STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445150	A. Building B. Wing	03/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Gardens at Memphis Rehab & Snc	131 N Tucker Memphis, TN 38104

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** 34153 Based on policy review, police report review, hospital record review, medical record review, and interview, the facility failed to ensure a safe environment to prevent an incident of elopement for 1 of 5 sampled residents (Resident #1) reviewed for elopement and wandering behaviors, which resulted in Immediate Jeopardy (IJ) and actual Harm when a vulnerable cognitively impaired resident exited the facility without authorization or staff supervision. The facility was unaware of Resident #1's location for 12 days. Resident #1 called the facility and stated that he was in a (Named) hospital, in another state, located approximately 1,922 miles from the facility. Resident #1 required medical treatment for elevated blood sugar and blood pressure (the resident was without his prescribed medications for blood pressure and blood sugar when he left the facility). 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. The Administrator was notified of the Immediate Jeopardy on 3/9/2022 at 5:25 PM, in the Administrator's Office. The facility was cited Immediate Jeopardy at F-689. The facility was cited at F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ existed from 2/13/2022 through 3/13/2022. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on 3/10/2022 at 11:06 AM. The corrective actions were validated onsite by the surveyors on 3/10/2022 through 3/14/2022 through observations, policy review, medical record review, review of education records, auditing tools, and staff interviews conducted on all shifts. The findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, ELOPEMENT, revealed .Staff shall investigate and report all cases of missing residents .Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing .If an employee observes a resident leaving the premises, he/she should: Attempt to prevent the departure in a courteous manner; Get help from other staff members in the immediate vicinity, if necessary; and Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises .complete and file Report of Accident/Incident . Review of the facility's undated policy titled, Discharge of Resident: Against Medical Advice [AMA], revealed . Purpose: To describe the discharge process for a patient departing from the center against medical advice . Discuss with patient or legal representative the desire to leave the center against medical advice .inform physician of patient's intent to discharge against medical advice .physician orders as needed .assist in fully explaining .the risk of discharge against medical advice .Provide written and verbal education to the patient and legal representative .Inform patient .that leaving the center prevents the provision of necessary care and services and that the physician and center are not responsible for the welfare and wellbeing of a patient . Complete Release for Discharge Against Medical Advice form with patient or legal representative's signature . Ensure that all belongings are packed and sent with patient .escort and assist patient to transport vehicle . Review of the facility's undated policy titled, Leave of Absence Policy (LOA), revealed .permit residents to leave the Facility premises for designated time periods and (2) ensure that the Facility is aware of the whereabouts of its residents .All residents leaving the Facility premises must be appropriately signed out and signed in upon return .Staff members should promptly inform supervisor for any requests received for a LOA . The Resident and/or the Resident Responsible Party shall sign the LOA form and Release .if staff has any concerns with regard to the Resident leaving with a specific individual, staff should contact one of their supervisors . Review of the closed medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Diabetes, Cerebral Infarction, Acute Kidney Failure, Vascular Dementia with Behavioral Disturbance, Disorder of Prostate, History of Falling, (Past Surgical) Absence of Left Toes, and Personal History of COVID-19. Review of the DESIGNATION OF RESIDENT REPRESENTATIVE form dated 11/18/2021, revealed .The individual(s) whose name(s), address(es) and telephone number(s) are listed below has/have been authorized to be the Resident's Representative. This authorization was determined as follows .(X) The Resident (with capacity) has made the designation .Resident Representative Designation: I understand the above and hereby designate: (X) I ELECT TO HAVE A RESIDENT REPRESENTATIVE AT THIS TIME . Name of Representative [Daughter's Name] .Duties: Power of Attorney [POA] . This document was signed by Resident#1's daughter. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician Orders dated 12/27/2021, revealed medication orders for Aspirin once daily (preventative to thin the blood), Coreg two times a day (used to treat blood pressure), Depakote two times a day (used to treat seizures), Ferrous Sulfate once daily (used to treat iron deficiency), Finasteride once daily (used to treat enlarged prostate), Gabapentin every 8 hours (used to treat neuropathy, nerve pain) , Insulin inject 32 units twice a day morning and bedtime (used to treat diabetes), Metformin twice a day (used to treat diabetes), Rosuvastatin once daily at bedtime (used to treat elevated cholesterol), Tamsulosin once daily (used to treat enlarged prostate), and an Accucheck (bedside test that checks the blood sugar level) every morning and night. There were no orders for LOA or AMA. Review of the Care Plan dated 12/28/2021, revealed .Focus .The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] dementia .Focus .The resident has an ADL [Activity of Daily Living] Self Care Performance Deficit r/t disease process . Review of an admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 was assessed with a Brief Interview of Mental Status (BIMS) of 8, indicating moderate cognitive impairment. Resident #1 required supervision with bed mobility, limited assistance with one person assistance with transfers, ambulating in room and corridor, locomotion on and off unit, dressing, and toilet use. Resident #1 required extensive assistance with personal hygiene. Review of a Psychiatric Note dated 1/6/2022, revealed .referred for evaluation and review of meds [medications] .Mental Status Exam .disoriented, ST [short term] impaired .confusion .Clinical Status and Impressions: Vascular Dementia-patient is confused .monitor for changes in mood and behaviors. Redirect as needed . Review of a BIMS assessment dated [DATE], revealed Resident #1 was assessed with a BIMS of 9, indicating moderate cognitive impairment. Review of a Late Entry Plan of Care Note dated 2/13/2022 at 11:00 PM (with a created date of 2/16/2022 at 11:33 AM), written by Registered Nurse (RN) #2, revealed .found [Named Resident #1] not in the room .went to front door .couldn't find the patient .CNA [Certified Nursing Assistant #1] stated patient in parking lot with daughter in the car .I went to the parking lot, couldn't find the patient .asked CNA [CNA #1] who opened the door .CNA [CNA #1] said she opened the door for the patient .I told her he was not in the parking lot . Review of a Late Entry Plan of Care Note dated 2/13/2022 at 11:25 PM (created on 2/15/2022 at 1:22 PM), written by RN #1, revealed .Arrived for shift and was reported to this nurse that pt [patient] [Resident #1] left AMA .reported left with a friend . Review of a discharge assessment-return not anticipated MDS dated [DATE], revealed the Staff Assessment for Mental Status was assessed with short-term memory problems and modified independence with regards to daily life. Resident #1 required supervision with bed mobility, transfers, ambulating in room and corridor, locomotion on and off unit, toilet use, and supervision with dressing and personal hygiene. Review of Social Services Progress Note dated 2/14/2022, revealed .[Named Resident #1] left AMA on 2/13/22 [2022] .Called [Named Sergeant] with .Police Department about an open APS [Adult Protective Services] case to inform that [Named Resident #1] left AMA on 2/13/22 [2022] . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Police Report narrative dated 2/14/2022 at 2:45 AM, revealed .responded to a Missing Person . Victim [Resident #1] was last seen leaving the premises with an unknown female .is noted as being diagnosed with early stages of dementia .was informed by his daughter that the female in question was not her .If located, complainant wishes victim to be returned to [facility's address] . Resident #1 walked out of the Long-Term Care Facility (LTCF) unsupervised by facility staff and was later located in another state 1,922 miles from the LTCF in a hospital requiring medical care. Review of the Hospital Emergency Department Notes dated 2/17/2022, revealed .Pt [Resident #1] was at [Named Restaurant] and staff noticed he was there for a long time acting strange .the PD [Police Department] was called .admitted [DATE] .Daughter [Named] called [the hospital] to give her contact info [information]. She states that she recently learned the client has shown up in [Named City]. He has been missing from [Named State] for several days. She states the client has dementia, but he will deny this Patient presents with Hypertension [elevated blood pressure] .Patient on 5150 hold [allows a clinician to involuntarily confine a person who is deemed to have a mental disorder that makes him or her danger to themselves or others] is missing person from [Named City and State] .gravely disabled and missing person from skilled nursing facility .Pt is poor historian .he thought he was in a different state and did not realize he was in [Named City and State] .also missed his [Named] bus to [Named City and State] and did not have any luggage or personal belongings has no form of ID [identification], large sum of cash [$]692.00 .Per family, he walked out of the rehabilitation center in [Named city and state] without letting family know .elevated BP [blood pressure] 181/99, Initial blood glucose > [greater than] 600, A1c [measures the average blood glucose over the past 3 months] 10.2 [target for people with diabetes is usually less than 7%] .admitted for placement .Physical Examination .AO [alert and oriented] x 2 [person and place] .Extremities .2+ [plus] swelling R [Right] > L [Left] .Neurological .follows simple command .states can ambulate but appears weak .Forgets limitations .During course of hospital stay, [Named Resident #1] pulled IV [Intravenous line