STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445165	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Health and Rehabilitation Center	3549 Norriswood Memphis, TN 38111

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34153 Based on the facility's timeline review, policy review, medical record review, and interview, the facility failed to provide a safe environment and ensure supervision to prevent neglect for 1 of 4 residents (Resident #1) reviewed for elopement risk. The facility's failure to provide care and services necessary to prevent neglect resulted in Immediate Jeopardy when Resident #1, a moderately impaired vulnerable resident wearing an ankle wander guard monitor (a monitoring device to alert staff when a resident attempts to exit a door in the facility) was left unsupervised at a medical appointment and the resident left the appointment without authorization or necessary supervision. The facility was unaware of the resident's location for 8 hours and 39 minutes. Resident #1 was located approximately 7.1 miles from the facility, sitting outside a convenience store, drinking alcohol, and smoking a cigarette when the facility staff arrived at the store. 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 and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 2/16/2022 at 6:31 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600. The facility was cited F-600 at a scope and severity of J, which is Substandard Quality of Care. The IJ existed from 2/10/2022 through 2/11/2022. The Immediate Jeopardy was removed onsite when the facility implemented a corrective action plan. The corrective actions were validated onsite by the surveyors on 2/14/2022 through 2/18/2022. The facility was cited past noncompliance and is not required to submit a Plan of Correction. The findings include: Review of the facility's titled, Policy and Procedure .Abuse Prohibition, dated 2015, revealed .Neglect' means failure to provide goods and services necessary to avoid physical harm . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Traumatic Hemorrhage of the Cerebrum, Cardiomegaly, Hyperglycemia, Anemia, Alcohol Abuse, Cocaine Abuse, and Seizures. Review of the admission Elopement Risk Evaluation dated 5/7/2021, revealed Resident #1 was assessed at a high risk for elopement and a wander guard monitor was placed on his left ankle. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 10 on the Brief Interview of Mental Status (BIMS), which indicated the resident was moderately impaired for decision making. Review of the Care Plan dated 11/16/2021, revealed Resident #1 was at risk for elopement, wore a wander guard, and was to remain safe during nursing home placement. Review of the facility's timeline dated 2/10/2022, revealed Resident #1 had an appointment with a Social Security Disability Psychiatric Doctor on 2/10/2022 at 9:45 AM. On 2 /4/2022, Resident#1's sister requested the Social Worker arrange transportation to the appointment and the sister would then meet Resident #1 at the appointment. On 2/10/2022 Resident #1 left the facility at 9:02 AM in the transport van with the transport driver. The transport driver was informed that Resident #1's sister would be at the appointment and to transfer responsibility of the resident to the sister upon arrival. The transportation driver escorted Resident #1 to the appointment on 2/10/2022 and left Resident #1 in the waiting room without checking to see if the sister was at the appointment. The transportation driver returned to the physician's office at 2:25 PM and found the building to be dark, the doors locked, and Resident #1 was not present outside the building. The facility was notified. The facility made attempts to notify the sister with no answer. Emergency 911 was called by the facility to report Resident #1 missing. Facility staff left the facility to search for Resident #1. At 4:15 PM, a facility staff member reported Resident #1 was at a Community Center, approximately 2.2 miles from the facility but had left the Community Center walking, approximately 20 minutes before staff arrived. At 4:48 PM, Resident #1's sister called and informed the facility that she did not go to the appointment. She had received a call from Resident #1 from a stranger's phone and he stated he was at an intersection that was approximately 4.1 miles from the facility and planned to go to the (Named) store where he used to work located approximately 7.1 miles from the facility. Staff arrived at the (Named) store at 5:41 PM and found Resident #1 drinking vodka from a bottle and smoking a cigarette. The facility staff escorted Resident #1 back to the facility at 6:04 PM. The facility failed to ensure Resident #1 was free from neglect and failed to provide supervision for him, a vulnerable moderately impaired resident, wearing an ankle wander guard monitor. Resident #1 was unsupervised for approximately 8 hours and 39 