STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yazoo City Rehabilitation and Healthcare Center	925 Calhoun Avenue Yazoo City, MS 39194

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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 - Some	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 staff interviews, resident interviews, observations, record reviews, and facility policy and procedure reviews, the facility failed to provide supervision to prevent the elopement of a delusional resident who voiced and was identified by the facility as being at high risk for elopement. Resident #1 was one (1) of six (6) Residents that the facility had identified as at risk for elopement. (Resident #1) The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) Past Non-Compliance (PNC) which began on [DATE], when the facility allowed Resident #1 to leave the facility through his disassembled bedroom window unsupervised and unwitnessed. Resident #1 was found several miles away by local Law Enforcement at a store. He was assumed by the facility to be away from his bedroom for approximately five and a half (5.5) hours. Resident #1 was last seen by Certified Nursing Assistant (CNA #1) on [DATE] at approximately 12:30 A.M. and was not seen again until his return to the facility at approximately 6:00 A.M. The facility's failure to provide supervision placed Resident #1 and other residents identified elopement risk placed the residents with likelihood of serious injury, harm, impairment, or death. On [DATE] at 2:00 P.M. the SA informed the facility's Administrator (ADM) of the Immediate Jeopardy (IJ) and provided the IJ Template. The facility provided an acceptable Removal Plan-Past Non-Compliance (PNC) on [DATE], in which the facility alleged all corrective actions were completed to remove the IJ (PNC) on [DATE], prior to the SA entering the building on [DATE]. The (SA) validated the Removal Plan on [DATE]-[DATE] and determined the IJ (PNC) was removed on [DATE], prior to SA's entering the building on [DATE]. The Scope and Severity (S/S) for F689-Accidents/Hazards/Supervision, was lowered from a K to an E due to the facility being recently cited for the same deficiency on [DATE]. Findings Include: The facility policy and procedure titled Wander Management, Monitoring System and Resident Elopement Protocol dated Revised [DATE] Reviewed ,d+[DATE] read: To monitor safety of residents at risk for elopement. To provide a system to alert staff that a resident may be attempting to leave the facility. It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents, so identified, will have these issues addressed in their individual care plans. (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 - Some	Interview on [DATE] at 9:50 A.M. with the facility Administrator (ADM) revealed that Resident #1 had made an attempt to leave the facility on [DATE] with staff following close behind him which prevented Resident #1 from leaving the front porch of the facility after he voiced that he needed to leave to get a job. On [DATE] Resident #1 had a Brief Mental Status Score (BIMS) of 14 which indicated that he was cognitively intact, but he did voice delusional statements such as he needed to return to his job and/or report for a job interview. Resident #1 had written large documents in a note book that he explained to staff were his resume' documents and that he needed to leave to take his resume' with him to job interviews. The ADM stated that Resident #1 had been admitted to the facility from another nursing home. The ADM stated that Resident #1 had a known history of wandering and was an elopement risk. The ADM stated that Resident #1 was identified as one (1) of six (6) residents living in the facility that were wanderers and high risk for elopement. The ADM stated that Resident #1 had been given a wander guard to sound when Resident #1 got close to the exit doors. The ADM stated that the wander guards do not work on the windows, but on [DATE] after midnight that Resident #1 left the facility through his disassembled bedroom window and he had taken his wander guard off and left it on his bedroom dresser. The ADM provided pictures made with her cell phone of the disassembled window, a broken and bent window screen, and the window taken completely out of its frame and sitting on top of room air conditioner inside Resident #1's private room. The ADM stated that when Resident #1 eloped undetected and unsupervised from the facility on [DATE] after midnight, he took with him a roll of toilet tissue, his note book of writings/resume', an extra pair of black tennis shoes and a black hooded sweat shirt that he had wrapped around his body as a make-shift back pack. Resident #1 was wearing a white T-shirt, olive green cargo pants, eye glasses and blue tennis shoes. Resident #1 was last seen by a Certified Nursing Assistant (CNA#1), at 12:30 A.M. on [DATE] and at approximately 2:00 A.M. on [DATE] LPN #1 discovered that Resident #1 had disassembled his bed room window and had left out his window unsupervised and undetected. The local Law Enforcement contacted the ADM at approximately 5:44 A.M. that Resident #1 was at the Dispatch Office waiting for