STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255114	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND NURSING AND REHABILITATION CENTER	**4036 HIGHWAY 8 EAST CLEVELAND, MS 38732**

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 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The State Agency (SA) conducted a Complaint Survey for CI MS # on 07/08/2020 through 07/09/2020 and substantiated CI MS # related to an elopement, when the facility failed to provide adequate supervision to prevent Resident #1's elopement from the facility on 06/14/2020 at approximately 3:00 AM to 3:10 AM. Resident #1 was missing, unsupervised and away from the facility for approximately 20 to 35 minutes. The facility staff was not aware of Resident #1's absence until he was discovered in the parking lot of a local business by a store employee, who notified the facility of Resident #1's whereabouts at 3:30 AM. Resident #1 was returned to the facility at 3:45 AM by the Sheriff's Department. Resident #1 was assessed for any signs and symptoms of injury and pain, which was negative. Resident #1 was found fully clothed. The facility's immediate investigation revealed Resident #1 stated he had pulled the wanderguard wiring on the kitchen exit door and exited from there, but the investigation found it was the dining room door Resident #1 pulled the wiring and therefore not allowing the door to alarm. Resident #1 was placed on one to one (1:1) supervision from the time of his return until 1:00 PM on 6/14/2020 when he was transferred to a behavioral facility. The facility failed to develop and implement a care plan for Resident #1 to prevent the possibility of elopement. Resident #1 was identified by the facility on his admission, 09/15/2017 for wandering behavior. A wanderguard was used for a time due to his wandering and pacing behavior day and night, exit seeking behavior and pushing on doors. The Interdisciplinary Team (IDT) determined Resident #1 was no longer an elopement risk on 03/12/2019 because he no longer was exhibiting exit seeking behavior or pushing on doors. However, Resident #1 did continue the wandering and pacing day and night. The wandering and pacing behavior day and night was confirmed by staff interviews. Resident #1's Care Plan, dated 10/09/2017, identified Resident #1's wandering behavior, but did not address how the staff was to monitor him to prevent the possibility of elopement. During the survey, the SA identified an Immediate Jeopardy (IJ) on 07/08/20, which occurred on 06/14/2020 and existed at: 42 CFR(s): 483.21(d)(1)(2)-Develop/Implement Comprehensive Care Plan (F656). The facility's failure to implement and develop a comprehensive care plan, for Resident #1 with a history of elopement risk and current wandering behavior, placed this resident and other residents who are an elopement risk and/or exhibited wandering behavior to a likely cause of serious injury, harm, impairment or death. Based on the facility's implementation of corrective actions on 06/14/2020, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed as of 06/15/2020, prior to the SA's first entrance on 07/08/2020. The SA notified the facility's Administrator of the PNC IJ 07/08/2020 at 3:30 PM. At the time of the survey, the facility had a census of 113, and held a license of 120 beds. Based on record review, staff and resident interview and facility policy review, the facility failed to develop and implement a Comprehensive Care Plan to provide Resident #1 with adequate staff supervision to prevent an elopement from the facility, for one (1) of four (4) residents reviewed for elopement risk, Resident #1. Findings include: A review of the facility's policy, Comprehensive Person Centered Care Plans, dated, March 2018, revealed, Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the team will provide care. Further review revealed, Procedure: 4. The Interdisciplinary Team along with the resident and/or Resident Representative will identify resident problems, needs, strengths, life history, preferences, and goals. 5. For each problem, need, or strength a resident-centered goal is developed. Goals should be measurable (i.e. walk from nurse's station to room by (date). 6. Staff approaches are to be developed for each problem/strength/need (including PASSARR/Preadmission Screening and Resident Review recommendations as applicable). Assigned disciplines will be identified to carry out the intervention. 9. Upon a change in condition, the Comprehensive Person Centered Care Plan or Baseline Care Plan will be updated or an Instant Care Plan will be initiated if applicable. Review of the facility's policy, Behavior Management and Psycho-pharmacological Medication Monitoring Program, reviewed/revised 03/18 (March 2018), revealed, The Interdisciplinary Team (IDT) will update the care plan to include the problem behavior, goals, and approaches. The planned interventions, for each individual resident's behavior will be communicated to the appropriate staff members. Interventions and response will be documented. Review of Resident #1's Comprehensive Person Centered Care Plan, dated 10/09/2017, revealed the resident was on a behavior management program which included wandering. The Approaches did not include monitoring or supervising Resident #1 for his wandering and pacing behavior day and night. Review of the facility's Resident Incident Report, dated 06/14/2020 at 3:45 AM, revealed the type of incident was Resident #1 wandered off the facility grounds. Resident #1 was returned to the facility at approximately 4:00 AM. No injuries or complaints of pain. Resident stated he was trying to get home to (Name of City). Resident #1 was immediately placed on one on one (1:1) monitoring with staff. The Medical Doctor (MD) was notified. Resident #1 is his own Representative Person (RP). Review of the facility's Supervisor Investigation Summary Form, dated and signed by the Administrator on 06/16/2020, revealed on June 14, 2020 at 3:30 AM, (Name of Business Manage) came in to report resident was at (Name of Business) . The facility's Dr. Wander (the facility's wandering/elopement procedure) was initiated for resident. Resident #1 was safely returned to the facility by the Sheriff's Department. Resident reported he exited facility through the dining room door by disarming the wander guard system. He stated he snatched it lose and the door opened. Resident said he was trying to get home to (Name of City). An immediate assessment by Licensed Practical Nurse (LPN) #4 was completed and revealed no injuries or pain. Resident was not on wandering monitoring prior to incident and was not at risk for elopement. Resident has no elopement attempts. Follow Up Actions: Resident #1 was admitted to the facility, on 09/15/2017, with [DIAGNOSES REDACTED]. Resident #1 was immediately assessed and placed on 1:1 monitoring. The Administrator's interview with Resident #1 revealed he stated he went out the kitchen door, however, upon investigation the kitchen door was locked and exit secure and the wires were found to be torn lose on the dining room door. Resident #1 then stated he went through the dining room door by snatching the wires and the door opened. Resident stated he was sorry for his behavior. Resident said he walked through the wooded/grass area behind the facility and continued walking to (Name of Business) trying to get a ride. Administrator interviews with the staff on duty at the time of the incident revealed Resident #1 was last seen at 3:00 AM in the dayroom. Staff also reported resident was walking in the halls on and off, and that Resident #1 was usually up at night in the day room watching television or walking off and on in the hall. (Due to COVID-19, Resident #1 was only able to ambulate on his unit, the dayroom and dining room). New Interventions-Keypad lock was placed on dining room doors per Maintenance on, 06/15/2020. The Wanderguard system at dining room door was repaired by the Maintenance Director on 06/14/2020. Resident #1 was added to wander and elopement with monitoring of whereabouts every hour upon return to facility. The Mississippi State Department of Health was notified, on 06/14/2020 by the Administrator. After investigation, interview with the resident and staff revealed the resident was very knowledgeable and aware of his actions and able to exit the facility. An observation, on 07/08/2020 from 12:00 PM until 12:30 PM, revealed Resident #1 ambulatory throughout the south hallway with a fast pace. Resident #1 walks back and forth, up and down the hallways of the

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.

