STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255127	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tishomingo Comm Living Center	1410 West Quitman Street Iuka, MS 38852

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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	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** 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 five (5) residents who were at risk for elopement and wandering, Resident #68.On 12/10/25, at approximately 2:53 PM a member of the facility staff reported in the staff meeting that Resident #68 was found inside the pharmacy across the street. At 2:55 PM Resident # 68 was located by facility staff, approximately 100 yards away from the facility across a busy two-lane street inside the pharmacy where he was observed standing, laughing and conversing with the pharmacy staff. The temperature at the time was cloudy and 55 degrees; the resident was dressed in lace up tennis shoes, pants and a long sleeve shirt.The facility's failure to provide adequate supervision to prevent the elopement of Resident #68 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 12/10/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity (S/S) of J.The SA notified the facility's Administrator of the IJ and SQC on 12/15/25, at 3:30PM and provided the Administrator with the IJ template.Based on the facility's implementation of corrective actions on 12/11/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 12/12/25, prior to the SA's first entrance on 12/15/25.Findings include:Record review of facility Elopement/Unsafe Wandering Plan dated 02/07/2012 revealed, Policy: It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life and safe environment.Procedures. Risk Evaluation: An evaluation of the resident's risk for unsafe wandering or elopement is to be conducted on admission, quarterly, after a significant change in condition, and after an incident of elopement. Identification: Residents at risk will have some type of identifier on their person. Plan of Care: If a resident is identified at risk for elopement or unsafe wandering, a preventative plan of care is to be implemented at the time the risk is identified. Unsafe wandering and/or elopement potential is to be entered into the ADL (activity of daily living) system and ADL plan of care.Supervision: Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary. Facility Systems: Systems such as alarms, Wander guard systems and special locks/keypads as allowed by state and local authorities will be utilized to the extent possible.Record review of the admission Record for Resident #68 revealed the facility admitted the resident on 12/5/25 and the resident had diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery with Other Forms of Angina Pectoris, Type 2 Diabetes Mellitus with Hyperglycemia, Dementia in Other Diseases Classified Elsewhere, Severe, with Other Behavioral Disturbance, Alzheimer's Disease with Late Onset, and Chronic Obstructive Pulmonary Disease, Unspecified.Record review of the admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 12/5/25 for Resident #68 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment.Record review of the Quarterly Wander Evaluation dated 12/6/2025 (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	revealed Resident #68 was a wander/elopement risk.During an interview on 12/15/25 at 11:30 AM Licensed Nursing Home Administrator (LNHA) described her understanding of the incident involving Resident #68. She stated she first became aware of the elopement when the Business Office Manager (BOM) came into their staff meeting to alert them that Resident #68 was inside the pharmacy across the street from the facility. She said this occurred at 2:53 PM on 12/10/25. She stated that Social Services, Activities Director, and the Director of Nursing immediately left the facility to go across the street to the pharmacy. She stated that at 2:55 PM, Social Services, Activities Director, and the Director of Nursing walked into the pharmacy where Resident #68 was observed standing, laughing and conversing with the pharmacy staff. She confirmed that Resident #68 was returned to the facility at 3:00 PM. During an interview on 12/16/25 at 10:54 AM, Pharmacy Technician stated she works at the pharmacy across the street from the facility. She reported that between approximately 2:30 PM and 3:00 PM she had just delivered medications to the facility. She stated that she entered the facility through a side door that was unlocked. After she dropped off the medications, she was sitting in her car in the parking lot when a male individual flagged her down and walked up to her car window. She stated the individual asked if she could give him a ride to (proper name of a nearby town), stating he was a good person, loved the Lord, and only needed to be dropped off at the city limits. She stated he told her his name and offered her $350 to provide the ride. She reported she declined his offer and drove away. She further stated that after leaving the facility parking lot, she realized the individual was a resident of the facility and remembered his name as that of a resident that she had just delivered medications for to the facility. She contacted her boss at the pharmacy, who instructed her to return to the facility and let the staff know about the possible elopement. While she was in route back to the facility and on the phone with her boss, she was informed that the resident had just walked into the pharmacy. Additionally, she stated she turned around and went back to the facility and told them that the resident had been in the parking lot when she was outside and he was