STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255185	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indianola Rehabilitation and Healthcare Center	401 Highway 82 West Indianola, MS 38751

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** Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to provide adequate supervision to prevent a resident who was identified as having exit-seeking behaviors from leaving the facility unnoticed and unsupervised for one (1) of three (3) residents reviewed for wandering/elopement risk (Resident #1).On 12/30/25 around 7:30 PM Resident #1 was able to gain access to an unlocked door and exited the building and was in the courtyard area, unattended and unsupervised for an undetermined amount of time. The temperature was 34 degrees at the time between 8:00 PM and 9:00 PM when staff revealed the resident was found and brought back inside the building.The elopement placed Resident #1, as well as other residents at risk for wandering and elopement, at risk for the likelihood of serious injury, harm, impairment, or death.The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 12/8/25 when Resident #1 began exhibiting exit seeking behaviors. The State Agency (SA) notified the facility's Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 1/12/26 at 4:30 PM and provided the IJ template to the Administrator.Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) existed at 42 CFR S483.25(d)(1)(2), Free of Accident Hazards/Supervision/Devices (F689), Scope and Severity J.The facility submitted an acceptable Removal Plan on 1/14/26, alleging all corrective actions to remove the IJ were completed on 1/13/26. The SA validated the Removal Plan on 1/14/26 and determined the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for F689 was lowered from J to D while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:Review of the facility policy titled Wander Management, Monitoring System & Resident Elopement Protocol, last revised 7/1/25, revealed the stated purpose was to monitor the safety of residents at risk for elopement and provide a system to alert staff that a resident may be attempting to leave the facility. The policy further stated all staff are responsible for ensuring resident safety and providing adequate supervision to maintain the safest environment possible.Record review of the admission Record revealed Resident #1 was admitted on [DATE] with diagnoses including personal history of unspecified dementia, muscle wasting and atrophy, protein calorie malnutrition, multisystem inflammatory syndrome, and osteoarthritis. Record review of the Brief Interview for Mental Status (BIMS) dated 11/12/25 revealed a score of 3, indicating Resident #1 was severely cognitively impaired.Record review of the Wander Data Collection dated 6/24/25 revealed Resident #1 was identified as high risk for wandering. Review of the Wander Data Collection dated 11/7/25 revealed the resident was identified as low risk for wandering. Review of the Wander Data Collection dated 12/31/25 revealed the resident was again identified as high risk for wandering.Record review of the Medication Administration Record (MAR) for October 2025 revealed a physician order for a wander bracelet related to dementia and exit-seeking behaviors, initiated on 6/24/25 (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	and discontinued on 10/28/25.Record review of a Social Services Progress Note dated 12/8/25 at 10:04 AM revealed Resident #1 was agitated, sitting in the lobby doorway, yelling that he wanted to go home, tapping on the door, and required redirection by nursing staff.An interview with the Social Worker on 1/12/26 at 11:54 AM confirmed she authored the note and confirmed the resident exhibited exit-seeking behaviors. She stated additional interventions such as increased monitoring and a wandering assessment should have been implemented after the 12/08/25 incident but confirmed that increased monitoring and supervision was not put in place. She stated that on the night that the resident left the building and was outside on 12/30/25 could have been really bad and the resident could have frozen to death if not discovered.Record review of the Plan of Care (POC) Response History revealed that on 12/30/25 at 11:18 AM staff documented behavioral symptoms of wandering, marked that the resident had exhibited these behaviors previously, and documented the nurse was notified.An observation of Resident # 1 on 1/12/26 at 10:20 AM revealed resident was alert, sitting in his wheelchair propelling around the room. Resident #1 was asked if he had gone outside at night when it had been cold and he stated that he did one time can't remember when, but he wanted to meet his girlfriend. He stated he went around the yard and tried to come back in, but the door was locked. He stated he sat outside