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) south unit. Resident #1 stopped to sit in a chair in the hallway for several minutes and then is up pacing down the hallway again. Resident #1 was observed to have a wander guard on his wrist. An interview, on 07/08/2020 at 12:00 PM, with Resident #1 revealed he was confused to date and time and he recalled the elopement when he was asked and stated, I was trying to get to (Name of City) to go and see my family. I'm not gonna try and leave again. Continued conversation with the resident indicated that he could not hold focus and attempted to hug SA surveyor several times and talked about how the door just popped open when he pulled the wires around the door. An interview with Social Services Director (SSD), on 07/08/2020 at 1:50 PM, revealed Resident #1 was previously an elopement risk when he was admitted , on 09/15/17, because he did just what he does now and wandered and paced, but after we saw that was just what he did and he wasn't trying to leave the building we discontinued his care plan for elopement and wandering. The Social Services Director wasn't sure when the elopement monitoring care plan had been discontinued, but confirmed that Resident #1 was not monitored for an elopement risk prior to his elopement, on 06/14/2020. The SSD also confirmed Resident #1 did not have a wanderguard on at that time. The SSD confirmed Resident #1 was assessed on 06/14/2020 and was identified as an elopement risk after he was returned to the building by the local police. The SSD stated Resident #1 now has a wander guard on his wrist and he is monitored every hour for his presence. The SSD confirmed that he had implemented a care plan for elopement for Resident #1 on 06/14/2020. Review of a Psychological Assessment, dated 02/07/2020, revealed Resident #1 was easily agitated, manipulative, verbally and physically aggressive and wanders into other (resident) rooms stealing. Record review of Departmental Notes, dated 03/12/19 stated, Interdisciplinary Team (IDT) members evaluated resident for risk of elopement. Resident is no longer at risk for elopement d/t (due to) no longer exhibiting exit seeking behaviors, such as wandering aimlessly or pushing on exit door handles. Resident has not exhibited any wandering/exit seeking behaviors in the past year. Review of the facility's Elopement Audit, dated 06/15/2020, revealed seven (7) resident names on the list, Resident #1's name was not on the list. Review of the facility's Wanderguard Tracking System, dated 06/15/2020, revealed eight (8) resident names on the list, Resident #1's name was not on the list. Review of Resident #1's Care Plan, dated 06/14/2020, revealed the Problem for Resident #1's elopement and now wears a wanderguard. The Approaches included: Staff to observe resident for elopement attempts as resident may go to the door, alert staff to resident wandering behavior, observe whereabouts of resident and redirect wandering and elopement behavior. The Care Plan, dated 06/22/2020, the day of Resident #1's return to the facility revealed checking the wanderguard function every shift and monitor Resident #1's whereabouts every hour. An interview, on 07/08/2020 at 12:15 PM, revealed the Activity Director stated, He walks constantly, it's hard to get him to sit down for activities. During an interview with Licensed Practical Nurse Supervisor (LPN) #2, on 07/08/2020 at 12:20 PM, she stated, That's his normal, he paces all the time, he doesn't sit for very long. Review of Resident #1's Behavior Intervention Monthly Flow Record, dated May and June, 1st through the 14th, 2020, revealed wandering behavior was not addressed. The June 2020 flow sheet began addressing wandering behavior on the 22nd, upon his return to the facility from the behavioral unit. During an interview, on 07/08/2020 at 3:15 PM, LPN #1, who was the night shift supervisor, on 06/14/2020, stated Resident #1 stays up late and watches television in the dayroom and he walks the halls constantly. LPN #1 stated, The last time I saw him was around 2:30 AM that morning and he was in the dayroom. An interview with the Administrator and the Director of Nursing (DON), on 07/08/2020 at 3:30 PM, confirmed Resident #1 was identified as an elopement risk on admission in 2017, and he was taken off as an elopement risk in March 2019 and the wanderguard was discontinued. The Administrator and DON stated, He was doing good, we assess him every quarter. When he first came in the facility, he did walk constantly so we used a wanderguard until March 2019, and then we decided to take it off because he had not went to the door and attempted to exit, he just walked around the facility. An interview with the Administrator, on 07/08/2020 at 11:30 AM, revealed Resident #1 was placed on 1:1 supervision upon return to the facility until he was transferred to the behavioral facility to prevent further elopement and was care planned for the elopement. During an interview, on 07/09/2020 at 12:10 PM, the Medicaid Nurse stated, He walks constantly but he doesn't push on the doors like he did when he was first admitted . Social Services did update his care plan. Before COVID, he would walk throughout his hallway, the dining room and would sit up front at the front entrance and look out the door. But, now because of the isolation, residents are not allowed to go to the dining room or throughout the building. The Medicaid Nurse confirmed that the isolation has changed a lot of the resident's normal behaviors. An observation, interview and tour, on 07/08/2020 at 11:30 AM, of the facility with the Administrator, revealed staff was not aware that Resident #1 was outside of the south hall unit and that staff was not aware the Resident #1 was even out of the building until they received a call from a local business that the resident was in their parking lot. The south and north hallways have double doors closed leading to the residents rooms to prevent further spread of COVID. Resident #1 is located on the south hall. The Administrator explained that in the morning hours, of 06/14/2020 at 3:00 AM, Resident #1 walked through the closed double doors and into the open foyer area and walked into the dining room and made his way to the fire exit door at the back of the dining room and pulled the wiring on the door until it was disconnected and it opened. The resident then walked through an outside storage building which is in close proximity to the dining room fire door and exited the back of the storage shed which housed equipment The facility investigation was unable to conclude his path that was taken that caused him to arrive in the parking lot of a local business and was discovered there by an employee. The facility Administrator confirmed that the facility does not have cameras inside the building or on the outside of the building that would have confirmed the exact path of the resident. An interview, on 