now across the street inside the pharmacy. During an interview on 12/16/25 at 11:12 AM, Licensed Practical Nurse (LPN) #1 revealed that she worked at the front nursing station on the day of the elopement. She reported that the resident repeatedly attempted to go to the exit door and stated that he needed to go home to his wife. LPN #1 stated that she placed a chair at the nursing station and had the resident sit beside her. She reported that Resident #68, for the most part, remained seated at the nurses' station. She offered him magazines to look at and allowed him to watch videos on her phone. She stated that she conducted visual checks at least every hour. LPN #1 stated that the resident was already listed in the facility's elopement book as being at risk for elopement. She confirmed that she had no idea how the resident had gotten through the locked door and got outside of the building and stated, We think he probably walked out with a visitor. She reported that the facility currently has five residents on elopement precautions. She stated that she maintained her own visual list of the resident's location, checking his whereabouts every 30 minutes to one hour. LPN #1 reported that when the resident returned following the elopement, he was confused and restless, and the facility initiated one-to-one observation. She stated that after the elopement incident, the facility provided education to staff regarding elopement precautions. LPN #1 stated that her shift was from 6:00 AM to 6:00 PM. She reported that at 6:00 PM, the night shift nurse assumed care of the resident, and the resident remained on one-to-one observation.During an interview on 12/16/25 at 11:20 AM, Certified Nursing Assistants (CNA) #1 and #2 both stated that although they do usually work the hall where Resident #68 resides, they were interviewed regarding training implemented after the elopement incident. They both confirmed that Resident #68 was anxious and exit seeking prior to his elopement. Both CNAs stated that they were off duty on the day of the elopement. CNAs #1 and #2 stated that since the elopement, the facility had implemented new training and protocols for residents at risk of elopement. They reported that CNAs are required to document every 30 minutes for residents identified as being at risk for elopement and listed in the facility's elopement book. They stated that documentation is completed every 30 minutes in the computer charting system.During an (continued on next page)

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She reported that when they arrived, the resident appeared happy to see them and did not appear distressed or aware that he had done anything wrong. She stated that the resident told her he was trying to get to where his wife was, and she stated that I told him that his wife was coming to the facility and he returned to the facility without difficulty. The DON stated that the resident was wearing lace-up tennis shoes, pants, and a long-sleeved shirt. She reported that the weather was cool but not frigid. The DON further stated that once the facility became aware of the elopement, staff immediately checked all doors and windows and completed a headcount of all residents. She reported that after the resident returned to the facility, staff completed a body audit to ensure he was not injured. She stated that the facility contacted a local business to install a keypad on the front door. The DON reported that the facility conducted in-service education on elopement and abuse. She stated that once the issue was identified, the resident was placed on one-to-one observation, with one staff member assigned to continuously monitor the resident to prevent further elopement.During an interview on 12/16/25 at 11:34 AM, Social Services (SS) #1 reported that prior to the elopement, she had not observed exit-seeking behaviors for this resident. She stated that on the day of the elopement, she observed the resident standing in a resident's doorway at approximately 2:39 PM while she was walking to a meeting. SS #1 stated that once staff were notified of the elopement, she and other staff immediately got into a vehicle and went to the drugstore across the street to retrieve the resident. She reported that the resident appeared happy to see staff. She stated that the resident may have made a comment at the drugstore about needing to get to his wife. SS #1 stated that after the resident returned to the facility, several interventions were implemented. She reported that the facility had installed a new lock on the front door. She stated that going forward, the front door must be physically opened by staff using a keypad code. She reported that after 5:00 PM, the facility limits access to one entrance only, and individuals must be buzzed out by staff. SS #1 stated that family members were notified of these changes, including the limitation to one entrance after 5:00 PM and on weekends, to more closely monitor all comings and goings. SS #1 stated that when the resident first arrived at the facility, he was constantly pacing, but she believed he had calmed down somewhat since admission. She reported that on the day of the elopement, the resident was dressed in street clothes and was wearing a jacket. She stated that the jacket covered his identification bracelet, and she could see how a visitor might mistake him for another visitor rather than a resident. SS #1 stated that she believed the resident may have exited the building behind a visitor. She reported that on the first night of his admission, the resident paced throughout the facility and was unable to remain still. She stated that staff had CNAs follow behind him throughout