minutes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/14/2022 at 5:15 PM, Resident #1 stated, .I went to an appointment .the Social Worker made arrangements for them to take me .my sister told me she was not coming, she had to work [the resident did not tell the facility this] .I went outside to look for my ride, and the driver was not there, he was gone .I sat and talked to the homeless people, and they gave me cigarettes. I got tired of waiting .I went back into the office they told me to wait outside. I went outside and sat on the steps .I walked to a friend's house that lived in the area, he was not there so I came back [to the appointment location] and went and asked again where my ride was .they told me to go outside so the driver could see me. I waited until I started to get cold and hungry. I walked back to my friend's house, he was home, and he took me to East [part of the city where he lived]. I called my sister and told her to come and get me and that's when she told me the [facility] had been calling her looking for me .then I went to the place I used to work [Named Store] they were glad to see me, they said they thought I was dead. My friends gave me some vodka and cigarettes .I was outside drinking .nurses caught me when I was turning the bottle up drinking my friends gave me 2 small bottles [of alcohol] and I put it in my pocket .I drank them on the way back. I told them I didn't want to come back .I'm trying to get out of here .I don't belong here .I was hungry and sleepy .just having a good time . During an interview on 2/15/2022 at 6:12 PM, the Administrator stated .when he left the facility to go to the appointment he was wearing a wander guard monitor .he should have been supervised .he is our responsibility . During a telephone interview 2/16/2022 at 11:27 AM, the transport driver stated, .picked him [Resident #1] up around 9:00 AM .I noticed he had an ankle monitor on, I wondered about it .I walked upstairs with him to the office [physician's office] .I don't know if his sister was there or not; I just walked him to the door and left . when I came back around 2:45 PM to pick him up the whole building was dark, the doors were locked, didn't see him .I called [Named Social Worker] and told her he wasn't there .I had a feeling I knew I shouldn't have left him . During an interview on 2/16/2022 at 12:02 PM the Social Worker (SW) confirmed she did not follow up to ensure Resident #1's sister would be attending the appointment with the resident. The SW stated, he wears the wander bracelet for his safety .he verbalizes going home and wanting to leave .he's not safe because of his drinking and drug history .he should've had an escort . During an interview on 2/18/2022 at 2:58 PM, the DON stated, .because of his drinking and drug history and verbalizing he wants to go home .don't know if we can trust him .he should have been supervised . The facility's corrective action plan included the following: 1. On 2/10/2022, an investigation of the incident was initiated. The surveyors reviewed the facility's investigation, interviewed the DON, Administrator, and facility staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 2/10/2022, an AdHoc (as needed)/Quality Assurance Performance Improvement (QAPI) meeting was conducted with the Medical Director, Administrator, DON, and Director of Social Services participating in the meeting. The meeting was held to notify and discuss the incident and receive input from the Medical Director. During this meeting, a new policy was developed and implemented that no residents are to go to appointments without a facility staff member escort. The surveyors reviewed the AdHoc sign in sheet and interviewed the Medical Director, Administrator, DON, Social Worker, and facility staff. The surveyors reviewed the new policy for transport. 3. On 2/10/2022, in-service education regarding the new policy was completed with the Social Worker. The surveyors interviewed the Social Worker and reviewed the in-service sign in sheets. 4. Beginning on 2/10/2022, Resident #1 was educated daily following the incident by the Psychiatrist, Nurse Practitioner (NP), DON, and Social Services that he does not need to attempt to leave on his own because the facility needs to be aware of where he is for his own safety. The surveyors interviewed the NP, DON, Social Services, and Resident #1 about the education provided. The surveyors reviewed the medical record for documentation of the education. 5. On 2/11/2022, the DON, Administrator, and Registered Nurse (RN) #1 initiated education for all staff regarding the new policy for resident transport. All staff will be educated prior to working their next shift. The education is ongoing. The surveyors interviewed facility staff on all shifts and reviewed the in-service sign in sheets. 