07/08/2020 at 1:30 PM, revealed the Administrator stated there was not a care plan in use for Resident #1's wandering behavior and/or elopement risk prior to this incident on 06/14/2020. Review of Resident #1's June and July 2020 Physician's Orders did not reveal an order to monitor Resident #1's wandering behavior. Review of the Face sheet revealed Resident #1 was admitted by the facility, on 09/15/2017 with a history of Mood Disorder, Major [MEDICAL CONDITIONS], Dementia, Kleptomania, Impulse Disorder and [MEDICAL CONDITION]. Review of a Quarterly MDS, dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate to severe cognitive impairment. Further review of the MDS revealed Resident #1's Section D. Mood was checked never or one (1) day for feeling down, depressed, little sleep, tired/no energy, trouble concentrating, slow, fidgety and restless. Section E. Behavior was checked for none of the above, indicating no psychotic hallucinations and/or delusions. The behaviors for physical and verbal behavior symptoms directed toward others, other behavior symptoms not directed toward others, rejection of care and wandering were checked as behavior not exhibited. The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions prior to the State Agency (SA) entrance on 07/08/20. In Response to the Past Noncompliance IJ and SQC cited at 3:30 PM on 07/08/20, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility to remove the IJ. Description of Incident: On June 14, 2020 around 3:30 AM the facility LPN Charge Nurse received a phone call from a local business that a resident was in their parking lot. The LPN Charge Nurse verified that the resident was from their facility. The facility immediately initiated the facility wide elopement protocol. The local sheriff's department staff was at the business and returned the resident back to the facility at 4:00 AM. Upon return to the facility on [DATE] at 4:00 AM Resident #1 was evaluated for injuries by the LPN Charge Nurse. Resident #1 did not complain of any pain or injuries, nor were there any injuries noted upon evaluation of resident. Resident #1 is his own responsible representative (RR). The facility Registered Nurse (RN) #1 completed an elopement audit of Resident #1 on 6/14/2020. Based on Resident #1's earlier decision to disarm the dining room door and exit the facility, the facility deemed elopement precautions were necessary. The facility staff immediately placed Resident #1 on one on one monitoring on his return to the facility at 4:00 AM until resident was later transferred to a behavior unit on 6/14/2020 at 1:30 PM. On 6/14/2020 an immediate head count of all residents was completed by facility staff nurses LPN #1, LPN #3 and LPN #4. The results of the facility head count of all residents revealed that all residents (100%) were present and accounted for in the facility. Resident #1's physician and facility medical director, was notified on 6/14/2020 that Resident #1 had disarmed the dining room door by ripping out the doors wander guard wiring. The Medical Director physician ordered to admit to behavior unit. On 6/14/2020 the Director of Nursing (DON) initiated an in-service to facility staff on resident wandering, elopement, and supervision. No staff will be allowed to return to work until in-service was complete. 8 RNs 17LPNs, 50 CNAs, 16 dietary, 10 housekeeping/laundry, 2 activities, 2 maintenance, 1 medical record, 2 business office, 2 social, 1 admissions. On 6/14/2020 the Administrator initiated staff interviews regarding the incident of Resident #1's exit of the facility. These staff interviews revealed that Resident #1 was last seen by facility staff between the hours of 3:00 AM and 3:10 AM. The State Agency was immediately notified of incident on 6/14/2020. A completed investigation was faxed on 6/16/2020. All residents were evaluated for wander, elopement, and supervision risk 6/14/2020 by the facility social worker. The evaluation results revealed no wander, elopement, and supervision changes were necessary at that time. On 6/14/2020 the facility social worker reviewed the elopement books. This review revealed that the elopement books were up

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) to date appropriately placed, and did not require any needed changes. An elopement drill was initiated on 6/14/2020 by the social service department. The elopement drill was conducted with staff participation, appropriate response, and no issues noted. Prior elopement drills had been conducted on 5/26/2020. On 6/14/2020 the wander guard system at the dining room exit door was immediately repaired by the Maintenance Director. The facility discussed Resident #1's incident of elopement from the facility at an emergency Quality Assurance (QA) meeting on June 14, 2020. The QA team discussed that Resident #1 had never since admission left the facility unsupervised there was a need to to monitor resident #1's whereabouts with a wander bracelet and supervision due to the elopement, whereby reevaluation would be conducted at the next quarterly QA meeting. The QA team also concurred that sending resident to the behavior unit had been appropriate. The QA team did not suggest any additional interventions at that time. Upon return from the behavior unit on 06/22/20, Resident #1 wander assessment was updated upon readmission. Resident #1's plan of care was updated on readmission on 06/22/20 to include elopement monitoring of Resident #1 every hour with wander bracelet. Review on 6/14/2020 of Resident #1's medical record conducted by the DON as part of the QA process revealed resident had been evaluated for elopement quarterly with no risk for elopement with last evaluations completed 8/30/2019, 11/29/2019, 2/28/2020, and 5/27/2020. The facility corrective actions were initiated on 6/14/2020. All activities to remove IJ was initiated on 6/14/2020 and completed on 6/15/2020. The facility alleges the IJ was removed on 6/15/2020. The SA validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observations, facility record review and interview. The SA validated through record review and interview that Resident #1 was evaluated for injuries by the LPN Charge Nurse. Resident #1 did not complain of any pain or injuries, nor were there any injuries noted upon evaluation of resident. Resident #1 is his own responsible representative (RR). The SA validated through record review that an elopement audit of Resident #1 on 6/14/2020. Based on Resident #1's earlier decision to disarm the dining room door and exit the facility, the facility deemed elopement precautions were necessary. The SA validated through record review that the facility staff immediately placed Resident #1 on one on one monitoring on his return to the facility at 4:00 AM until resident was later transferred to a behavior unit on 6/14/2020 at 1:30 PM. The SA validated through record review and interview that on 6/14/2020 an immediate head count of all residents was completed by facility staff nurses LPN #1, LPN #3 and LPN #4. The results of the facility head count of all residents revealed that all residents (100%) were present and accounted for in the facility. The SA validated through interview that Resident #1's physician and facility medical director, was notified on 6/14/2020 that Resident #1 had disarmed the dining room door by ripping out the doors wander guard wiring. The Medical Director physician ordered to admit to behavior unit. The SA validated through record review and interviews that on 6/14/2020 the Director of Nursing (DON) initiated an in-service to facility staff on resident wandering, elopement, and supervision. No staff will be allowed to return to work until in-service was complete. 