STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255322	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Village Terrace	725 Dunbar Ave Bay Saint Louis, MS 39520

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** 41306 Based on interviews, record review, facility policy review, and facility investigation review, the facility failed to provide adequate supervision to prevent Resident #1, who was identified as an elopement and wandering risk and had moderate cognitive impairment, from exiting the facility unnoticed and unsupervised for one (1) of four (4) residents reviewed. Resident #1 Resident #1 was observed by a therapy staff member to be in the lobby of the facility at approximately 12:00 PM on 4/6/24. The therapy staff member left the facility to pick up lunch and as she returned to the facility, she observed Resident #1 near the side of the main road, approximately 100 feet from the facility grounds at approximately 12:08 PM. The facility staff were unaware that Resident #1 had exited the facility. The facility's failure to provide supervision resulted in Resident #1's elopement and has the likelihood to result in serious harm, serious injury, serious impairment, or death for Resident #1 and all other cognitively impaired residents who leave the facility unsupervised. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 4/6/24. The SA notified the Administrator of the IJ on 4/11/24 at 4:35 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 4/6/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 4/7/24, prior to the SA's entrance on 4/11/24. Findings include: A review of the facility's, Missing Resident Policy, dated 5/2018, revealed the facility had a process in place regarding missing residents. A record review of the Admission Record revealed the facility admitted Resident #1 on 3/24/23 with current diagnoses including Dementia. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date of 3/13/24 revealed Resident #1 required a staff interview to asses her cognition and her cognitive skills for daily decision making was moderately impaired. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Investigative Report, dated 4/8/24, revealed on 4/6/24 at 12:00 PM, Resident #1 left the facility unwitnessed with a wander guard (device worn by a resident to trigger an alarm near exit doors) on and was found approximately 100 feet off campus by Certified Occupational Therapist Assistant (COTA) and Certified Nurse Assistant (CNA) #1. The resident had been having exiting behavior earlier that day and was redirected. Upon leaving the facility, the COTA noticed the resident was engaging in conversation in the front room of the facility. She drove to a local restaurant to pick up her lunch and upon her return CNA #1 was looking for Resident #1 in the front room. The COTA asked CNA #1 if Resident #1 was their resident and pointed in the direction of the resident. CNA #1 retrieved Resident #1 and brought her back to the facility. The resident was dressed in pants, a top, an overcoat, a hat, and slip-on shoes, and the weather was 71 degrees and sunny. Record review of the local weather history revealed on 4/6/24 at 11:53 AM, the temperature was 71 degrees Fahrenheit and the weather conditions were fair. During an interview on 4/11/24 at 12:33 PM, CNA #1 confirmed Resident #1 was approximately 100 feet from the facility grounds, sitting on the lawn next to the street. CNA #1 stated on 4/6/24, she last observed Resident #1 at approximately 11:45 AM while she was passing out lunch trays to the residents. CNA #1 reported that at approximately 12:08 PM she went to look for Resident #1 when the COTA entered the facility and asked if the lady wearing the white hat was the facility's resident. CNA #1 immediately ran towards the resident to bring her back to the facility and reported the incident to the Director of Nurses (DON). On 4/11/24 at 12:50 PM, during an interview with CNA #1 and observation of the route from the front door of the facility to the location where Resident #1 was located, there was an incline from the front door down to the parking lot. The parking lot was paved to the roadway, but there were no sidewalks beside the roadway. The grass was short, and the ground was even. CNA #1 pointed out the cement slab where Resident #1 was sitting. The cement slab was slightly raised from the ground, approximately six (6) inches high and was within five (5) feet of the main roadway, across from a residential driveway. In the area behind the cement slab where she was sitting, there was a steep embankment. The traffic was light with one (1) car observed passing by on the roadway at the time of the observation. The resident was located approximately 220 yards from the front door and approximately 50 yards down the road from the facility grounds. On 4/11/24 at 1:15 PM, during an interview with the Director of Nurses (DON), she confirmed on 4/6/24 after lunch, CNA #1 informed her of finding Resident #1 outside the facility. The DON was at the facility and immediately assessed the resident and notified the Administrator. The DON stated she found no physical injuries and no psychosocial harm when she assessed Resident #1. The facility began their investigation and reported the event to the required agencies. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/11/24 at 2:22 PM, during an interview with the Maintenance Director, she stated she had been informed Resident #1 had exited the building on 4/6/24 while she was wearing a wander guard device. She came to the facility on [DATE] to check the door alarms and wander guard devices and did not find an issue. The Maintenance Director stated she routinely checked both exit doors two times daily, and checked the wander guards to ensure the alarms were functioning properly. She explained the housekeeping staff were responsible for checking the doors on weekends. The door alarm vendor came to the facility on [DATE] and determined there was radio static interference (service interruptions caused by external radio waves or electrical activity). Prior to the elopement, the doors at the front entrance were not locked, but now the doors are locked, and a code must be entered in the keypad to open the doors. On 4/11/24 at 3:00 PM, during an observation and interview, Resident #1 was ambulating in the hallway with a fast-paced and steady gait. She was unable to recall anything that occurred on 4/6/24 when she left the facility, and she was unable to recall how or why she exited the facility. During a phone interview on 4/11/24 at 4:00 PM, with the COTA, she confirmed on 4/6/24 she was at work at the facility. She explained that she worked part-time and did not know all the residents at the facility. On 4/6/24 at 12:00 PM, she noticed a person in the front lobby wearing a white hat. The COTA left the facility and went through a drive through at a local sandwich shop to pick up her order. On the way back to the facility, at approximately 12:08 PM, she noticed the same woman, wearing a white hat, sitting on the ground on a sidewalk on the side of the road. The COTA walked into the facility and asked CNA #1 if the person sitting on the side of the road was a resident and informed her where she was sitting. CNA #1 immediately ran to Resident #1 and brought her back to the facility. On 4/11/24 at 4:15 PM, during an interview with the Administrator, she confirmed on 4/6/24 at approximately 12:00 PM, the COTA, who worked part-time at the facility was not knowledgeable of all the residents. The COTA happened to notice Resident #1 because of her white hat in the front room before going to a local restaurant to get lunch. Upon her return, she observed Resident #1 sitting on a sidewalk about 100 feet from the facility grounds, but since she was not aware she was a resident, she did not stop. She informed CNA #1 and questioned if Resident #1 was the facility's resident, and pointed to the direction of where she was sitting. CNA #1 immediately ran to her and brought her back to the facility. The DON was present in the facility at that time and immediately assessed the resident for injuries, of which she had none. The Administrator confirmed Resident #1 was a wandering risk and was wearing a wander guard device. The Administrator was notified of the incident, came to the facility, and reported to the required agencies within two (2) hours of the incident. The facility began the investigation, which they felt was a faulty wire of the wander guard system since the system worked when tested . The facility submitted a corrective action plan as follows: 1. On April 11, 2024, the Administrator (ADM) and Director of Nurses (DON) were notified of an immediate jeopardy for F689 for failure to provide supervision to prevent an elopement for Resident #1 who was identified as an elopement and wandering risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On April 6, 2024, when Resident #1 was retrieved and re-entered the building at approximately 12:08pm, she was immediately assessed by the DON. A body audit was completed with no injury noted. Resident was interviewed by the DON. The DON verified that her wander guard was properly placed and functioning. 3. Resident #1 was immediately placed on alert charting by the DON on 4/6/2024 to identify location every hour. 4. The DON immediately notified the ADM of the elopement on 4/6/2024 by 12:20pm. The DON then notified the responsible party of the resident and the Medical Director by 12:30pm. The ADM notified the Maintenance Director 1:00pm. 5. The ADM notified the State Agency on 4/6/2024 by 2:00pm 6. The ADM notified the Attorney General on 4/6/2024 4:00pm. 7. On 4/6/2024, all residents were checked and accounted for in the building by the Certified Nursing Assistants (CNAs) and reported to the ADM. Staff was interviewed by the DON and the ADM to determine if any resident was exit seeking that had not already been identified. None were identified. 8. The DON and ADM began investigation and collection of statements from all staff present on 4/6/2024. 9. All residents with wander guards were checked for proper placement and function by the Licensed Practical Nurse (LPN) Supervisor on 4/6/2024. All were found to be properly placed and functioning. 10. All exit doors and alarms were checked for proper functioning by the Maintenance Technician on 4/6/2024 by 1:15pm. 11. Vendor #1, the door alarm provider, was called by the Maintenance Director on 4/6/2024 to schedule an onsite visit. 12. The ADM began a 24-hour door monitoring schedule on 4/6/2024 until Vendor #1 could conduct an on-site visit. 13. The notice to visitors on the door was revised by the ADM to be bigger and brighter instructing to not let any resident out of the door without notifying staff on 4/6/2024. 14. ADM began inservicing all staff on the Missing Resident policy and the Safe Guarding the Wandering Resident policy on 4/6/2024. Staff to be inserviced before returning to work. 15. The plan of care of Resident #1 was updated to reflect the elopement by the Registered Nurse on 4/6/2024. 