the facility to come and pick him up. The ADM and the DON drove to the Dispatch office and obtained Resident #1 and brought him back to the facility at approximately 6:00 A.M. The DON and nursing staff assessed Resident #1 and found him to be delusional but not physically injured. The facility placed Resident #1 on one to one (1:1) close observation with documented visual accountability every 15 minutes. The wander guard was re-placed on Resident #1 and his bedroom window was re-paired and fastened with screws drilled into the frame by the Maintenance Department. Resident #1 has remained on 1:1 since his return to the facility and his 1:1 will remain in place until he is discharge on [DATE] to a locked unit at another facility. Interview and observation of Resident #1 on [DATE] at 10:15 A.M. revealed Resident #1 made no attempts at conversation. Resident #1 stated that he was getting in his exercise. Observation of his room revealed that he was in a private room with no roommate, the bedroom window was securely attached and in working order. The window would not open all the way but provided approximately six (6) inches of an opening for fresh air. The screen on the outside of the window was attached. Resident #1 had an over bed table in front of a straight back chair that contained a note book and a pen for writing. The note book appeared to be filled with Resident's personal writings. The ADM demonstrated to surveyor how the window was now securely screwed in to the frame of the window and that it would no longer lift out of the frame. The windows were large and were designed to slide from side to side in order to open. The windows were currently secured as not to slide from side to side but only open approximately six (6) inches. Resident #1 was not present when the ADM demonstrated the current status of his bedroom window. Resident #1 was walking all about the facility with a staff member. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 10:30 A.M. with the Director of Nursing (DON) revealed that she had ridden to the Dispatch Office with the ADM to pick up Resident #1 on [DATE] at approximately 6:00 A.M. The DON stated that the weather conditions on [DATE] were not good and that it was raining and hot. Upon returning Resident #1 to the facility on [DATE] at approximately 6:00 A.M. the DON, along with other nursing staff, LPN #1 and RN Supervisor #2, assessed Resident #1 and all identified wanderers and found no physical injuries and wander guards were in place and functioning properly. The DON stated that she over saw the verification and accountability of all residents per the census of 149 residents. DON stated that Resident #1 had been assessed upon his admission to be at high risk for elopement and a wander guard was put in place. The DON stated that she re-assessed Resident #1 on [DATE] and documented his High Risk for Wandering on the Wander Data Collection form. The DON stated that the Maintenance department had been at the facility on [DATE] and had secured the bedroom window of Resident #1's room prior to 7:00 A.M. on [DATE]. The DON stated that she also re-assessed Resident #1 for his high risk for wandering again on [DATE]. The DON confirmed that on [DATE] the Quality Assurance (QA) committee members met and discussed the events of Resident #1's elopement. The DON stated that all corrections had been completed on [DATE]-[DATE]. The DON stated that Resident #1 had been on 1:1 close observation with a staff , d+[DATE] since the elopement on [DATE] and would remain on 1:1 until his discharge to a locked unit at another facility. The DON stated that the immediate dangers of the elopement were corrected on [DATE] when Resident #1 was returned safely, placed on 1:1 close observation with a new functioning wander guard system and the window of Resident #1's room secured and repaired by Maintenance. The facility continued with in-servicing of staff and assessing of residents, and the first QA meeting was on [DATE]. The Psychiatric Nurse Practitioner came to the facility on [DATE] and re-assessed Resident #1 and wrote orders to continue the 1:1. Interview on [DATE] at 2:40 P.M. with Certified Nursing Assistant (CNA #1) revealed that she was a new employee to the facility that was hired on [DATE]. She stated that on the night of Resident #1's elopement she and two (2) other CNA's were working on the unit and two (2) LPN's. CNA #1 stated that there was plenty of staff working on the unit. She stated that Resident #1 was his normal self and was not acting like he was going to leave and he had not voiced anything unusual to her. Resident #1 was assigned to her and she had been checking on him throughout the night. CNA #1 saw Resident #1 sleeping in his bed at 12:30 A.M. on [DATE] in his private room. Then the LPN #1 went at 2:00 A.M. to check on him and he was gone. The entire staff began to look for Resident #1. CNA #1 stated that Resident #1 had not expressed to her that he wanted to leave the facility. CNA #1 stated that Resident #1 eloped through his bed room window. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 3:28 P.M. with the Licensed Social Worker (LSW) , revealed that she had been the LSW at the facility during Resident #1's admission. LSW stated that Resident #1 had delusions and that he had voiced exit seeking behaviors. Resident #1 believed that he needed to get a job and that he must get a job to survey the land and water. The LSW stated that Resident #1 had made an attempt to leave the facility on [DATE] when he left out the front door by pushing the door open as another resident entered from the front porch. There were staff members and the receptionist with him and they eventually were able to talk resident into coming back into the building. The LSW stated that she updated the incidents on Resident #1's care plan and had obtained an evaluation at a geriatric psychiatric facility as a result of his exit attempt on [DATE]. The psychiatric facility came and picked Resident #1 up to transport him to the psychiatric facility and while in transit Resident #1 became combative and the transport van turned around and brought Resident #1 back to the facility on [DATE]. The LSW provided the care plan documentation outlining the events of [DATE] and [DATE]. The LSW verified that the facility staff had been attending in-services since the elopement attempt on [DATE]. The LSW stated that Resident #1 is active and strong bodied and walks several miles per day throughout the facility for exercise and he continues to believe he has a job. The LSW stated that Resident #1 had a diagnosis of frontal lobe traumatic brain injury and that he does not have the ability to reason and he does have a delusional thought process. The LSW stated that Resident #1 would better benefit on a locked unit with memory care. The LSW stated that the psychiatric facilities would not consent to admit Resident #1 because he would not give his consent for treatment. The LSW stated that Resident #1's family do not want Resident #1 to be discharged and the family does not come to visit the facility often but they do call Resident #1 and he does talk to family on the telephone. The LSW stated that the family was in agreement with his discharge to a locked unit with memory care. The LSW stated that Resident #1 will remain on 1:1 until his anticipated discharge on [DATE]. LSW stated that she updated the wandering information and high risk for elopement residents list and made sure that the books with their information were all updated and current as well as accessible to all staff. Interview and observation on [DATE] at 4:00 P.M. with Resident #1, revealed that he was sitting in his private room with his feet up in a reclining chair watching television. Resident was dressed in olive green cargo pants with black tennis shoes and a black t-shirt. Sitting across from Resident #1 in a chair with an over bed table was a Certified Nursing Assistant (CNA) charting on the resident every thirty (30) minutes. Resident #1 stated to surveyor that he was watching a preacher on the TV but was unable to recall what the preacher's name was or what the sermon was about. Resident's speech was pressured and rapid and he was talking about his resume' and his job interviews that he had arranged. Resident's thoughts were loose and his sentences were disconnected. He rapidly changed from subject to subject and his thought process was disconnected from his answers. The writings were not comprehendible. On [DATE] at 4:00 P.M. Resident #1 told surveyor that he needed to leave in order to get to work. Resident #1 presented as ambulatory and agile. Resident had an agenda and he expressed that he was leaving. Resident was unable to recall ever being in an accident. Resident said that his brain had been cut open and taken out and cleaned and sewed back in his head. Resident rambled on in a rapid and repetitive manner. Resident was oriented to self, but was not oriented to situation, time, place, or date. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 5:30 P.M. with the evening Receptionist #1, revealed that she worked the front desk and was in charge of the front door exiting and entering. She worked Monday -Friday 5:00 P.M.-7:00 PM and she worked weekends 8:00 A.M. -7:00 P.M. She stated that she was at the front desk on [DATE] at approximately 6:00 P.M. when Resident #1 attempted to leave the facility. She stated that she attempted to hold the door shut when Resident #1 pushed her and the door open. Resident #1 got out on the front porch but staff were able to distract him and coax him back in to the building. She stated that Resident #1 walked constantly and that he walked approximately ,d+[DATE] miles per day throughout the facility. Interview on [DATE] at 7:07 P.M. with Registered Nurse (RN#1). She stated that she was the supervisor for the night shift at the facility on [DATE] when Resident #1 eloped. She stated that there were plenty of staff in the building and that the unit that housed Resident #1 contained three (3) CNA's and two (2) LPN's and one (1) RN supervisor. She stated that she was called to report Resident #1 was missing at approximately 2:00 A. M. on [DATE]. She stated that she saw the window in his room removed from the frame and the screen broken out and Resident #1 was no where in the facility. The entire staff immediately began searching for Resident #1. RN#1 stated that she was at the facility when Resident #1 was returned on [DATE] at approximately 7:00 A.M. RN #1 stated that the weather conditions on [DATE] were rainy and hot. RN #1 stated that Resident #1 had a fixed delusion that he was going to leave and go to work. When Resident #1 returned to the facility she assessed him and other residents. RN#1 began in-services with staff on [DATE]. All residents were accounted for and unharmed. Interview on [DATE] at 8:55 A.M. with Registered Nurse (RN#3) revealed she was responsible for compiling the care plans for all the residents along with the LSW. She stated that she and the LSW revised and updated Resident #1's care plan. She stated that all staff have access to the care plans and that the care plan information was available to the CNA's through the care giver guide that the CNA's maintained on each unit. RN#3 confirmed that after the failed elopement attempt of Resident #1 on [DATE] the care plan was updated and after his combative episode on the transportation van, the Care Plan of Resident #1 was updated and again after the elopement on [DATE] the Care Plan of Resident #1 was updated. Interview on [DATE] at 9:15 A.M. with Maintenance revealed that he was called to the facility on [DATE] in the early morning hours and told that Resident #1 had left the facility through the window of his room. He came to the facility at approximately 2:30 A.M. and assisted with the search of Resident #1. The weather was rainy and visibility was poor. The maintenance man was surprised to see the window taken out of the frame and the screen bent back. Maintenance stated that he never would have thought that someone would be able to remove the window from the frame and leave the facility. Maintenance stated that Resident #1 was brought back to the facility between 6:00 A.M. and 7:00 A.M. on [DATE]. Maintenance had placed the window back and screwed the frame into the wall preventing the window to slide out of its track. Resident #1 was placed on 1:1 with staff at his side ,d+[DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 9:30 A.M. with Licensed Practical Nurse (LPN #1) revealed that she had worked at the facility for about four (4) years as the night LPN. She stated that Resident #1 would wake up during the night several times and come up to the nursing station asking for snacks to eat. LPN #1 stated that she thought it odd that he had not been up to the desk asking for his snacks so about 2:00 A.M. she took a snack to Resident #1's room and found him gone and the window removed. LPN #1 stated that there were plenty of staff working at the facility on [DATE] during the evening shift. LPN #1 called the ADM and DON and the Resident's Representative and the nurse practitioner to report the elopement. LPN #1 stated that CNA #1 had reported seeing Resident #1 in his bed sleeping at approximately 12:30 A.M. and that CNA #1 was the last person to see him. LPN #1 stated that Resident #1 was returned to the facility at approximately 6:30 A. M. on [DATE] with the ADM and the DON. The local Sheriff 's office had found Resident #1. It was approximately 5.5 hours that Resident #1 was reported to be missing from the facility. No one saw him leave and no one knew what time it was when he eloped. Interview and observation on [DATE] at 2:30 P.M. with Receptionist #2 of the front desk and front door of the facility revealed that she sits at the front desk monitoring the front door from 8:00 A.M. - 5:00 P.M. Monday through Friday and she had the high risk for elopements book at the desk with her and she knew the names and faces of all six (6) residents on the list. Receptionist #2 showed surveyor the high risk for elopement binder with all the information on all six (6) wanderers. The wander guard system was tested with a wander guard and it sounded loudly when it reached the front door. Wander guard system intact and working properly. The front door was observed to be locked and the Receptionist #2 was observed to push a button or use a code on a punch pad to open the door to let visitors and residents and staff in and out. No resident was observed to use the punch pad entering a code to release the door. Only staff were observed using the punch pad to enter and exit. Record review of the Face Sheet of Resident #1 revealed that he had an admitted to the facility of [DATE]. Resident #1's admitting diagnoses were Traumatic Subdural Hemorrhage without loss of Consciousness; Epilepsy; Frontal Lobe and Executive Function Deficit; Mild Cognitive Impairment; Confusion Arousals; Difficulty Walking; Lack of Coordination; Muscle Weakness; among other diagnoses. Record review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated he was not cognitively impaired. Record review of the facility's assessment for Risk of Elopement dated [DATE], [DATE], and [DATE] revealed that Resident #1 was assessed as a High risk for Wandering. Record review of the psychiatric Nurse Practitioner's assessment of Resident #1 dated [DATE] revealed: Resident is referred by staff for severe confusion, delusions, and wandering/leaving facility. The note indicated Multiple redirections required throughout visit but thoughts return to severe delusions .I cannot recommend that 1:1 observation be discontinued at this time as risk of elopement remains high. Recommendations: Add diagnosis of Vascular Dementia with Psychotic disturbance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. On [DATE] at approximately 5:44 A.M., the facility Administrator was notified by the Sheriff Department that Resident #1 had been located. 