8 RNs 17 LPNs, 50 CNAs, 16 dietary, 10 housekeeping/laundry, 2 activities, 2 maintenance, 1 medical record, 2 business office, 2 social, 1 admissions. The SA validated that on 6/14/2020 the Administrator initiated staff interviews regarding the incident of Resident #1 exit of the facility. These staff interviews revealed that Resident #1 was last seen by facility staff between the hours of 3:00 AM and 3:10 AM. The SA validated through record review that The State Agency was immediately notified of incident on 6/14/2020. A completed investigation was faxed on 6/16/2020. The SA validated through record review and interviews that all residents were evaluated for wander, elopement, and supervision risk 6/14/2020 by the facility social worker. The evaluation results revealed no wander, elopement, and supervision changes were necessary at that time. The SA validated that on 6/14/2020 the facility social worker reviewed the elopement books. This review revealed that the elopement books were up to date appropriately placed, and did not require any needed changes. The SA validated through record review and interviews that an elopement drill was initiated on 6/14/2020 by the social service department. The elopement drill was conducted with staff participation, appropriate response, and no issues noted. Prior elopement drills had been conducted on 5/26/2020. The SA validated through observation and record review that on 6/14/2020 the wander guard system at the dining room exit door was immediately repaired by the Maintenance Director. The SA validated through record review and interviews that the facility discussed Resident #1's incident of elopement from the facility at an emergency Quality Assurance (QA) meeting on June 14, 2020. The QA team discussed that Resident #1 had never since admission left the facility unsupervised there was a need to to monitor resident #1's whereabouts with a wander bracelet and supervision due to the elopement, whereby reevaluation would be conducted at the next quarterly QA meeting. The QA team also concurred that sending resident to the behavior unit had been appropriate. The QA team did not suggest any additional interventions at that time. The SA validated through observation and record review that upon return from the behavior unit on 06/22/20, Resident #1 wander/elopement assessment was updated and a wanderguard was placed on Resident #1 on his admission back into the facility. The SA validated through record review and interview that Resident #1's plan of care was updated on readmission on 06/22/20 to include elopement monitoring of resident every hour with wander bracelet.
F 0689 **Level of harm -** Immediate jeopardy **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** The State Agency (SA) conducted a Complaint Survey for CI MS # , on 07/08/2020 through 07/09/2020, and substantiated CI MS # related to an elopement due to the facility's failure to provide adequate supervision to prevent Resident #1's elopement from the facility on 06/14/2020 at approximately 3:00 to 3:10 AM. Resident #1 was missing, unsupervised and away from the facility for approximately 20 to 35 minutes. The facility staff was not aware of Resident #1's absence until he was discovered in the parking lot of a local business by a store employee, who notified the facility of Resident #1's whereabouts at 3:30 AM. Resident #1 was returned to the facility at 3:45 AM by the Sheriff's Department. Resident #1 was assessed for any signs and symptoms of injury and pain, which was negative. Resident #1 was found fully clothed. The facility's immediate investigation revealed Resident #1 stated he had pulled the wanderguard wiring on the kitchen exit door and exited from there, but the investigation found it was the dining room door Resident #1 pulled the wiring and therefore not allowing the door to alarm. Resident #1 was placed on one to one (1:1) supervision from the time of his return until 1:00 PM on 6/14/2020 when he was transferred to a behavioral facility. The facility failed to provide adequate staff supervision which resulted in Resident #1's elopement from the facility at approximately 3:00 AM to 3:10 AM on 06/14/2020. Resident #1 was identified by the facility on his admission, 09/15/2017 for wandering behavior. A wanderguard was used for a time due to his wandering and pacing behavior day and night, exit seeking behavior and pushing on doors. The Interdisciplinary Team (IDT) determined Resident #1 was no longer an elopement risk, on 03/12/2019, because he no longer was exhibiting exit seeking behavior or pushing on doors. However, Resident #1 did continue the wandering and pacing day and night. The wandering and pacing behavior day and night was confirmed by staff interviews. Resident #1's Care Plan, dated 10/09/2017, identified Resident #1's wandering behavior, but did not address how the staff was to monitor him to prevent the possibility of elopement. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 07/08/20, which occurred on 06/14/2020 and existed at: 42 CFR(s): 483.25(d)(1)(2)-Free of Accidents, Hazards/Supervision/devices (F689). The facility's failure to provide adequate staff supervision for Resident #1, with a history of elopement risk and current display of wandering behavior, placed this resident and other residents who exhibit wandering behavior and at risk for elopement risk a likelihood for serious injury, harm, impairment or death. Based on the facility's implementation of corrective actions on 06/14/2020, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 06/15/2020, prior to the SA's first entrance on 07/08/2020. The SA notified the facility's Administrator of the PNC IJ and SQC on 07/08/2020 at 3:30 PM. At the time of the survey, the facility had a census of 113, and held a license of 120 beds. Based on staff and resident interviews, record review and facility policy review, the facility failed to provide adequate staff supervision to prevent Resident #1's elopement from the facility, on 06/14/2020 at approximately 3:00 to 3:10 AM. Resident #1 exhibited wandering and pacing behavior day and night per staff interviews prior to the incident and yet the facility did not initiate any specific monitoring for staff to follow and possibly prevent an elopement. The facility staff did not know Resident #1 was off the facility grounds until the store employee called to notify them. This concern was identified for one of four (1 of 4) residents reviewed for wandering behavior and risk for elopement. Findings include: Review of the facility's policy, Missing Resident/Elopements, dated, July 2018, revealed, The Unit Charge Nurse is responsible for knowing the location of their residents. Post survey, the facility's Administrator provided by an email statement, dated 7/30/2020 at 8:09 PM, that revealed the facility did not have a policy for supervision. Review of the facility's policy, Behavior Management and

