STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195388	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY NURSING AND REHABILITATION OF FRANKLIN	**1907 CHINABERRY STREET FRANKLIN, LA 70538**

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 -** Minimal harm or potential for actual harm **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 interview and record review, the facility failed to ensure a resident did not elope by failing to have a window alarm and/or increase supervision on a resident identified as having a history of eloping from the facility through a window. This deficient practice was identified for 1 of 5 sampled residents (Resident #1), but had the potential to affect any of the 12 residents identified as being wanderers as documented on the facility's list of wanderers. Findings: Review of Resident #1's Elopement/Wandering Risk (MDS) data set [DATE], revealed he was assessed as being at risk for elopement. Review of Resident #1's current Care Plan revealed in part, a problem onset date of 09/01/2016, where Resident #1 was severely cognitively impaired and was identified as being an elopement risk. Further review revealed Resident #1 had climbed out of the window on 03/23/2018, and had eloped from the secure unit on 03/19/2019. Resident #1's Care Plan also revealed Resident #1's whereabouts were to be monitored every 2 hours. In interview on 06/19/2020 at 12:25pm, S1Director of Nursing (DON) indicated Resident #1 exit seeks all day long. In interview on 06/22/2020 at 9:48am, S2Licensed Practical Nurse (LPN), indicated Resident #1's usual routine was always walking around and exit seeking. Review of Resident #1's Departmental Notes dated 05/26/2020, revealed in part, Resident #1 was moved to a room off of the secure unit; therefore, a wanderguard bracelet was placed on his ankle. In interview on 06/19/2020 at 11:02am, S1DON indicated Resident #1 was transferred from the secure unit on 05/26/2020 because the secure unit had to be terminally cleaned. Resident #1 was transferred to a room off of the secure unit with other residents in the general population. S1DON further indicated Resident #1 got out of the hall where his new room was located once, so Resident #1 was transferred to another room on 05/27/2020 which was not located on the secure unit. S1DON further indicated Resident #1 was not on 1:1 supervision, and remained on checks every two hours. Review of Resident #1's Departmental Notes dated 05/31/2020 revealed, in part, at around 4:20pm, Resident #1's nurse discovered Resident #1 was not in his room, and could not be located in the facility. Further review revealed the nurse noted Resident #1's room window was up, the window blind was down, the window screen was torn, and appeared that the screen was taken off and replaced in the window. Further review revealed a chair was observed by the outside fence/gate. Further review revealed staff found Resident #1 walking on a road, returned to the facility around 4:40pm, and had no injuries. Review of the facility's incident investigation for Resident #1's 05/31/2020 elopement revealed, in part, that Resident #1 had eloped from his window, used a chair to climb over a six foot fence, and walked to a road located less than 200 feet from the facility. In interview on 06/19/2020 at 12:21pm, S1DON indicated all the windows on the secure unit have alarms, but the window that Resident #1 eloped from did not have an alarm because the room was not part of the locked unit. In interview on 06/23/2020 at 12:42pm, S1DON indicated Resident #1 was moved to a second roomd located off of the secured unit because he kept trying to elope, but they did not increase supervision or put an alarm on his window, because she never thought Resident #1 would elope through the window and jump over a six foot fence.

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

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.