to deliver fluids and medicines through the veins] out after receiving 1 liter of Normal Saline infusion, was evaluated by a psychiatrist to have a diagnoses of Neurocognitive impairment [decreased mental function due to medical disease other than psychiatric illness], vascular dementia . Review of a Hospital Case Management note dated 2/18/2022, revealed disoriented to date and situation . He [Resident #1] states that he plans to stay in [Named State] because he will be staying momentarily with family that resides in [Named State] but they are unsure he is here and that he was planning to stay. He does not have their contact information .he took a [Named] bus from [Named state] to [Named state] .missed his second bus and does not have a plan to take care of himself .has no medications, luggage, no address/residence to where he was trying to find family .does not have contact information to the siblings he reports residing in [Named State] and has not spoken to them recent .Discharge plan: Pt [Patient] is expected to discharge to custodial care [non-medical assistance for activities of daily living care] once medically clear . Review of the LTCF Social Service Note dated 2/25/2022, revealed .[Named Resident #1] called facility today and SW [Social Worker] and Unit Manager spoke with him .stated he is in [Named City and State] . tried to call daughter .was unsuccessful .texted and asked daughter to call SW [Social Worker] because [Named Resident #1] and SW have talked to each other . Review of the Social Service Note dated 3/1/2022 and 3/2/2022, revealed that Resident #1 had called the facility from the hospital in the other state. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/2/2022 at 3:30 PM, the Administrator stated, .I was notified that [Named Resident #1] had left the facility .he walked out behind a visitor who the resident said was his daughter .he told staff that he was going to the parking lot to see his grandkids .he did not come back .he has called the facility and said he was in [Named city and state] and he was doing fine .This was not elopement .he just left .he was not impaired, he knew exactly what he was doing, he wanted to leave .he did not elope from the facility, he left AMA .we reported it to the police that he left the facility .he planned to leave .I don't see this incident as an elopement . The Administrator confirmed that Resident #1 and Resident #1's responsible party did not sign the AMA or LOA paperwork prior to him leaving the facility. The Administrator confirmed that AMA and LOA paperwork had not been completed prior to him leaving the facility. During an interview on 3/3/2022 at 3:22 PM, the Social Service Director stated, .his daughter has always been his responsible party .we discussed all care with her .I've never met his children .he discharged home in December and was readmitted from the hospital after getting into a fight with his son .an APS case was opened .APS said the resident had to be discharged to a licensed home .I couldn't just discharge him to the street or put him back in that home, that would be an unsafe discharge .he was agreeable to go to the licensed home until he got that card [Social Security] .then he said that's not where I want to go .I got a text message the next morning [after the incident] telling me he left .the police had already been notified .he talked about leaving often .he left out the building with a visitor saying he was going to see his grandkids .he decided he would leave .staff looked for him and could not find him .concerned about his safety because the visitor was not his daughter .his BIMS was 9 .we were trying to safely discharge him, could not discharge him out on the street, he could not go home with his son .Against Medical Advice or Leave of Absence had not been discussed or paperwork signed . During an interview on 3/2/2022 at 3:30 PM, the Administrator stated, .the resident's [Resident #1] girlfriend came to the facility to visit that night she was posing as his daughter, he [Resident #1] stated he wanted to go outside to see his grandchildren .staff let him out, he got in the car and they drove off .he called the facility and said he was ok, he is living in [Named State] with his family .the only reason we reported it was because we didn't want you [surveyors] to come in here and say it was an elopement .he just left . During an interview on 3/4/2022 at 10:13 AM, Registered Nurse (RN) #1 stated, .he [Resident #1] didn't tell anybody he was leaving that night .is his own responsible party so he can do what he wants to do .he left, I was on break away from the facility, when I returned, staff had looked for him and was not able to find him in the parking lot .I looked for him around the facility and parking lot I did not see him .I notified his daughter, I told her the resident had left the facility .the daughter stated he was not with her .I called the police because we were concerned wanted to make sure he was safe .there was a APS case going on with him and a son . he might have had a low BIMS but he was able to make that decision to leave .he wanted to leave, he made the decision .we can't hold him here against his will . RN #1 was asked if Resident #1 was safe to be outside unsupervised and RN #1 stated, .not for me to decide .it's a matter of opinion .whether he was safe or not . he could make his own decisions he was his own RP [Responsible Party] .I have talked with him since he left .he is in [Named state] . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 3/4/2022 at 1:53 PM, RN #2 stated, .was rounding with oncoming nurse . [Named Resident #1] was not in his room .went to the front lobby did not see him .[Named CNA #1] said he went to the parking lot to see his grandchildren, she told me she scanned the door to let his daughter out and he went out behind her, saying he was going to see his grandkids in the car in the parking lot .I looked in the driveway alongside the building and parking lot did not see him .called the daughter (RP) asked if he was with her and she said 'no he is not with me, it was not me I'm in [Named State] .went outside again and searched the parking lot, and we did not see the car or the resident .I called the Unit manager and the Director of Nursing [DON] .told them [Named Resident #1] had left the facility . During an interview on 3/4/2022 at 4:16 PM, CNA #1 stated, .I was in the front lobby waiting on my ride home .a little before 11:00 [PM] .[Named Resident #1] was in the lobby told me to let his daughter in .I scanned the door to let her in and after a few minutes she wanted to be let out, I scanned the door she went out and he went behind her saying he was going to the parking lot to see his grandkids .I told him he could not do that, but he kept walking, so I came back in .it was dark did not see him get into a car .went with nurse to parking lot .did not see him .I did not initiate the elopement drill or notify nurse when [Named Resident #1] went out the door .I did not ask the visitor to sign in . During a telephone interview on 3/7/2022 at 1:26 PM, Resident #1's daughter (the Responsible Representative, POA) stated, .I am his Responsible party and only daughter .my father has dementia .in the facility because he was not taking care of himself .I was notified that my father had left the facility with someone who said they were his daughter .scared me to death because I'm here in [Named State] and only daughter .was told he left the facility .did not know who he left with or where he was .3 days later I was notified by a friend that my father was in the hospital in [Named City and State] .I contacted the police in [Named State] and was told my father was found confused at a restaurant, they had taken him to the hospital to be checked out. I called the hospital and he had been admitted .he [Resident #1] told me he had caught the bus to [Named State] with the intention to get to [Named City], he didn't remember much about how he ended up at the hospital. I notified the [Named] Police and APS to let them know where he was located . During an interview on 3/8/2022 at 11:43 AM, the Nurse Practitioner (NP) stated, .they called me that night in a panic, trying to figure out where he was and who the daughter was .there were no AMA orders given, no AMA paperwork signed .he's functional but something isn't quite right .he is not safe . During a telephone interview on 3/8/2022 at 11:45 PM, the Police Investigator stated, .a call came in for a missing person around 2:45 AM, an officer responded to the facility and made a report .I had a problem with how he [Resident #1] got out of the building because someone had to scan the door to come in or out . wondered why he was allowed to go out that time of night to visit because he has a diagnoses of dementia . he had a case with Adult Protective Service where he was assaulted by his son .yes it concerned me. Someone let him out the door with someone that posed as his daughter .we were instructed to return resident to the facility if found .the daughter called and reported he was in [Named City and State] on 2/18 [2022] .she said he had money in his pocket and was confused when he was found . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/8/2022 at 3:35 PM, the DON stated, .no one signed him out .he said was going to the car to visit his grandkids .We didn't look at this as an elopement because he called someone he knew to come and get him .we didn't think about his BIMS score .this was not a AMA incident, no paperwork for AMA was completed by the resident or RP .we were concerned about his safety .a staff member scanned the visitor in and out .we do not restrict visiting and we do not monitor if visiting takes place outside . During an interview on 3/8/2022 at 4:08 PM, the DON stated, .if AMA there would have been an AMA paper signed, his [Resident #1's] medications and his clothing would have went [gone] with him .I called the daughter to see when he would be returning to the facility since he had left all of his belongings .she informed me that he was not with her . During a telephone interview on 3/9/2022 at 10:46 AM, Resident #1 stated, .called a close friend to come pick me up from the facility that night. She took me to a hotel where I spent the night. The next morning, I caught the city bus to the [Named] bus terminal to go to [Named City]. There was a 3-hour layover in [Named City and State], the bus left me and 6 others at the terminal and did not return. I caught rides with different people and ended up in [Named City and State]. I was lost and trying to find the bus station to get to [Named City], I flagged the police down to ask directions, the next thing I remember here I am in the hospital .I did not sign any papers [for LOA or AMA] .the visitor I left with was not my daughter, I did not receive any medications before I left the facility .My daughter [Named his daughter] is my RP . The surveyors verified the Removal Plan by: 1. Residents will be educated during the initial discharge planning on the AMA process. The surveyors verified by chart review and interviewed the Social Service Director. 