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Psycho-pharmacological Medication Monitoring Program, reviewed/revised 03/18 (March 2018), revealed, Residents with behaviors that are displayed routinely, that effect the resident's psychological well-being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with [REDACTED]. The policy further revealed, The Interdisciplinary Team (IDT) will update the care plan to include the problem behavior, goals, and approaches. The planned interventions, for each individual resident's behavior will be communicated to the appropriate staff members. Interventions and response will be documented. Review of the facility's Resident Incident Report, dated 06/14/2020 at 3:45 AM, revealed the type of incident was Resident #1 wandered off the facility grounds. Resident #1 was returned to the facility at approximately 4:00 AM. No injuries or complaints of pain. Resident stated he was trying to get home to (Name of City). Resident #1 was immediately placed on one on one (1:1) monitoring with staff. The Medical Doctor (MD) was notified. Resident #1 is his own Representative Person (RP). Review of the facility's Supervisor Investigation Summary Form, dated and signed by the Administrator on 06/16/2020, revealed on June 14, 2020 at 3:30 AM, (Name of Business Manage) came in to report resident was at (Name of Business) . The facility's Dr. Wander (the facility's wandering/elopement procedure) was initiated for resident. Resident #1 was safely returned to the facility by the Sheriff's Department. Resident reported he exited facility through the dining room door by disarming the wander guard system. He stated he snatched it lose and the door opened. Resident said he was trying to get home to (Name of City). An immediate assessment by Licensed Practical Nurse (LPN) #4 was completed and revealed no injuries or pain. Resident was not on wandering monitoring prior to incident and was not at risk for elopement. Resident has no elopement attempts. Follow Up Actions: Resident #1 was admitted to the facility, on 09/15/2017, with [DIAGNOSES REDACTED]. Resident #1 was immediately assessed and placed on 1:1 monitoring. The Administrator's interview with Resident #1 revealed he stated he went out the kitchen door, however, upon investigation the kitchen door was locked and exit secure and the wires were found to be torn lose on the dining room door. Resident #1 then stated he went through the dining room door by snatching the wires and the door opened. Resident stated he was sorry for his behavior. Resident said he walked through the wooded/grass area behind the facility and continued walking to (Name of Business) trying to get a ride. Administrator interviews with the staff on duty at the time of the incident revealed Resident #1 was last seen at 3:00 AM in the dayroom. Staff also reported resident was walking in the halls on and off, and that Resident #1 was usually up at night in the day room watching television or walking off and on in the hall. (Due to COVID-19, Resident #1 was only able to ambulate on his unit, the dayroom and dining room). New Interventions-Keypad lock was placed on dining room doors per Maintenance on, 06/15/2020. The Wanderguard system at the dining room door was repaired by the Maintenance Director on 06/14/2020. Resident #1 was added to wander and elopement with monitoring of whereabouts every hour upon return to facility. The Mississippi State Department of Health was notified, on 06/14/2020 by the Administrator. After investigation, interview with the resident and staff revealed the resident was very knowledgeable and aware of his actions and able to exit the facility. The Post-Incident Actions, revealed, Resident safely returned to the facility at Approximately 4:00 AM. No injuries noted. No complaint of pain noted. Resident stated that he was trying to get home to (Name of City). Immediately placed on one to one monitoring with staff. Medical Director notified. Resident is own Responsible Party (RP). Review of the facility's staff handwritten statements revealed: Certified Nursing Assistant (CNA) #1 stated she last placed her eyes on Resident #1 in the dayroom at 3:00 AM on 06/14/2020. CNA #2 stated herself, CNAs #1 and #4, Resident #1 and another staff member were sitting in the dayroom. Then she and CNA #1 left to go assist another resident and returned to the dayroom in about 15 minutes. CNA #2 and #1 left the dayroom again about 3:00 AM to 3:10 AM to go care for another resident. CNA #2 reported Resident #1, CNA #4 and the other staff member was still in the dayroom. CNA #3 reported the last time she saw Resident #1 was at 11:30 PM, when she arrived to work. CNA #4 reported she saw Resident #1 at 2:30 AM in the dayroom, he got up and left out and she did not see him again. Licensed Practical Nurse (LPN) #4 stated she observed Resident #1 walking the halls at 11:44 PM. LPN #1/Charge Nurse Night Shift stated she observed Resident #1 at the snack machine at 1:30 AM. No exit behavior was observed. On 07/08/2020 from 12:00 PM until 12:30 PM, an observation revealed Resident #1 was ambulatory throughout the south hallway with a fast pace. Resident #1 walks back and forth, up and down the hallways of the south unit. Resident #1 stopped to sit in a chair in the hallway for several minutes and then is up pacing down the hallway again. Resident #1 is observed to have a wander guard on his wrist. On 07/08/2020 at 12:00 PM, an interview with Resident #1 revealed he was confused to date and time and he recalled the elopement when he was asked and stated, I was trying to get to (Name of City) to go and see my family. I'm not gonna try and leave again. Continued conversation with the resident indicated that he could not hold focus and attempted to hug SA surveyor several times and talked about how the door just popped open when he pulled the wires around the door. During an interview, on 07/08/2020 at 3:15 PM, Licensed Practical Nurse (LPN) # 1, who was the night shift supervisor on 06/14/2020, revealed the last time she saw Resident #1 was around 2:30 AM that morning and he was in the dayroom. LPN #1 