

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Lauderdale Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Lackey Lane Ripley, TN 38063	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, facility investigation review, timeanddate.com weather website review, police report review, observation, and interview, the facility failed to provide adequate supervision to ensure the resident environment was free of accident hazards for 1 of 3 (Resident #1) residents reviewed with wandering/exit seeking behaviors. On 2/9/2025 between 7:00 PM and 7:20 PM, Resident #1, a vulnerable resident with Dementia, who experienced hallucinations, exit seeking behaviors and was cognitively impaired, eloped through an unlocked and unsecured door that malfunctioned on C Hall. Resident #1 exited the facility, left his wheelchair at the door, went down a steep embankment, and was found on the ground at the driveway entrance, beside a two-way street, and sustained head injuries that required hospital transfer and evaluation in the local Emergency Department (ED). The temperature outside on 2/9/2025, between 7:00 PM and 7:20 PM, was 37 degrees Fahrenheit. Resident #1 was observed, lying on the ground beside the road by an unknown passerby who called 911. The facility staff was not aware Resident #1 had exited the building. The police department contacted the facility and reported Resident #1 was lying on the ground, down a steep embankment at the end of the facility drive (that was approximately 110 yards from the facility), by the roadside. The facility's failure resulted in Immediate Jeopardy for Resident #1.</p> <p>Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>A partial extended survey was conducted on 4/29/2025 through 4/30/2025.</p> <p>The Administrator was notified of the Immediate Jeopardy (IJ) on 4/29/2025 at 10:20 AM, in the private dining room.</p> <p>The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J, which is Substandard Quality of Care.</p> <p>The IJ began 2/9/2025 through 4/29/2025. The Immediate Jeopardy was removed on 4/30/2025 when the facility implemented a corrective action plan. The corrective actions were validated onsite by the surveyor on 4/30/2025.</p> <p>The facility is required to submit a plan of correction.</p> <p>The findings include:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Review of the undated facility policy titled, Emergency Procedure-Missing Resident, revealed .Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety .</p> <p>Review of the undated facility policy titled, Accidents and Incidents-Investigating and Reporting, revealed . Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities .</p> <p>2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, Hallucinations, Depression, and Anxiety.</p> <p>Review of the Comprehensive Care Plan dated 9/23/2024, revealed Resident #1 was at risk for elopement related to severe confusion, was mobile with a wheelchair and able to walk, and had a history of trying to open exit doors to facility, especially when looking for spouse. The goal listed for Resident #1 was will not leave facility unattended.</p> <p>Review of the Wander Evaluation assessment dated [DATE], revealed Resident #1 was a wandering/elopement risk as a result of being cognitively impaired, had poor decision-making skills, could ambulate with and without assistive device (wheelchair), and frequently looked for his spouse.</p> <p>Review of a Progress Note dated 12/28/2024 at 5:29 AM, revealed . [Resident #1] has been up all night, actively attempting to open doors .voices concerns about his wife's illness .resident also told this nurse that someone came into his room and put glue on his head .</p> <p>Review of the Significant Change Minimum Data Set (MDS) dated [DATE], revealed Resident #1's Brief Interview for Mental Status (BIMS) score of 7 indicated severe cognitive impairment. Further review of the MDS revealed Resident #1 experienced hallucinations and delusions, independently propelled a wheelchair for mobility, and required supervision and/or assistance with all aspects of personal care. Wandering behavior was not identified on the MDS assessment, although the medical record revealed Resident #1 exhibited wandering and exit seeking behavior.</p> <p>Review of a progress note dated 2/9/2025 at 10:13 PM, revealed .At 1925 [7:25 PM] a .police officer alerted the 6p-6a [6:00 PM - 6:00 AM] staff that they had observed [Resident #1] at the entrance drive at the front of the facility and that he [Resident #1] had fallen and injured the back of his head, this resident eloped from facility through the exit door at the end of C-Hall, staff was unaware that this client was missing from the facility due to clinical staff observing him wandering on A-Hall and ambulating without his w/c [wheelchair], it was noted that the door alarm did not function properly at the time of this [resident]'s elopement therefore clinical staff was not alerted to resident elopement from the facility .</p> <p>Review of a body audit assessment dated [DATE] at 11:55 PM, revealed an abrasion to back of head with small amount of blood oozing (bleeding).</p> <p>3. Review of the weather history for [NAME], TN on 2/9/2025 at approximately 7:20 PM, according to timeanddate.com weather website, the temperature outside was 37 degrees Fahrenheit.</p> <p>4. Review of the facility investigation dated 2/9/2025, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Review of the facility incident report dated 2/9/2025 at 7:30 PM, by LPN A revealed .Police notified clinical staff .