following the incident, RN #1 stated that Resident #1's care plan was updated, he was placed on one-on-one observation, and his room was changed to one closer to the nurse's station. She confirmed the facility held a Quality Assurance and Performance Improvement (QAPI) meeting, conducted in-services for all staff regarding elopement, and completed mock elopement drills that same day. She further explained that it was determined Resident #1 exited the building through the kitchen door at the loading dock. During the observation of the loading dock with RN #1, there was a sloped, paved, and covered loading dock area that opened into the rear parking lot and grassy yard. An uneven paved path extended around the building, bordered by dense woods, with the front of the building facing the main road. The surrounding area included a nearby hospital, a furniture store, and audible heavy traffic from a local highway.<br><br>On 05/13/25 at 12:30 PM, during an interview with Social Services #1, she explained that she was not at the facility during the morning hours of 05/09/25 but was notified of the elopement prior to her arrival. She stated that while driving to the facility, she actively searched for Resident #1 along her route. She arrived around 8:55 AM and immediately joined staff in the search, both inside and outside the building. She confirmed that Resident #1 had previously been identified as an elopement risk and was wearing a wander guard at the time of the incident. Once the resident was located and returned to the facility, the DON notified all staff that the search was complete. Social Services #1 stated she is responsible for maintaining the facility's elopement books and performs random checks to ensure all information remains accurate. She noted there are three (3) elopement books kept in the facility. There is one (1) at each nurse's station and one (1) at the front office. She is the only staff member authorized to add or remove resident information from these books. She confirmed that she completed the post-trauma psychosocial assessment for Resident #1 upon his return, and no concerns were identified.<br><br>On 05/13/25 at 12:50 PM, during an interview with RN #2, she reported that she was notified via text message on 05/09/25 regarding the elopement of Resident #1. She arrived at the facility at approximately 8:10 AM and immediately joined the search efforts. RN #2 stated she promptly notified the facility's Medical Director and Nurse Practitioner about the resident's elopement. While participating in the search, she also checked on other residents to ensure they were accounted for. Upon Resident #1's return to the facility, she and the Director of Nursing (DON) walked the resident to his room, performed a head-to-toe assessment, and assessed for pain. Resident #1 expressed that he was tired, and Tylenol was administered for comfort. Food was also offered. RN #2 confirmed that the assessment was documented in the resident's progress notes, and staff communicated with the resident's daughter regarding his return.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/13/25 at 2:00 PM, during an interview with Housekeeping #1, he stated that he was present at the facility on 05/09/25 at the time of Resident #1's elopement. He explained that he arrived at the facility around 5:45 AM and observed Resident #1 standing at the front door with his walker, appearing to attempt to exit the building. Housekeeping #1 noted there were no staff members nearby at the time, but the resident was wearing a wander guard, and the alarm activated when the door opened. He redirected Resident #1, who then walked back toward his room. He recalled having seen Resident #1 previously attempting to exit the facility through various doors, but assumed the wander guard system would alert staff. He did not recall seeing Resident #1 again that morning. Around 8:00 AM, he heard the overhead announcement for Dr. Wander, indicating a resident elopement. He immediately got into his vehicle and drove around nearby areas, including the hospital and near other roadways, in an effort to locate the resident. He was later informed via phone that Resident #1 had been found, and upon returning to the facility, the resident had already been brought back.<br><br>The facility provided the following Corrective Action Plan:<br><br>On 05/09/25 at 09:40 AM, RN #2 performed a head-to-toe assessment with the resident's daughter, Executive Director, and DON present. There were no visible physical injuries.<br><br>On 05/09/25 a 100% audit of all Wander/Elopement Risk residents were assessed for placement and proper functioning with no adverse findings.<br><br>On 05/09/25 at 07:50 AM, all the facility's entrance and exit door's alarm systems were checked. All the alarms were functioning properly.<br><br>On 05/09/25 at 09:32 AM, Resident #1 checked for wander guard placement and properly working. His wander guard was intact and working properly.<br><br>On 05/09/25 at 09:40 AM, head-to-toe assessment of Resident #1 completed by the Unit B Manager and DON. There were no negative findings.<br><br>On 05/09/25 at 09:50 AM, Resident #1 was interviewed by the Unit B Manager. No negative statements were made by the resident.<br><br>On 05/09/25 at 09:55 AM, upon Resident #1's return he was placed on 1:1 location monitoring x (times) 72 hours then tapered down to every 15 minutes then every 30 minutes then every hour. The Unit Manager, DON, and Social Services will determine when the resident may be removed from 1;1. The resident was placed on 24 hours charting for the nurses to document and notifying the MD/NP of any significant changes in the resident physical or mental status.<br><br>On 05/09/25 at 10:00 AM, a keypad lock was placed on the kitchen entrance door in the dining room by the Housekeeping Supervisor. The Housekeeping Supervisor replaced the old door handle on the kitchen door next to Unit-B with a keypad. The code will be given to dietary workers and key staff.<br><br>On 05/09/25 at approximately 10:00 AM, the Maintenance Supervisor contacted Systronic Alarms Systems on installing a wander guard alarm on the kitchen door leading to the loading dock. A representative from the company will be at the facility on Monday, 05/12/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 05/09/25 at 10:00 AM, Resident #1 was moved closer to the nurses station. He moved from B 118P to B 108P. The Elopement Wander guard book reviewed. The Elopement Book was correct. A 100% check of the Wander/Elopement Risk were assessed for placement and proper functioning.<br><br>On 05/09/25 at 11:00 AM, the Dietary Workers on shift during the time of the incident received 1:1 Educational In-Services on Exit Doors in the kitchen and written corrective counseling by the Executive Director.<br><br>On 05/09/25 at 11:00 AM, Educational In-services for the facility's staff conducted by the Staff Development/Executive Director were initiated on Friday and included: a) Exit Doors in the kitchen b) Resident's Rights c) Abuse Prevention and Reporting d) Abuse and Neglect e) Residents expression to go home f) Missing Resident/Elopement.<br><br>On 05/09/25 at 11:00 AM the Unit B Manager re-schedule Resident #1's eye appointment. Resident's appointment is scheduled for Friday, May 16, at 11:30 AM, as a follow-up consult visit to rule out retinal vein occlusion with macula edema to the left eye.<br><br>On 05/09/25 at 01:00 PM, Resident #1's care plan and pain assessment up-dated. Social Services Director preformed a Trauma Screen.<br><br>On 05/09/25 at 02:00 PM, the facility prepared a formal letter to mail to each resident's representative. The letter requests that during visits, if the resident expresses wish to leave the facility or return home, the family should inform nurse management, the Executive Director, or Social Services.<br><br>On 05/09/25 at 02:30 PM, we had a Family Meeting with Resident #1's daughter. The daughter did not express any concerns about her father's care or safety with the facility.<br><br>Starting on 05/09/25, Nursing will review 24 hour progress notes on the following week day and/or Monday following the weekend for any resident's voicing wanting to go home or exhibits exit seeking behavior to ensure proper intervention are in place.<br><br>A QAPI was implemented with an emergency QA meeting reviewing Resident #1's incident on Friday, May 9, 2025.<br><br>Validation:<br><br>The SA validated on 5/14/25, through interview and record review, that all corrective actions had been implemented as of 5/9/25, and the facility was in compliance as of 5/10/25, prior to the SA's entrance on 5/13/25. |