stated Resident #1 stays up late and watches television in the dayroom and he walks the halls constantly. LPN #1 stated she was the one who received the call from the business employee who reported Resident #1 wandering in the store's parking lot. LPN #1 reported the store employee said he was one of our residents and she guessed he must have told the store employee he was a resident here. LPN #1 said she called the Administrator and she came to the facility right away. LPN #1 revealed Resident #1 was not on any type supervision prior to that night. LPN #1 reported Resident #1 was sent to the behavioral unit on 06/14/2020 and returned to the facility on [DATE] with orders for a wanderguard and to check him every hour for his location and check the wanderguard every shift. An interview, on 07/08/2020 at 4:00 PM, with Certified Nursing Assistant (CNA) #1 revealed the last time she saw Resident #1, on 06/14/2020, was at 3:00 AM in the dayroom. CNA #1 reported Resident #1 walked the hall and to the dayroom at night. CNA #1 said this was how Resident #1 was at night. He used to go to the doors and push on the handles, but no longer does that, and hasn't in a while. CNA #1 stated Resident #1 was not on any specific supervision prior to his leaving the facility that night. CNA #1 confirmed they did not know Resident #1 was gone or his whereabouts until that (Name of Business) employee called LPN #1 to report him wandering in their parking lot. CNA #1 reported Resident #1 was sent to a behavioral hospital after that night, and did come back to the facility a week or so later. CNA #1 also said the resident is wearing a wanderguard now and his whereabouts is checked every hour. An interview, on 07/08/2020 at 4:40 PM, with CNA #2 revealed the last time she saw Resident #1, on 06/14/2020 was about 3:00 to 3:10 AM. CNA #2 stated the same information as her written statement that CNA #1, CNA #4, Resident #1 and another staff member were sitting in the dayroom. Then she and CNA #1 left to go assist another resident and returned to the dayroom in about 15 minutes. CNA #2 and #1 left the dayroom again about 3:00 AM to 3:10 AM to go care for another resident. CNA #2 reported Resident #1, CNA #4 and the other staff member was still in the dayroom. CNA #2 stated Resident #1 was not on any special supervision, and he did walk the hall and go to the dayroom pretty much all night, this was nothing different. CNA #2 said he used to go to the doors, push on the handles, but has not that in a while. CNA #2 said they did not know Resident #1 had left the building that night. CNA #2 said they did not know where he was until the store employee called and told the charge nurse. A review of Resident #1's Behavior/Intervention Monthly Flow Record, dated May 2020 and June 1st to the 14th, revealed wandering behavior was not addressed. Wandering behavior was added on 06/22/2020, the date Resident #1 returned from the behavioral unit. Resident #1 was admitted to a behavioral unit on 06/14/2020. Review of Resident #1's Psychological Evaluation, dated 03/26/2020, revealed [DIAGNOSES REDACTED]. The Behavior/Symptoms included: false accusation, easily agitated, verbal/physical aggressiveness, manipulative, wandering in other resident rooms/stealing, and socially inappropriate language. The evaluation further stated, will continue plan of care, will review in 30 days. Follow Up Date: 04/02/2020-No behaviors noted, will continue plan of care. Will review in 30 days. Follow Up Date: 05/14/2020-No behaviors noted/observed, no exit seeking behavior. Will continue with plan of care and review in 30 days. Review of Resident #1's Risk of Elopement Evaluation, dated 08/30/2019 and signed by the Director of Nurses (DON), revealed Resident #1 was not at risk for elopement. The form had review dates of, 11/29/2019, 02/28/2020 and 05/27/2020. The Risk of Elopement Evaluation, dated 06/22/2020, stated Resident #1 was at risk for elopement, he had a past history of leaving the facility and ambulates independently. Visual checks are to be done hourly. Review of Resident #1's Admission/Re-Admission Evaluation, dated 09/15/2017, signed by the Director of Nurses (DON), revealed Resident #1 ambulated independently and had a history of [REDACTED].#1 was his own designated Representative Person (RP). During an interview, on 07/08/2020 at 1:50 PM, the Social Services Director (SSD), stated Resident #1 was previously an elopement risk when he was admitted , on 09/15/2017, because he did just what he does now and wandered and paced, but after we saw that was just what he did and he wasn't trying to leave the building we discontinued it. The SSD stated he wasn't sure when the elopement monitoring had been discontinued and did confirm Resident #1 was not monitored for an elopement risk when he eloped on 06/14/2020 and that he did not have a wanderguard on at that time. The SSD confirmed Resident #1 was assessed on 06/14/2020 and marked as an elopement risk after he was returned to the building by the local police. The SSD stated Resident #1 now has a wander guard to his wrist and is

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	255114	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND NURSING AND REHABILITATION CENTER	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) monitored every hour for his presence. Review of the Departmental Notes, Social Services, dated 03/12/2019, revealed the Interdisciplinary Team (IDT) members evaluated Resident #1 for risk of elopement. Resident is no longer at risk for elopement due to no longer exhibiting exit seeking behaviors, such as wandering aimlessly or pushing on exit door handles. Resident has not exhibited any wandering/exit seeking behaviors in the past year. Resident is alert to person, time and place. An interview with the Administrator, on 07/08/2020 at 11:30 AM, revealed Resident #1 had indicated to the staff which door he had went out of when he left the building. The Administrator stated they checked the dining room door and it was closed, but not secured because he had torn the wires. The Administrator said she called the Maintenance Director to the building right away and he fixed the fire door to secure it again. The Administrator reported Resident #1was placed on one on one (1:1) supervision to prevent further elopements and was care planned for elopement after that incident. The Administrator stated Resident #1 was sent for a behavior evaluation that same day. During an interview with the Maintenance Director, on 07/08/2020 at 2:55 PM, he confirmed he arrived at the facility shortly after 4:00 AM to repair the door. The Maintenance Director stated the dining room door was closed, but not secured because the resident had pulled the wires out of the wanderguard system and it had disarmed the magnet system that keeps the door locked and secured. The Maintenance Director stated he built boxes around all of the wanderguard