that first night. SS #1 stated that when the drugstore clerk first observed the resident, he was standing on the sidewalk and had not traveled far from the facility before staff became aware of his location.During an interview on 12/16/25 at 11:41 AM, LPN #2 stated that she was working at the back nursing station on the same hall as the resident on the day of the elopement. She reported that she had been talking with the resident about his past work as a game warden and stated that the resident engaged in conversations with different people. She reported that the resident was trying to find his house and talking about how he needed to get home and check on his wife. LPN #2 stated, I don't know how he got out. Maybe someone was coming in and he slipped out. She further stated that nurses document on residents identified as wanderers every hour. She reported that nursing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documentation includes the resident's location and behaviors and that this hourly documentation was already in place at the time of the elopement. She stated that the change implemented after the elopement was that CNAs are now required to document every 30 minutes. She reported that CNAs document every 30 minutes, while nurses continue to document hourly on the resident's behaviors and location.On 12/15/25 at 2:30 PM observed that the facility front lobby is a separate area from where the resident rooms are and the residents reside. There is a set of double doors with a coded, locked entrance to enter the area where the resident rooms are found. Prior to this incident on 12/10/25 the front lobby area was unsecured, and the multiple entrance and exits were unlocked and unsecured. Observation on 12/15/25 at 2:35 PM revealed that the exits and entrances in the front lobby are coded and locked now and you must have a code to leave the building or be let into the building. Observation revealed the distance from the facility to the pharmacy, where the resident was found, was approximately one hundred yards. The pharmacy is located across the street from the facility, and the resident would have crossed a busy two-lane street with no cross walks with speed limits of 35 miles per hour to have reached the pharmacy parking lot.Record review of the local weather history according to Custom Weather, Inc., for the facility for 2:53 PM on 12/10/25 revealed the temperature was fifty-seven (57) degrees Fahrenheit, passing clouds with zero (0) precipitation, eighteen (18) mile per hour winds. Corrective Action PlanOn 12/15/25 at 3:30 PM the State Agency presented an Immediate Jeopardy [NAME] which notified the Administrator of the facility that the facility failed to ensure Resident #68, who has a BIMS score of 3 (cognitively impaired) was adequately supervised to prevent elopement.On 12/10/25 at 2:53 PM it was reported to administrator that Resident #68 was noted in the drug store located across from the facility, asking for a ride to see his wife. Staff members assisted residents safely back inside the facility. Decision was made to report and start investigation.Notifications:Son Responsible Party notified by phone on 12/10/25 at 3:23 PMMedical Director notified 12/10/25 with no new ordersState Department of Health notified on 12/10/25 at 5:28 PMRegional Director of Operations/Regional Nurse Consultant 12/10/25 per phoneDirector of Nursing, Assistant Director of Nursing, Social Services, notified 12/10/25 in personOmbudsman notified 12/10/25 per phonePolice Department 12/10/25 at 3:40 PM Immediate Actions:1. Body Audit: with no negative findings performed on 12/10/252. Resident #68 placed on 1:1 on 12/10/253. 100% head count of residents on 12/10/254. Door codes changed at all entrances 12/10/25 by maintenance director.5. Education of all staff started on 12/10/25 on wandering/elopement and completed 12/10/25. No staff will be allowed to work until in-services are complete.6. Education to all staff on not providing the code to anyone other than staff. Education began on 12/10/25 and was completed on the same day by the Director of Nursing.7. Magnetic lock doors activated at front lobby entrance doors on 12/10/25.8. 100% audit of elopement books completed, noted that these were up to date and updated 12/10/25 by Social Services director. No negative findings were noted with this audit.9. All residents in the Elopement book were placed on 1-hour visual checks per nursing and 30-minute visual checks per Certified Nursing Assistants on 12/10/25.10. Elopement drill completed on 12/11/25 by maintenance director.11. Emergency Quality Assurance and Performance Improvement meeting with Medical Director and Interdisciplinary team on 12/11/25.12. 100% psychosocial orders put into place for all residents on 12/10/25.13. Wandering/elopement evaluation form completed for 100% of all residents on 12/11/25.14. All families were notified of the new entrance process into the facility on [DATE].15. Checked all doors and windows on 12/10/25 by the Maintenance Director. Continued Monitoring:1. Code W drills will be done weekly x (times) 4 weeks then monthly and as needed (PRN) starting on 12/11/25.2. Newly hired staff will be trained on the wandering/elopement prevention plan starting on 12/11/25.3. Residents will be assessed for elopement risk on admission, quarterly, and with any significant changes starting on 12/11/25.4. Resident continues 1-hour visual checks per nursing and is now placed on 30-minute visual checks for Certified Nursing Assistants (CNA)s starting 12/10/25.5. Social Services to audit the elopement/wander book weekly x 4 weeks, then biweekly x 4 weeks, then monthly thereafter (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	