[Resident #1] lying on the ground at the entrance driveway, at the front of the facility and he [Resident #1] had fallen and injured the back of his head, this nurse observed .police, fire and rescue, and ambulance . [Resident #1] was .transferred to the hospital .after checking all the doors and windows in the facility, staff had found that [Resident #1] had eloped out of the exit door on C-Hall and through the gate leading to the property at the front of the facility, the alarm for the exit door on the C-Hall was not functioning and gave no alert to staff that the exit door had been breached .Injuries observed at time of incident .</p> <p>b. A signed, written statement dated 2/9/2025, by Certified Nursing Assistant (CNA) B revealed, .Me [CNA B] and [named CNA C] found that [Named Resident #1] got out on C Hall. The doors on C Hall was [were] open and the [door] codes was [were] not working we went out the doors to find that the gate was wide open and that's how he [Resident #1] got out. No alarm went off to let us know the door had came [come] open .</p> <p>c. A signed, written statement dated 2/9/2025, by CNA C revealed, .I heard a knock on the front door it was the police they asked me do we [facility] have a [named Resident #1], I say [said] yes, [police officer] told me that [Resident #1] had fell [fallen] outside and he finna [fixing to] go to the hospital so I ran and found [named Licensed Practical Nurse (LPN) A].</p> <p>d. A signed, written statement dated 2/9/2025, by LPN A revealed, .At 1930 [7:30 PM], [named CNA C] alerted this nurse that the police need to speak [with] this nurse regarding a [Resident #1]. Upon speaking [with] the police officer it was apparent that [named Resident #1] had somehow eloped from the facility with his w/c [wheelchair] and made it to the end of the facility driveway in front of the building before falling and injuring himself .This nurse observed police, fire and rescue, and EMT[Emergency Medical Technician]/ambulance on [named street] in front of the facility. The police officer stated that [Resident #1] was being .transferred to the hospital in [relation to] .striking and injuring the back of his head upon falling to the ground .[Resident #1] had pushed the Exit Doors open at the end of C-Hall, pushed the double gate open at the front of the facility, and made his way down the hill to the parking lot entrance .</p> <p>e. A signed, written statement dated 2/9/2025, by the former Maintenance Director revealed, .I got here at 8:00 PM [on 2/9/2025]. I checked the door on C Hall and one door was open so I shut the door .</p> <p>f. Review of the hospital medical record dated 2/9/2025 at 8:00 PM, revealed Resident #1 was evaluated in the ED for head injuries sustained during the fall. A Computerized Tomography Scan report (CT scan/CAT scan provides detailed images inside of the body) of the head dated 2/9/2025 at 10:12 PM, revealed posterior scalp (back of the head) swelling and a laceration (open area of the skin). The hospital Discharge summary dated [DATE], revealed Resident #1 was diagnosed with head trauma, contusions (bruising) and abrasions (scrape, graze or superficial injury) sustained during the fall.</p> <p>g. Review of an e-mail correspondence dated 2/10/2025 at 9:07 AM, written by the Administrator to the Ombudsmen revealed, .I wanted to inform you that [Resident #1] exited the facility and made it to the end of the driveway. [Resident #1] was taken to the hospital .</p> <p>h. Review of the Ad Hoc (special) QAPI (Quality Assurance and Performance Improvement) meeting minutes dated 2/10/2025, revealed .Maintenance has identified a defect in door closure .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 4/29/2025 beginning at 1:45 PM, the Regional Director of Maintenance (RDM) measured the distance from the exterior C Hall door, down a steep embankment to the estimated location Resident #1 was found on the ground at the end of the drive near the two-way street. The distance was approximately 110 yards (330 feet). The RDM stated the keypad code to all exterior doors had been reset.</p> <p>During an interview on 4/30/2025 at 3:04 PM, CNA C verified his/her signed written statement dated 2/9/2025. CNA C stated Resident #1 would sometimes leave the facility with family members and would frequently be difficult to redirect upon return to the facility. CNA C stated the C Hall door was open and no alarm had sounded when Resident #1 exited the facility on 2/9/2025.</p> <p>Attempts to interview LPN A and CNA B by phone during the survey were unsuccessful.</p> <p>An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F689 was received on 4/29/2025 and validated onsite by the surveyor on 4/30/2025 through observation of exterior doors including keypad enabling exterior doors to open and staff interview. The Removal Plan included the following:</p> <p>On April 29, 2025, at 10:30 PM, the State Agency informed the Administrator that the facility had failed to provide adequate supervision to prevent the elopement of Resident#1, a vulnerable individual who exited the facility unnoticed and without supervision.</p> <p>On February 9, 2025, at 7:30 PM, facility staff were notified by local law enforcement that the residents (resident) were (was) not present in the building. The resident had been transported to the emergency room.</p> <p>1. On February 9, 2025, at 7:28 PM, missing resident procedures were initiated, and all residents were accounted for.</p> <p>2. On February 9, 2025, the LPN notified both the Director of Nursing and the Administrator. The Administrator instructed the LPN to contact the Maintenance Supervisor and directed that a CNA be stationed at the door until maintenance arrived. The LPN also attempted to contact the resident's next of kin; however, the call went to voicemail. The resident had a BIMS score of 0, indicating severe cognitive impairment.</p> <p>3. On February 9, 2025, at 7:50 PM, the Maintenance Supervisor arrived at the facility. He inspected all exit doors to ensure proper functionality. A CNA remained Stationed at the door until the necessary repairs were completed.