wires. The Maintenance Director stated the doors are checked daily. Review of the facility's Educational In-Service Record, dated 06/14/2020, revealed the facility provided all the staff an in-service on elopement which included following orders for visual checks/monitoring resident location, function of wanderguard per orders, answering alarms in a timely manner, and door/wanderguard alarms. An interview, on 07/09/2020 at 12:10 PM, with the Medicaid Nurse revealed, He walks constantly but he doesn't push on the doors like he did when he was first admitted . Social Services did update his care plan. Before COVID, he would walk throughout his hallway, the dining room and would sit up front at the front entrance and look out the door. But, now because of the isolation, residents are not allowed to go to the dining room or throughout the building. The Medicaid Nurse confirmed that the isolation has changed a lot of the resident's normal behaviors. An interview and observation of the facility's layout, at 11:30 AM on 07/08/2020, with the Administrator, revealed the south and north hallways have the double doors closed leading to the residents rooms to prevent further spread of COVID. Resident #1 is located on the south hall and in the morning hours of 06/14/2020 at 3:00 AM, Resident #1 walked through the closed double doors into the open foyer area, and into the dining room and then made his way to the fire exit door at the back of the dining room and pulled the wiring on the door until it was disconnected and it opened. The resident then walked through an outside storage building which is in close proximity to the dining room fire door and exited the back of the storage shed which housed equipment. Staff were not aware that Resident #1 was outside of the south hall unit and records revealed that staff were not aware the resident was even out of the building until they received a call from a local business that the resident was in their parking lot. The facility investigation was unable to conclude his path that was taken that caused him to arrive in the parking lot of a local business and was discovered there by an employee. The facility Administrator confirmed that the facility does not have cameras inside the building or on the outside of the building that would have confirmed the exact path of the resident. It was determined the distance from the facility to the (Name of Business) is 1.4 miles. On 07/08/2020 at 12:10 PM, an interview with a Housekeeping staff member on the hall revealed Resident #1 walking constantly. An interview with the Activity Director, on 07/08/2020 12:15 PM, revealed, He walks constantly, it's hard to get him to sit down for activities. During an in interview with Licensed Practical Nurse Supervisor (LPN) #2/Day Shift Supervisor, on 07/08/2020 at 12:20 PM stated, That's his normal, he paces all the time, he doesn't sit for very long. During an interview with the Administrator and the Director of Nursing (DON), on 07/08/2020 at 3:30 PM, they confirmed that Resident #1 was an elopement risk on admission in 2017, and he was taken off as an elopement risk in March 2019 and the wanderguard was discontinued. The Administrator and DON stated, He was doing good, we assess him every quarter. When he first came in the facility, he did walk constantly so we used a wanderguard until March 2019 and then we decided to take it off because he had not went to the door and attempted to exit, he just walked around the facility. Review of Resident #1's June and July 2020 Physician's Orders did not reveal an order to monitor Resident #1's wandering behavior. Review of the Face sheet revealed Resident #1 was admitted by the facility, on 09/15/2017 with a history of Mood Disorder, Major [MEDICAL CONDITIONS], Dementia, Kleptomania, Impulse Disorder and [MEDICAL CONDITION]. Review of a Quarterly MDS, dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate to severe cognitive impairment. Further review of the MDS revealed Resident #1's Section D. Mood was checked never or one (1) day for feeling down, depressed, little sleep, tired/no energy, trouble concentrating, slow, fidgety and restless. Section E. Behavior was checked for none of the above, indicating no psychotic hallucinations and/or delusions. The behaviors for physical and verbal behavior symptoms directed toward others, other behavior symptoms not directed toward others, rejection of care and wandering were checked as behavior not exhibited. The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions prior to the State Agency (SA) entrance on 07/08/20. In Response to the Past Noncompliance IJ and SQC cited at 3:30 PM on 07/08/20, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility to remove the IJ. Description of Incident: On June 14, 2020 around 3:30 AM the facility LPN Charge Nurse received a phone call from a local business that a resident was in their parking lot. The LPN Charge Nurse verified that the resident was from their facility. The facility immediately initiated the facility wide elopement protocol. The local sheriff's department staff was at the business and returned the resident back to the facility at 4:00 AM. Upon return to the facility on [DATE] at 4:00 AM Resident #1 was evaluated for injuries by the LPN Charge Nurse. Resident #1 did not complain of any pain or injuries, nor were there any injuries noted upon evaluation of resident. Resident #1 is his own responsible representative (RR). The facility Registered Nurse (RN) #1 completed an elopement audit of Resident #1 on 6/14/2020. Based on Resident #1's earlier decision to disarm the dining room door and exit the facility, the facility deemed elopement precautions were necessary. The facility staff immediately placed Resident #1 on one on one monitoring on his return to the facility at 4:00 AM until resident was later transferred to a behavior unit on 6/14/2020 at 1:30 PM. On 6/14/2020 an immediate head count of all residents was completed by facility staff nurses LPN #1, LPN #3 and LPN #4. The results of the facility head count of all residents revealed that all residents (100%) were present and accounted for in the facility. Resident #1's physician and facility medical director, was notified on 6/14/2020 that Resident #1 had disarmed the dining room door by ripping out the doors wander guard wiring. The Medical Director physician ordered to admit to behavior unit. On 6/14/2020 the Director of Nursing (DON) initiated an in-service to facility staff on resident wandering, elopement, and supervision. No staff will be allowed to return to work until in-service was complete. 