starting 12/10/25.6. Minimum Data Set Nurse to audit wander/elopement care plans weekly x 4 weeks, then biweekly x 4 weeks starting 12/10/25. Timeline:At 2:45 PM LPN was doing rounds and visualized resident speaking to another resident on nursing station 1 hallway while she was sitting in her doorway. Resident #68 was dressed in pants, a long sleeve jacket, and lace up shoes. The nurse continued to make rounds while the residents visited with one another. Numerous staff members wrote statements of visualizing the resident on the hall around the same time frame.At 2:50 PM Pharmacy Tech with local pharmacy arrived at the facility and came inside to deliver meds.At 2:53 PM The Business office manager came into our staff meeting to alert us that Resident #68 was inside the pharmacy.At 2:55 PM Social Services, Activities Director, and the Director of Nursing walked into the pharmacy where the Resident #68 was observed standing, laughing and conversing with the pharmacy staff.At 2:57 PM Resident #68 willingly came with us back to the facility.At 3:00 PM Resident #68 was back and safely inside the facility. Facility alleged that all corrective actions were implemented on 12/11/25 and the Immediate Jeopardy removed on 12/12/25.On 12/15/25, the SA validations were made onsite during the complaint investigation through interviews, observations and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 12/12/25, prior to the SA entrance on 12/15/25.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. 4th Quarter 2025. Findings Include:Record review of the facility policy titled, Staffing Hours-Monitoring of Policy and Procedure undated, revealed, Purpose: To assure the facility staffing meet federal and state guidelines. Record review of PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 4 2025 (July 1-September 30), revealed the facility triggered on this report for excessively low weekend staffing.During an interview on 12/17/2025 at 3:20 PM, the Administrator revealed that after auditing the low weekend staffing data, she discovered that the data submitted to PBJ was inaccurate. She revealed that both she and the Director of Nurses (DON) had worked some weekends, and their salary hours were not accurately converted to hourly. The Administrator also revealed that, after further investigation into the excessively low weekend staffing, it was discovered that there was a data entry error with their vendor Paylocity, which failed to capture all employees who worked during the time period in question.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to provide written notification to the resident/representative regarding bed hold when the resident was sent to the hospital for two (2) of two residents reviewed for hospitalization. Resident #1 and Resident #65Findings Include: Review of the facility policy titled, Bed hold Policy and Procedure revealed Policy: Before the facility transfers a resident to the hospital or allows a resident to go on therapeutic leave, written information should be provided to the resident and family member or legal representative specifying the following information: (i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the facility; and (ii) The policies regarding bed-hold periods, which should be consistent .In the case of an emergency transfer, a written notification should be given to the family, surrogate, or representative within 24 hours of the transfer. A copy of the notice should be sent with the resident in the transferring paperwork. Resident #1 Review of Resident #1's Health Status Note, dated 11/24/25, revealed that the Medical Director (MD) ordered the resident be sent to emergency room (ER) for treatment and evaluation. Record review of the Transfer/Discharge Notice Form revealed that Resident #1 was transferred/discharged to the hospital on [DATE]. During an interview on 12/18/25 at 9:25 AM, the Business Office Manager (BOM) confirmed that the facility did not provide a written bed-hold notice to the resident or the resident's representative at the time of transfer. She acknowledged that she is responsible for ensuring the written bed hold notifications are sent to the resident/resident representative when a resident is transferred to the hospital. She confirmed that the bed hold policy, which includes the reserve bed payment, was not sent for Resident #1 and Resident #65. During an interview on 12/18/25 at 10:25 AM, the Administrator confirmed that whenever a resident is discharged or transferred, they are supposed to receive a notification of bed-hold, including the amount, so the resident or resident representative will know how much they will need to pay to hold their bed. Record review of the admission Record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that include, Hemiplegia and Hemiparesis, Type 2 Diabetes Mellitus, and Dysphagia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/17/25 revealed Resident #1 is rarely/never understood. Resident #65 Review of Resident #65's Health Status Note, dated 10/08/25, revealed that the MD ordered the resident be sent to ER for treatment and evaluation. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Transfer/Discharge Notice Form revealed that Resident #65 was transferred/discharged to the hospital on [DATE]. Record review of the admission Record revealed Resident #65 was admitted to the facility on [DATE] with a diagnosis that included Metabolic Encephalopathy. Record review of Resident #65's MDS with ARD of 10/08/25 revealed Resident #65's BIMS was incomplete, as the majority of cognitive interview questions were marked not assessed, and no BIMS summary score (0-15 or 99) was entered.