2. AMA forms will be available for staff access at each Nursing Station. The surveyors made observations and interviewed agency and facility staff on all shifts. 3. Residents will be required to sign-out when leaving the facility via AMA form with education or LOA form which will be provided by the attending nurse or designee. The surveyors reviewed education and interviewed agency and facility staff on all shifts. 4. LOA sign out log will be located at each Nursing Station. The surveyors made observations and interviewed agency and facility staff on all shifts. 5. Any Leave of Absence or AMA discharge will be authorized by the resident responsible party if BIMS is below 12 or has a diagnosis of Dementia or Alzheimer's. The surveyors made observations and interviewed agency and facility staff on all shifts. 6. Staff In-services will be inclusive to full-time, part-time, and agency staff. In-services will include AMA policy and procedure, location of AMA discharge forms, LOA policy and procedure, location of LOA sign out log, proper supervision of resident visitation, BIMS education including PCC (electronic medical record) EMAR (Electronic Medication Administration Record). All staff will be required to complete the in-services prior to their next shift. The surveyors made observations and interviewed agency and facility staff on all. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34153 Based on policy review, Board of Examiners for Nursing Home (BENHA) Form, job description review, and interview, the facility Administration failed to administer the facility in a manner that enabled the facility to use its resources effectively to attain and maintain the highest practicable well-being of vulnerable moderately impaired residents with dementia. The Administration failed to provide oversight to monitor and ensure resident safety and supervision to prevent an incident of elopement when Resident #1, a vulnerable resident with dementia, left the facility's premises without authorization, with a visitor, posing as the resident's representative. Administration failed to provide oversight and guidance of nursing and facility staff to ensure vulnerable residents were provided with a safe environment for visitation. The facility's failure resulted in Immediate Jeopardy and actual Harm when Resident #1 was found in a (Named) hospital in another state, located approximately 1,922 miles from the facility. Resident #1 required medical treatment for elevated blood sugar and blood pressure (the resident was without his prescribed medications for blood pressure and blood sugar when he left the facility). The facility was unaware of the resident's location for 12 days. 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 the resident. The Administrator was notified of the Immediate Jeopardy on 3/11/2022 at 11:51 AM, in the Administrator's Office. The facility was cited Immediate Jeopardy at F-689, F-835, and F-867. The facility was cited at F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 2/13/2022 through 3/13/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 3/12/2022 at 8:24 PM, and was validated onsite by the surveyors on 3/13/2022 through 3/14/2022 through observations, review of meeting minutes, education, audits, policies, medical record reviews, and staff interviews conducted on all shifts. The findings include: Review of the facility's undated policy titled, ELOPEMENT, revealed .Staff shall investigate and report all cases of missing residents .Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing .If an employee observes a resident leaving the premises, he/she should: Attempt to prevent the departure in a courteous manner; Get help from other staff members in the immediate vicinity, if necessary; and Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises .complete and file Report of Accident/Incident . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Gardens at Memphis Rehab & Snc	131 N Tucker Memphis, TN 38104

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, Discharge of Resident: Against Medical Advice [AMA], revealed . Purpose: To describe the discharge process for a patient departing from the center against medical advice . Discuss with patient or legal representative the desire to leave the center against medical advice .inform physician of patient's intent to discharge against medical advice .physician orders as needed .assist in fully explaining .the risk of discharge against medical advice .Provide written and verbal education to the patient and legal representative .Inform patient .that leaving the center prevents the provision of necessary care and services and that the physician and center are not responsible for the welfare and wellbeing of a patient . Complete Release for Discharge Against Medical Advice form with patient or legal representative's signature . Ensure that all belongings