for a long time before someone opened the door. He stated he was shaking when he came back in, he was so cold.An observation of the courtyard and the exit door on 1/12/26 at 10:30 AM with the Administrator, revealed the door was secure, a code was required to open it, did not release after holding the handle down, and the entire courtyard is fenced and locked and there is a sidewalk path located in the middle of the courtyard. An interview with the Administrator on 1/12/26 at 11:30 AM revealed she was notified a little after 9:00 PM on 12/30/25 that Resident #1 had exited through the courtyard door. She instructed staff to apply a wander guard and initiate one-on-one supervision. She stated the Maintenance Director was contacted due to concerns the door's fire safety feature did not function properly and confirmed that sustained pressure on the door handle would cause the door to be released. An interview with the Director of Nursing (DON) on 1/12/26 at 11:56 AM revealed Registered Nurse (RN) #1 notified her that Resident #1 had exited the building and was returned inside. She stated she instructed staff to initiate one-on-one supervision and apply a wander guard. She confirmed she completed the incident report on 12/31/25 and did not come to the facility the night of the incident to begin an investigation.An interview with the Maintenance Director on 1/12/26 at 12:08 PM revealed he was contacted on 12/30/25 at approximately 9:13 PM and arrived at the facility at 9:53 PM. He stated sustained pressure on the door handle caused the door to release without activating the alarm. He stated he adjusted the magnet and the door functioned properly thereafter.A phone interview with Certified Nursing Assistant (CNA) #3 on 1/12/26 at 12:12 PM revealed that on 12/30/25 he was walking down the hall, happened to look out the courtyard door, and observed someone sitting outside. He stated it was unknown at the time if the individual was a resident. He immediately obtained another CNA, who identified the individual as Resident #1. They immediately brought the resident back inside. CNA #3 stated the resident was wearing a hat, shoes, and a flannel jacket, and was shivering, rubbing his hands together, and his hands appeared white or pale. He stated he did not hear any alarms sounding and confirmed it was dark outside, but the patio and courtyard lights were on.A phone interview with CNA #5 on 1/12/26 at 1:12 PM revealed she responded as staff were bringing Resident #1 back inside the building and she observed that holding the door handle down caused the door to release and open and the door did not alarm.An interview with CNA #2 on 1/12/26 at 3:10 PM revealed she was notified that Resident #1 was outside and confirmed the resident was shivering and stated that he was cold. She confirmed that she did not hear an alarm and believed the resident already had a wander (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	guard due to his frequent exit-seeking behaviors.An interview with CNA #1 on 1/12/26 at 3:18 PM revealed she was assigned to Resident #1 on the night of 12/30/25. She stated she took residents out to the smokers' courtyard at approximately 6:20 PM and the door functioned normally, requiring a code to open the door and exit into the courtyard. She stated she returned a little after 7:00 PM and Resident #1 was still watching television in the lobby. She confirmed that she later began charting and completing rounds and, at nearly 9:00 PM, went to get Resident #1 for bed and observed the staff bringing him back inside the building around 9:00 PM. She stated the resident was shivering, rubbing his hands, and stated he was going home. She confirmed that she notified the nurse immediately and maintained one-on-one supervision from 11:00 PM to 7:00 AM.An interview with CNA #6 on 1/12/26 at 3:30 PM revealed she did not hear an alarm sounding. She stated she had been in the breakroom near the courtyard exit until approximately 8:30 PM and did not observe or hear anything unusual. She confirmed the resident exit-seeks daily.An interview with Licensed Practical Nurse (LPN) #1 on 1/13/26 at 12:00 PM revealed she was assigned to Resident #1 on 12/30/25 from 7:00 AM to 3:00 PM. She confirmed the resident was always exit-seeking and required frequent redirection. She stated she assumed the resident had a wander guard in place and confirmed the resident used a wheelchair for mobility.An interview with CNA #4 on 1/13/26 at 12:13 PM revealed she was assigned to Resident #1 on 12/30/25 on the day shift and confirmed the resident exhibited daily exit-seeking behaviors, including going room to room and pushing on doors. She stated she documented the behaviors and could not recall whether additional interventions were implemented.Record review of the Incident Report dated 12/30/25 at 09:00 (PM) revealed