7. On [DATE] at approximately 5:51 A.M., the Administrator and Director of Nurses picked up Resident #1 at local dispatch office. 8. On [DATE] at approximately 6:00 A.M., the RN (Registered Nurse) Supervisor #1 conducted a head-to-toe body assessment on Resident #1 to review for any skin abnormalities or concerns. Resident #1 had no negative skin issues or concerns. 9. On [DATE] at about 6:00 A.M., the DON oversaw verification of all residents in facility using census. The census in the facility was 149 with 2 residents in the hospital. All 149 residents were accounted for or verified. 10. On [DATE] at approximately 6:15 A.M., Resident #1 was placed on 1:1 monitoring. 11. On [DATE] at approximately 6:15 A.M., the wander guard bracelet was verified to work properly by checking function with door alarm by DON, and then placed on Resident #1's left wrist. 12. On [DATE] at approximately 6:20 A.M., the facility staff was interviewed by the Administrator to determine the timeline of events leading up to Resident #1's exit of facility. Statements were collected. 13. On [DATE] at approximately 6:30 A.M., staff present in the facility during the time of Resident #1 exit, received immediate in-service by the DON and Administrator on the Elopement procedures, Abuse/Neglect, Vulnerable Adult Act and Rounding. 14. On [DATE] at approximately 6:40 A.M., all required state agencies were notified of Resident #1 elopement. 15. On [DATE] at approximately 7:00 A.M., Maintenance assessed Resident # 1's window. Window glass appeared intact and window stopper in place. Maintenance reassembled window and inserted additional safety mechanisms to prevent window from being disassembled in the future by Resident #1. 16. On [DATE] approximately 7:15 A.M., the LPN #1 initiated facility-based incident reporting on Resident #1. 17. On [DATE] at about 7:20 A.M., Maintenance initiated an audit of all 1st floor windows to ensure they are intact and functioning properly. All windows were intact and functioning properly. Maintenance initiated adding additional safety mechanisms to prevent window from being disassemble from frame. 18. On [DATE] at approximately 07:27 A.M., the Nurse Practitioner (NP) was notified by the RN Supervisor #1 of Resident #1 elopement and return to the facility. 19. On [DATE] at approximately 07:27 A.M., Resident #1 Responsible Party was notified by the Administrator that Resident #1 had been returned to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yazoo City Rehabilitation and Healthcare Center	925 Calhoun Avenue Yazoo City, MS 39194

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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 - Some	20. On [DATE] at approximately 08:36 A.M., licensed nurses were notified to perform acute charting on Resident #1 every shift for the next 72 hours to review resident's physical, mental, and psychosocial needs. 21. On [DATE] at 7:04 P.M., the DON completed a post Elopement incident. Resident #1 remains high risk for Elopement. 22. On [DATE] at approximately 08:21 A.M., the Social Services Director followed up on resident's psychosocial needs and will continue for the next 72 hours. 23. On [DATE] at approximately 12:00 P.M., the Social Services Director reviewed the wander and elopement binders to ensure all are reflective of results. 24. On [DATE] at approximately 12: 43 P.M., Resident #1 was assessed by Psychiatric NP. 25. On [DATE] at approximately 2:00 P.M., a Quality Assurance Committee Meeting was held with the Medical Director, Administrator, Assistant Administrator, Director of Nursing/Infection Preventionist, and the Assistant Director of Nursing to discuss Resident #1 elopement along with plan of correction. 26. On [DATE] at approximately 6:00 P.M., the Assistant Director of Nursing audited current high-risk wander patients to review orders and care plans for accuracy. There are currently six (6) wander patients. 27. On [DATE] at approximately 7:25 P.M., the RN Supervisor #2 performed an elopement drill to review and educate night shift on policies and procedures on elopement. 28. On [DATE] at approximately 11:15 P.M., the RN Supervisor # 1 performed an elopement drill to review and educate evening shift on policies and procedures on elopement. 29. The facility could not anticipate that the resident would dissemble his window and leave the facility. The facility feels like the IJ's were removed on [DATE]. The facility alleged that all activities to remove the IJ were completed on [DATE] prior to the SA entering the building on [DATE]. State Agency (SA) Validations were made onsite during the complaint investigation, CI MS #25237. On [DATE], the SA validated through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on [DATE] prior to the SA entering the building on [DATE].