are packed and sent with patient .escort and assist patient to transport vehicle . Review of the facility's undated policy titled, Leave of Absence Policy (LOA), revealed .permit residents to leave the Facility premises for designated time periods and (2) ensure that the Facility is aware of the whereabouts of its residents .All residents leaving the Facility premises must be appropriately signed out and signed in upon return .Staff members should promptly inform supervisor for any requests received for a LOA . The Resident and/or the Resident Responsible Party shall sign the LOA form and Release .if staff has any concerns with regard to the Resident leaving with a specific individual, staff should contact one of their supervisors . Review of the undated Administrator Job Description revealed .the purpose of this position is to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet residents' needs .define problems, collect data, establish facts, and draw conclusions .develop, maintain, and implement operational policies and procedures to meet residents' needs develop a monitoring system to assure compliance . Review of the undated Social Services Coordinator Job Description revealed .assure that each resident attains .maintains his/her highest practicable physical, mental, and/or psychosocial wellbeing .maintaining contact with the resident's family members, involving them in the resident's total plan of care . Review of the undated Director of Nursing Services Job Description revealed .plan, organize, develop, and direct the overall operation .to ensure that the highest degree of quality care is maintained .developing appropriate plans of action to correct identified deficiencies . Review of the BENHA form revealed the Administrator was hired in 2/2017. During an interview on 3/2/2022 at 3:30 PM, the Administrator stated, .the resident's [Resident #1's] girlfriend came to the facility to visit that night she was posing as his daughter he stated he wanted to go outside to see his grandchildren .staff let him out, he got in the car and they drove off .he called the facility and said he was ok, he is living in [Named State] with his family .the only reason we reported it was because we didn't want you [surveyors] to come in here and say it was an elopement .he was going to be discharged but he just left . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Administration will provide in-service education to all staff on the necessary steps, authorizations, and supervision when interacting with cognitively impaired residents, all discharges will be to a safe/known location, LOA, and AMA process. The surveyors reviewed education and interviewed the Administrative staff, Agency staff, and Facility staff on all shifts. 3. Visitation for vulnerable residents will be adjusted according to risk factors directly related to each individual resident's needs. The surveyors interviewed the administrative staff, Care plan Coordinator, Agency, and Facility staff on all shifts. 4. All visitors must provide proof of Identification (ID) prior to a Leave of Absence or AMA discharge. If the visitor isn't the Responsible Party, the Responsible Party will be contacted prior to resident being released. The surveyors interviewed the Facility and Agency staff on all shifts. 5. Administrative staff will be in-serviced on safe discharge practices. The surveyors reviewed the education and interviewed the DON, the Unit Manager, and Social Services Director. 6. All reportable events and safety related breaches will be reported to the Governing Body for guidance and correction. The surveyors interviewed the Administrator. 7. Oversight will be provided monthly for 3 months in house for a Administration and Nursing with the Governing Body or designee. The surveyors interviewed the Administrator. 8. All the above steps were initiated on 3/11/2022 and will be monitored for 30 days for effectiveness and will be shared with Quality Assurance (QA) for evaluation. The surveyors interviewed the Administrator. The facility's noncompliance at F-835 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34153 Based on policy review, Quality Assessment and Assurance Committee (QAA) meeting minutes, and interview, the QAA Committee failed to identify ineffective policy and procedures related to Leave of Absence (LOA), Against Medical Advice (AMA), Planned/Unplanned discharges, and visitation for vulnerable residents, failed to maintain a process for monitoring and recognizing effective policies and protocols for vulnerable residents, to identify and screen visitors, and the authorizations of Responsible Parties and safety during visitation. The QAA committee's failure to identify areas of safety concerns including validation of a visitor's identity, notification of a resident's Responsible Party related to visitation, Leave of Absence, and Against Medical Advice, resulted in Immediate Jeopardy and actual Harm when a cognitively impaired resident left the facility for an outdoor visit, got in a car, and left the premises without authorization from the Responsible Party. Resident #1 was found in a (Named) hospital in another state, located approximately 1, 922 miles from the facility. Resident #1 required medical treatment for elevated blood sugar and blood pressure (the resident was without his prescribed medications for blood pressure and blood sugar when he left the facility). The facility was unaware of the resident's location for 12 days. 