documentation that Resident #1 exited the facility through the smokers' courtyard door. The report documented that the resident was assisted back into the facility, checked for injury, placed on one-on-one supervision, a wander guard was applied, and maintenance was contacted to check and reset the door. The report was completed by the Director of Nursing (DON). Record review of the Maintenance Director's timesheet, door audits, and maintenance request log revealed no prior documented concerns related to the courtyard door.Record review of the Vital Sign Record revealed Resident #1's vital signs, including body temperature, were not obtained until 12/31/25 at 10:50 AM.Record review of local weather data revealed temperatures ranged from 32 to 34 degrees Fahrenheit between 8:00 PM and 9:00 PM on 12/30/25.Immediate Jeopardy (IJ) Removal PlanOn 1/12/2026 at 4:20 PM, the State Agency (SA) notified the Administrator of Immediate Jeopardy (IJ). State Agency Surveyor provided the facility with the IJ templates. Facility respectfully submits this removal plan.Brief Summary of Events:On 12/30/2025 at 7:28 PM, Resident #1 exited the door leading to the facility courtyard. Resident #1 has a Brief Interview for Mental Status of 3. Resident #1 was seen by staff sitting on the patio area of the courtyard and brought back into the facility.Corrective Actions:On 12/30/2025 at 8:03 PM, Resident #1 was seen by the Certified Nursing Assistant (CNA) #3 sitting unattended in a chair on the patio of the facility located in the courtyard. He was knocking on the door trying to access the entrance back to the facility. CNA# 1 took him immediately to his room and alerted the charge nurse.On 12/30/2025 at 9:05 PM, Registered Nurse (RN) notified Director of Nursing (DON) that Resident #1 had exited the building and was found in the courtyard by CNA #3.On 12/30/2025 at 9:07 PM, DON notified the Administrator that Resident #1 exited the facility to the courtyard. DON told the Administrator that Resident #1 was back in the building. The Administrator instructed DON to have him 1:1 monitored the remainder of the night and to call the Maintenance Director to come and check the door. The administrator instructed DON that a head count of all residents needed to be done immediately.On 12/30/2025 at 9:11 PM, DON notified Maintenance to come back to facility and check the door.On 12/31/2025 at 8:15 A M, Resident #1 was assessed by nursing to no ill effects.On 12/30/2025 at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9:19 PM, DON spoke with CNA# 1. DON told CNA# 1 to stay with Resident #1 1:1 for the remainder of the night.On 12/30/2025 at 9:53 PM, Maintenance arrived in the building and found that door would open if handle was compressed longer than 10 seconds. Maintenance then adjusted bolt in door to disable the feature so that door would not open. All doors and windows checked.On 12/30/2025 at 10:13 PM, Maintenance called DON to notify her that the door had been corrected and would no longer open without code and room checks had been done and all residents were accounted for.On 12/31/2025 at 9:57 AM, Resident #1 was assessed as a wandering risk and a signaling device was placed on the right wrist of Resident #1 for monitoring. On 12/31/2025 at 10:30 AM, Social Services updated the Residents at Risk for Elopement in the Elopement Binder. Elopement Drills started 1/12/25 at 5:30 PM.On 1/12/2026 at 9:56 PM, the Administrator reported this incident to the Mississippi State Department of Health and Licensure.On 1/12/2026 at 10:00 PM, the Mississippi Attorney General's Office was notified of the incident.On 1/12/2026 at 5:30 PM, an Ad-Hoc Quality Assurance Performance Improvement (QAPI) was held to discuss this incident and findings from the State Surveyor.On 1/12/2026 at 11:00 PM, DON conducted an audit of Residents at Risk for Elopement to review wander risk care plans of those residents identified as at risk for wandering.On 1/12/2026 at 6:30 PM, in-services on Elopement, Resident's Rights, Proper Door Functioning, Abuse/Neglect/Reporting, and Notifying Staff of Observed Behaviors began for all staff. No staff will be allowed to work until Inservice has been completed.On 1/13/2026 at 10:30 AM, a revised Ad-Hoc QAPI was held to discuss this incident and findings from the State Surveyor.On 1/13/2026 at 8:30 AM, review of audit findings of Residents at Risk for Elopement was done with Administrator, DON, and ADON.Ombudsman was notified on 1/13/2026 at 12:10 PM.The facility alleges all corrective actions were completed on 1/13/26 and the IJ removed on 1/14/26.Validation:The State Agency (SA) validation of the Removal Plan was made on-site during the investigation through observations, record review and interviews on 1/14/26. The SA determined all corrective actions were completed on 1/13/26 and the IJ was removed on 1/14/26.