16. All tasks in the electronic healthcare record of residents with wanderguards were updated by the LPN Supervisor on 4/6/2024 to include the task of the Certified Nursing Assistant to check the proper placement of the wanderguard every shift. On 4/6/2024 the CNAs began to be inserviced on this by the LPN Supervisor. Staff to be inserviced before returning to work. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	17. The Elopement Risk Evaluation began being updated on all residents on 4/6/2024 by the nurse supervisors. No new residents with risk of elopement were identified. 18. The Elopement Risk Binder was created for all residents with wanderguards to include their picture, name, date of birth and medical record number by the LPN Supervisor on 4/6/2024. The staff was inserviced on these binders and their location at each nurse desk beginning 4/6/2024. Staff to be inserviced before returning to work. 19. All nurses were inserviced and completed a competency check-off on how to test a transmitter (wanderguard) every shift as indicated on the Medication Administration Record (MAR) beginning 4/6/2024 by the LPN Supervisor. Staff to be inserviced before returning to work. 20. Daily Stand Up Agenda in which all staff attends on two shifts was updated by the ADM on 4/6/2024 to include identifying what residents have wanderguards. Note that the agenda previously included to identify any doors/alarms not working properly and any elder who is at risk for elopement. 21. On 4/7/2024, Vendor #1 serviced the door and installed keypads in which the door remains locked. A code is required in order to enter and exit the door. 22. Quality Assurance and Performance Improvement (QAPI) committee met on 4/6/2024 that included the Administrator, Director of Nurses, Medical Director, RN Consultants, Infection Preventionist, LPN Supervisor, Maintenance Director, President/Co-Owner, and Chief Operating Officer to discuss the elopement of Resident #1 and updating the plan of care. Reviewed the Missing Resident policy. No recommendations for changes were made. 23. QAPI committee met again on 4/10/2024 to include Administrator, Director of Nurses, RN Consultant, Nurse Practitioner, Social Service Director, LPN Supervisor, Maintenance Director, Activities Director, Admissions Coordinator, Administrative Assistant, and Infection Preventionist as a follow up to ensure all interventions that were put in place were effective. No concerns were noted. All findings will be discussed at the monthly Quality Assessment and Assurance (QAA) meeting for a minimum of three months or until the compliance is maintained. 24. The Elopement Risk Evaluation is to be completed by the Registered Nurse (RN) Supervisor on all new residents upon admission and quarterly thereafter beginning 4/6/2024. 25. Beginning 4/6/24, visual checks to be initiated for all residents by the medication cart nurse for the first 72 hours upon admission and a wanderguard to be placed if deemed necessary. 26. Missing Resident and Safeguarding the Wandering Resident policies continue to be inserviced upon hire and quarterly thereafter. Monitoring to be completed as follows: Elopement Drill to continue to be completed quarterly. The wanderguard audit will continue to be completed monthly by LPN supervisor. Maintenance Director/Housekeeping to continue with daily door checks 2x/day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wanderguard proper placement and functioning to be checked every shift on the MAR. The Village alleges that all corrective actions were completed by April 6, 2024, and the Immediate Jeopardy is removed as of 4/7/2024. The SA validated the corrective action plan: On 4/12/24, the SA validated through interview and record review, on April 11, 2024, the Administrator (ADM) and Director of Nurses (DON) were notified of an immediate jeopardy for F689 for failure to provide supervision to prevent an elopement for Resident #1 who was identified as an elopement and wandering risk. On 4/12/24, SA validated through interview and record review, on April 6, 2024, when Resident #1 was retrieved and re-entered the building at approximately 12:08pm, she was immediately assessed by the DON. A body audit was completed with no injuries noted. Resident was interviewed by the DON. The DON verified that her wander guard was properly placed and functioning. On 4/12/24, the SA validated through interview and record review Resident #1 was immediately placed on alert charting by the DON on 4/6/2024 to identify location every hour. On 4/12/24, the SA validated through interview and record review the DON immediately notified the ADM of the elopement on 4/6/2024 by 12:20pm. The DON then notified the responsible party of the resident and the Medical Director by 12:30pm. The ADM notified the Maintenance Director at 1:00pm. On 4/12/24, the SA validated through interview and record review the ADM notified the State Agency on 4/6/2024 by 2:00pm. On 4/12/24, the SA validated through interview and record review the ADM notified the Attorney General on 4/6/2024 4:00pm. On 4/12/24, the SA validated through interview and record review on 4/6/2024, all residents were checked and accounted for in the building by the Certified Nursing Assistants (CNAs) and reported to the ADM. Staff was interviewed by the DON and the ADM to determine if any resident was exit seeking that had not already been identified. None were identified. On 4/12/24, the SA validated through interview and record review the DON and ADM began investigation and collection of statements from all staff present on 4/6/2024. On 4/12/24, the SA validated through interview and record review all residents with wander guards were