</p> <p>4. On February 9, 2025, the Director of Nursing informed the resident's physician to provide an update on the status of the missing resident. The Administrator also sent an email to the Ombudsman regarding the situation.</p> <p>5. An in-service training on elopement procedures was conducted. The elopement book and care plans were audited and reviewed. Additionally, a visual check every hour was implemented for all residents identified as at risk for elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6. A Quality Assurance and Performance Improvement (QAPI) committee meeting was held to review the incident involving Resident #1.</p> <p>QAPI minutes included:</p> <p>The QAPI committee reviewed the incident, the actions taken, and the existing policy. After careful consideration, no recommendations for changes were made.</p> <p>The care team conducted a 100% (percent) audit of the care plans for all residents identified as being at risk for elopement.</p> <p>The Maintenance Supervisor conducted elopement drills across all shifts on 2-9-25 (2025).</p> <p>Correction:</p> <p>This practice of elopement drills will continue under the oversight of the Director of Nursing or Administrator for the next four weeks, with the results presented at each monthly QAPI committee meeting for review and recommendations. Any identified issues will be promptly addressed by the Administrator.</p> <p>The Maintenance Supervisor has contacted the State system regarding concerns with the exit doors, and the necessary repairs have been completed.</p> <p>All doors will be logged daily, including documentation of door openings and alarm activity, for a period of four weeks. The logging frequency will then transition to twice weekly for two weeks, and subsequently to once monthly for three months. If any additional issues are identified during this period, the matter will be brought to the QAPI committee for review, and daily checks will be reinstated as necessary.</p> <p>Maintenance has begun replacing all window alarms. A log will be maintained and reviewed weekly for four weeks, then biweekly for two weeks, and subsequently monthly for three months to ensure proper functionality. If any additional issues are identified during this period, the matter will be brought to the QAPI committee for review, and daily checks will be reinstated as necessary.</p> <p>In-service training has been initiated to address procedures for emergencies and resident relocations. The training emphasizes that, in the event of a fire, all emergency exit doors will be released and opened to ensure the safety of both residents and staff.</p> <p>Subject: Plan of Correction and Follow-Up Regarding Immediate Jeopardy Removal and Elopement Incident</p> <p>1. Date of Immediacy Removal</p> <p>The facility alleges that the immediacy has been removed as of April 29, 2025,</p> <p>2. Door Codes and Keypads Audit</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An audit of all door codes and keypad systems was completed on April 29, 2025, by the current Maintenance Director. All keypads were reset to factory default, recommended with a new master code, and assigned a universal code. The Maintenance Director tested each keypad multiple times to confirm full operability.</p> <p>3. Staff Inservice Training</p> <p>Inservice's were conducted for all facility staff by the Director of Nursing and the Regional Nurse Consultant, training included all departments and all shifts, including evening staff. Staff verbalized understanding and demonstrated competence in the major use of secured (security) systems and elopement prevention protocols. An elopement drill was conducted on April 29, 2025, at 6:00 PM.</p> <p>4. Regional Oversight and Audit</p> <p>On April 29, 2025, Regional Oversight performed a comprehensive follow-up audit of the facility's doors and windows, including a walkthrough with the Life Safety Surveyor. The audit confirmed that all systems were compliant and functioning properly.</p> <p>5. Emergency Egress Protocol Education</p> <p>Staff education on emergency egress protocols was conducted by the Maintenance Director and Regional Nurse Consultant on April 29, 2025. All staff, including those on the evening shift, were trained. Understanding was verified through staff verbal feedback and real-time demonstration.</p> <p>6. Window Alarms System Audit</p> <p>A full audit of window alarms was conducted on April 29, 2025, by the Maintenance Director and Regional Maintenance Director. The audit included testing each alarm to confirm activation when windows were raised, replacing batteries as necessary, and ensuring all units were in the on position.</p> <p>7. Ongoing Compliance Monitoring</p> <p>Daily monitoring is now in place for all residents identified as being at risk for elopement. Clinical staff are responsible for daily risk assessments and documentation. Additionally, all secured doors will be inspected daily, with any discrepancies reported and addressed through the facility's QA PI (Quality Assurance Performance Improvement) process.</p> <p>8. Third-Party Verification and Resident Care Plan Review</p> <p>Third-party verification was completed on April 29, 2025, by the Life Safety Surveyor. The fire monitoring service has been contacted for an additional full-door inspection. All residents with known elopement or wandering behaviors are undergoing additional nursing assessments. 100 (percent) of their care plans have been reviewed, with no new interventions noted at this time.</p> <p>We trust these comprehensive actions demonstrate our commitment to resident safety and regulatory compliance. Please do not hesitate to contact us with any further questions or requests for documentation.</p> <p>(continued on next page)</p>		

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