8 RNs 17LPNs, 50 CNAs, 16 dietary, 10 housekeeping/laundry, 2 activities, 2 maintenance, 1 medical record, 2 business office, 2 social, 1 admissions. On 6/14/2020 the Administrator initiated staff interviews regarding the incident of Resident #1's exit of the facility. These staff interviews revealed that Resident #1 was last seen by facility staff between the hours of 3:00 AM and 3:10 AM. The State Agency was immediately notified of incident on 6/14/2020. A completed investigation was faxed on 6/16/2020. All residents were evaluated for wander, elopement, and supervision risk 6/14/2020 by the facility social worker. The evaluation results revealed no wander, elopement, and supervision changes were necessary at that time. On 6/14/2020 the facility social worker reviewed the elopement books. This review revealed that the elopement books were up to date appropriately placed, and did not require any needed changes. An elopement drill was initiated on 6/14/2020 by the social service department. The elopement drill was conducted with staff participation, appropriate response, and no issues noted. Prior elopement drills had been conducted on 5/26/2020. On 6/14/2020 the wander guard system at the dining room exit door was immediately repaired by the Maintenance Director. The facility discussed Resident #1's incident of elopement from the facility at an emergency Quality Assurance (QA) meeting on June 14, 2020. The QA team discussed that Resident #1 had never since admission left the facility unsupervised there was a need to to monitor resident #1's whereabouts with a wander bracelet and supervision due to the elopement, whereby reevaluation would be conducted at the next quarterly QA meeting. The QA team also concurred that sending resident to the behavior unit had been appropriate. The QA team did not suggest any additional interventions at that time. Upon return from the behavior unit on 06/22/20, Resident #1 wander assessment was updated upon readmission. Resident #1's plan of care was updated on readmission on 06/22/20 to include elopement monitoring of Resident #1 every hour with wander bracelet. Review on 6/14/2020 of Resident #1's medical record conducted by the DON as part of the QA process revealed resident had been evaluated for elopement quarterly with no risk for elopement with last evaluations completed 8/30/2019, 11/29/2019, 2/28/2020, and 5/27/2020. The facility corrective actions were initiated on 6/14/2020. All activities to remove IJ was initiated on 6/14/2020 and completed on 6/15/2020. The facility alleges the IJ was removed on 6/15/2020. The SA validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observations, facility record review and interview. The SA validated through record

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	255114	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEVELAND NURSING AND REHABILITATION CENTER	**4036 HIGHWAY 8 EAST CLEVELAND, MS 38732**

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) review and interview that Resident #1 was evaluated for injuries by the LPN Charge Nurse. Resident #1 did not complain of any pain or injuries, nor were there any injuries noted upon evaluation of resident. Resident #1 is his own responsible representative (RR). The SA validated through record review that an elopement audit of Resident #1 on 6/14/2020. Based on Resident #1's earlier decision to disarm the dining room door and exit the facility, the facility deemed elopement precautions were necessary. The SA validated through record review that the facility staff immediately placed Resident #1 on one on one monitoring on his return to the facility at 4:00 AM until resident was later transferred to a behavior unit on 6/14/2020 at 1:30 PM. The SA validated through record review and interview that on 6/14/2020 an immediate head count of all residents was completed by facility staff nurses LPN #1, LPN #3 and LPN #4. The results of the facility head count of all residents revealed that all residents (100%) were present and accounted for in the facility. The SA validated through interview that Resident #1's physician and facility medical director, was notified on 6/14/2020 that Resident #1 had disarmed the dining room door by ripping out the doors wander guard wiring. The Medical Director physician ordered to admit to behavior unit. The SA validated through record review and interviews that on 6/14/2020 the Director of Nursing (DON) initiated an in-service to facility staff on resident wandering, elopement, and supervision. No staff will be allowed to return to work until in-service was complete. 8 RNs 17 LPNs, 50 CNAs, 16 dietary, 10 housekeeping/laundry, 2 activities, 2 maintenance, 1 medical record, 2 business office, 2 social, 1 admissions. The SA validated that on 6/14/2020 the Administrator initiated staff interviews regarding the incident of Resident #1 exit of the facility. These staff interviews revealed that Resident #1 was last seen by facility staff between the hours of 3:00 AM and 3:10 AM. The SA validated through record review that The State Agency was immediately notified of incident on 6/14/2020. A completed investigation was faxed on 6/16/2020. The SA validated through record review and interviews that all residents were evaluated for wander, elopement, and supervision risk 6/14/2020 by the facility social worker. The evaluation results revealed no wander, elopement, and supervision changes were necessary at that time. The SA validated that on 6/14/2020 the facility social worker reviewed the elopement books. This review revealed that the elopement books were up to date appropriately placed, and did not require any needed changes. The SA validated through record review and interviews that an elopement drill was initiated on 6/14/2020 by the social service department. The elopement drill was conducted with staff participation, appropriate response, and no issues noted. Prior elopement drills had been conducted on 5/26/2020. The SA validated through observation and record review that on 6/14/2020 the wander guard system at the dining room exit door was immediately repaired by the Maintenance Director. The SA validated through record review and interviews that the facility discussed Resident #1's incident of elopement from the facility at an emergency Quality Assurance (QA) meeting on June 14, 2020. The QA team discussed that Resident #1 had never since admission left the facility unsupervised there was a need to to monitor resident #1's whereabouts with a wander bracelet and supervision due to the elopement, whereby reevaluation would be conducted at the next quarterly QA meeting. The QA team also concurred that sending resident to the behavior unit had been appropriate. The QA team did not suggest any additional interventions at that time. The SA validated through observation and record review that upon return from the behavior unit on 06/22/20, Resident #1 wander/elopement assessment was updated and a wanderguard was placed on Resident #1 on his admission back into the facility. The SA validated through record review and interview that Resident #1's plan of care was updated on readmission on 06/22/20 to include elopement monitoring of resident every hour with wander bracelet.