checked for proper placement and function by the Licensed Practical Nurse (LPN) Supervisor on 4/6/2024. All were found to be properly placed and functioning. On 4/12/24, the SA validated through interview and record review all exit doors and alarms were checked for proper functioning by the Maintenance Technician on 4/6/2024 by 1:15pm. On 4/12/24, the SA validated through interview and record review that Vendor #1, the door alarm provider, was called by the Maintenance Director on 4/6/2024 to schedule an onsite visit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/12/24, SA validated through interview and record review the ADM began a 24-hour door monitoring schedule on 4/6/2024 until Vendor #1 could conduct an on-site visit. On 4/12/24, SA validated through interview and record review The notice to visitors on the door was revised by the ADM to be bigger and brighter instructing to not let any resident out of the door without notifying staff on 4/6/2024. On 4/12/24, SA validated through interview and record review ADM began inservicing all staff on the Missing Resident policy and the Safe Guarding the Wandering Resident policy on 4/6/2024. Staff to be inserviced before returning to work. On 4/12/24, the SA validated through interview and record review the plan of care of Resident #1 was updated to reflect the elopement by the Registered Nurse on 4/6/2024. On 4/12/24, the SA validated through interview and record review all tasks in the electronic healthcare record of residents with wander guards were updated by the LPN Supervisor on 4/6/2024 to include the task of the Certified Nursing Assistant to check the proper placement of the wander guard every shift. On 4/6/2024 the CNAs began to be in-serviced on this by the LPN Supervisor. Staff to be in-serviced before returning to work. On 4/12/24, the SA validated through interview and record review the Elopement Risk Evaluation began being updated on all residents on 4/6/2024 by the nurse supervisors. No new residents with risk of elopement were identified. On 4/12/24, the SA validated through interview and record review the Elopement Risk Binder was created for all residents with wander guards to include their picture, name, date of birth and medical record number by the LPN Supervisor on 4/6/2024. The staff was in-serviced on these binders and their location at each nurse desk beginning 4/6/2024. Staff to be in-serviced before returning to work. On 4/12/24, the SA validated through interview and record review all nurses were in-serviced and completed a competency check-off on how to test a transmitter (wander guard) every shift as indicated on the Medication Administration Record (MAR) beginning 4/6/2024 by the LPN Supervisor. Staff to be in-serviced before returning to work. On 4/12/24, the SA validated through interview and record review Daily Stand-Up Agenda in which all staff attends on two shifts was updated by the ADM on 4/6/2024 to include identifying what residents have wander guards. Note that the agenda previously included to identify any doors/alarms not working properly and any Elder who is at risk for elopement. On 4/12/24, the SA validated through interview and record review on 4/7/2024, Vendor #1 serviced the door and installed keypads in which the door remains locked. A code is required to enter and exit the door. On 4/12/24, the SA validated through interview and record review Quality Assurance and Performance Improvement (QAPI) committee met on 4/6/2024 that included the Administrator, Director of Nurses, Medical Director, RN Consultants, Infection Preventionist, LPN Supervisor, Maintenance Director, President/Co-Owner, and Chief Operating Officer to discuss the elopement of Resident #1 and updating the plan of care. Reviewed the Missing Resident policy. No recommendations for changes were made. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/12/24, the SA validated through interview and record review QAPI committee met again on 4/10/2024 to include Administrator, Director of Nurses, RN Consultant, Nurse Practitioner, Social Service Director, LPN Supervisor, Maintenance Director, Activities Director, Admissions Coordinator, Administrative Assistant, and Infection Preventionist as a follow up to ensure all interventions that were put in place were effective. No concerns were noted. All findings will be discussed at the monthly Quality Assessment and Assurance (QAA) meeting for a minimum of three months or until compliance is maintained. On 4/12/24, the SA validated through interview and record review the Elopement Risk Evaluation is to be completed by the Registered Nurse (RN) Supervisor on all new residents upon admission and quarterly thereafter beginning 4/6/2024. Beginning 4/6/24, visual checks to be initiated for all residents by the medication cart nurse for the first 72 hours upon admission and a wander guard to be placed if deemed necessary. On 4/12/24, the SA validated through interview and record review Missing Resident and Safeguarding the Wandering Resident policies continue to be in-serviced upon hire and quarterly thereafter. On 4/12/24, the SA validated through interview and record review Monitoring to be completed as follows: Elopement Drill to continue to be completed quarterly. The wander guard audit will continue to be completed monthly by LPN supervisor. Maintenance Director/Housekeeping to continue with daily door checks 2x/day. Wander guard proper placement and functioning to be checked every shift on the MAR. All corrective actions were completed by 4/6/24, and the Immediate Jeopardy was removed as of 4/7/2024.