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 the resident. The Administrator was notified of the Immediate Jeopardy on 3/11/2022 at 11:51 AM, in the Administrator's Office. The facility was cited Immediate Jeopardy at F-689, F-835, and F-867. The facility was cited at F-689 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 2/13/2022 through 3/13/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 3/12/2022 at 8:24 PM, and was validated onsite by the surveyors on 3/13/2022 through 3/14/2022 through observations, review of meeting minutes, education, audits, policies, medical record reviews, and staff interviews conducted on all shifts The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, Quality Assessment and Assurance Committee revealed . establish and maintain a Quality Assessment and Quality Assurance Committee that oversees the identification and handling of quality issues .help identify negative outcomes .develop implementation, monitoring and evaluation of action to correct quality concerns and promote overall quality of care and services .actions that may be implemented to help address quality issues may include .educational training programs, new or revised policies and procedures .adjustment in .discharge practices .develop and implement plans of correction and monitoring approaches .should include specific timeframes for implementation and follow up .advise the administration of the need for policy or procedural changes . monitor to ensure that such changes are implemented . Review of the facility's Quality Assessment and Assurance Committee Emergency Meeting dated 2/14/2022, revealed .Purpose: To discuss occurrence related to resident leaving facility and to determine further actions needed .discuss current LOA [leave of Absence], AMA [Against Medical Advice], Planned/Unplanned discharge procedures .how to address unusual instances where the resident/representative choose not to participate in established practices and the measures to gather information related to said occurrence . Review/Actions: current LOA, AMA, Planned/unplanned discharge procedures are deemed to be effective and applicable . The QI (Quality Improvement) sign-in sheet showed signatures of the following attendees Administrator, Director of Nursing (DON), Minimum Data Set (MDS) Nurse, Medical Director (via phone), and Social Services. Review of the facility's Quality Assessment and Assurance Committee Emergency Meeting dated 2/21/2022, revealed .Purpose: To discuss potential actions/interventions to strengthen LOA procedures as it relates discharges related to LOA's, planned discharges, unplanned discharges, and resident who choose to not return and refuse to sign LOA, participate in teaching, and/or not participate in pre/post discharge teaching. Current LOA,AMA, Planned/Unplanned discharge procedures are deemed to be effective and applicable . unusual instances where the resident/representative choose not to participate in established practices and the measures to gather information related to said occurrence .the facility will exhaust all avenues and will contact RP [Responsible Party] .make report to appropriate agencies and document based on status of discharge .facility will take into consideration BIMS[Brief Interview for Mental Status] scores and elopement/wander risk during admission and discharge planning .Review/Actions: current LOA, AMA, Planned/unplanned discharge procedures are deemed to be effective and applicable .explore plan to identify documented representatives and/or notify those parties of visitors not on list of representatives when warranted . The QI sign-in sheet showed signatures of the following attendees: Administrator, DON, MDS Nurse, Medical Director (via phone), and Social Services. During the QAA meetings conducted on 2/14/2022 and 2/21/2022, the QA committee failed to identify this incident as an elopement, did not review the elopement policy/procedure, and did not review the visitation policy to ensure cognitively impaired residents were safe during visitation. The QAA committee failed to identify how the staff would be educated on the actions concerning the LOA policy. The QAA committee failed to identify when staff education would be provided and failed to identify a timeframe for completion of the education related to elopement, LOA, AMA, and Planned/Unplanned discharge. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/8/2022 at 11:43 AM, the Nurse Practitioner (NP) stated, .went back and forth about if it was an AMA or not because he called someone to get him .they called me that night in a panic, trying to figure out where he was and who the daughter was .there were no AMA orders given, no AMA paperwork signed .he's functional but something isn't quite right .he is not safe . During an interview on 3/8/2022 at 3:35 PM, the DON stated, .no one signed him out because he said was going to the car to visit his grandkids .that night I told the Unit Manager to call and report the resident missing when we found out the visitor was not his Responsible Party. We began the investigation as he went out with his daughter .I didn't go over the statements until the next morning .it was clear this was not an AMA .he did not go out LOA .he left when he got the opportunity .we did not consider his low BIMS score when we started the investigation .nothing has changed for visitation since this happened .residents can go outside to visit without supervision .the Administrator and I were talking today about how to revise the policy to ensure family members are who they say they are .just not sure how we are going to do that .ask for driver's license for identification .not sure how to proceed .no, there is not an incident report because we thought it was an AMA . During an interview on 3/10/2022 at 4:45 PM, the Administrator stated, .the 11:00 PM-7:00 AM shift is not familiar with the AMA procedure .most AMA discharges happen during the day when administrative staff is [are] here .this was a real gut punch for me .did not consider the resident's BIMS [Brief Interview for Mental Status] assessment of 9 in determining if the resident was safe to make the decision to leave for himself .did not think about if we had additional means to confirm the identity of the visitor .did not identify when the facility staff should contact the Responsible Party before the resident is released . During an interview on 3/13/2022 at 6:24 PM, the DON confirmed there was no documentation of the incident in Resident #1's medical record on 2/13/2022, the documentation was added on 2/15/2022 and 2/16/2022. On 3/3/2022, after a chart audit, Resident #1's evening medications were not documented as administered on 2/14/2022. The DON further confirmed that since there was no documentation the night of the incident, it would not have been on the 24-hour report which prompts the information used to conduct the Interdisciplinary Team Meetings. During an telephone interview on 3/14/2022 at 11:09 AM, the Governing Body member stated, .I believe we have had this conversation before about my role for the facility .I am not involved in any type of committee .I was notified .my direction was to try and locate the resident .he left AMA from the facility with his daughter .it is still an AMA from our perspective .resident expressed he wanted to leave without proper discharge instructions .he can leave without his belongings and discharge himself .my understanding is that he is capable of making those decisions .I haven't evaluated him and neither have you .you cannot establish the fact that he is not capable of making those decisions .no, he shouldn't have left the facility .not good for his health .BIMS 9 .he shouldn't have been out of the nursing home . The surveyors verified the Removal Plan by: 1. On 3/11/2022, an AdHoc (As needed) meeting was conducted to review, educate, and update policies in relation to: LOA, AMA, planned/unplanned discharges, visitation for vulnerable residents, to identify and screen visitors, and authorizations of Responsible Parties and safety during visitation. The surveyors interviewed the Administrator, DON, Agency, and Facility staff on all shifts. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. AdHoc meeting education was done covering events that warrant AdHoc meeting, which are reportable events, breaches of policy and procedure, and any upward trend in events affecting wellbeing of residents. The surveyors reviewed the education and interviewed the Administrator and the DON. 3. QAPI education was done for the Interdisciplinary Team (IDT). The surveyors reviewed the education and interviewed the Administrator, DON, Unit Manager, and Care Plan Coordinator. 4. Policies and procedures have been reviewed and updated for LOA, AMA, planned/unplanned discharges, and visitation for a vulnerable resident. The surveyors reviewed the updated policies and interviewed Agency and Facility staff on all shifts. 5. QA committee will meet monthly for 3 months and as needed to review any findings as related to breaches of policy and reportable events. The surveyors interviewed with Administrator and DON. 6. In-service was done for all staff on all policy and procedure updates. The surveyors reviewed the education and interviewed Agency and Facility staff on all shifts. 7. Corrective actions will be monitored for 30 days for effectiveness; all findings will be shared with QA for evaluation. The surveyors reviewed audit forms and interviewed the Administrator and DON. 8. All visitors must provide proof of Identification (ID) prior to a Leave of Absence or AMA discharge. If the visitor isn't the Responsible Party, the Responsible Party will be contacted prior to resident being released. The surveyors reviewed the updated policies and interviewed agency and facility staff on all shifts. 9. The QA committee will meet quarterly to review and update policies and procedures as related to vulnerable residents, visitor screening, authorization of Responsible Parties, and safety during visitation. Vulnerable resident's visitation will be care planned and adjusted depending upon the identified vulnerability. The surveyors interviewed the Administrator, DON, and Care plan Coordinator. 10. All the above steps were initiated on 3/11/2022, will be monitored for 30 days for effectiveness, and all findings will be shared with QA for evaluation. The surveyors reviewed meeting minutes and interviewed the Administrator and DON. The facility's noncompliance at F-867 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.