6. On 2/11/2022, all Elopement Risk Evaluations were reviewed for accuracy. Two residents were no longer an elopement risk and wander guards were removed. The orders were checked on all residents (Elopement Risk Evaluation) with a score of 10 or higher and requiring wander guards to ensure nursing is alerted on the Medication Administration Record (MAR) to check the wander guards for placement and functioning. Wander guards were noted to be in place and functioning. The wander guard binder was audited to ensure all residents at high risk for elopement had the residents' pictures and face sheets present. The surveyors reviewed the audit form, the medical records, and reviewed the wander guard binders. 7. On 2/11/2022, all appointments made in the last 30 days were audited to ensure the facility did not fail to provide adequate supervision to prevent an incident of elopement of a moderately impaired vulnerable resident wearing a wander guard bracelet with a history of alcohol and cocaine abuse. The outcome of the audit was that no appointments were noted. The surveyors reviewed the audit form and interviewed the facility staff. 8. Beginning 2/10/2022, all new employees will be in-serviced during orientation on the transportation escort policy going forward. The surveyors interviewed the DON regarding new employee education. 9. On 2/10/2022, education was provided for family members regarding the new transportation escort policy as appointments are scheduled. The surveyors interviewed the DON, the Administrator, and the Social Worker regarding family education. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. The Administrator will review appointment sheets weekly to ensure facility is providing an escort and to ensure that the facility is providing adequate supervision to prevent an incident of elopement of a vulnerable resident from an appointment. Review of appointment sheets will be done weekly for 4 weeks, bi-weekly for 30 days, monthly for 1 month, then quarterly. Findings will be reported to QA monthly for 3 months then quarterly. The surveyors reviewed the audit tool for appointments and interviewed the Administrator regarding the monitoring.

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(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 the policy review, facility's timeline review, medical record review, observation, and interview, the facility failed to ensure a safe, secure environment for a vulnerable, moderately impaired resident wearing a wander guard bracelet (a monitoring device to alert staff when the resident attempts to exit a door in the facility) for 1 of 4 sampled residents (Resident #1) reviewed for elopement. The facility's failure to ensure a safe, secure environment resulted in Immediate Jeopardy (IJ) when Resident #1 was transported to a medical office and left at the medical office without supervision. Resident #1 left the medical appointment unsupervised, without the facility's knowledge, and was found approximately 8 hours and 39 minutes after leaving 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 and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 2/16/2021 at 6:31 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-689. The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ existed 2/10/2022 through 2/11/2022. The Immediate Jeopardy was removed onsite when the facility implemented a corrective action plan. The corrective actions were validated onsite by the surveyors on 2/14/2022 through 2/18/2022. The facility was cited as past noncompliance and is not required to submit a Plan of Correction. The findings include: Review of the facility's undated policy titled, Elopement, Risk Prevention, and Management of Missing Residents, revealed, .facility strives to promote resident safety .elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Traumatic Hemorrhage of Cerebrum, Cardiomegaly, Hyperglycemia, Anemia, Alcohol Abuse, Cocaine Abuse and Seizures. Review of the admission Elopement Risk Evaluation dated 5/7/2021, revealed an elopement risk score of 13, which indicated a high risk for elopement, and a wander guard monitor was placed on his left ankle. (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 quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 10, which indicated the resident had moderate impairment for daily decision making. Resident #1 was independent with supervision for Activities of Daily Living (ADL). Review of the Care Plan dated 11/16/2021, revealed Resident #1 was at risk for elopement and had difficulty making daily decisions due to a Cerebrovascular Accident and a Traumatic Brain Injury. The intervention to address this concern was to implement a wander guard monitor. Review of Physician's Progress notes dated 1/5/2022 and 2/8/2022, revealed Resident #1 had a past medical history of Cerebral Hemorrhage and Intracranial Bleed, Seizures, Diabetes, Hypertension, Alcohol Abuse, was alert, was oriented times two to person and place, and had paranoia attributes. Review of the monthly summaries dated 1/8/2022 and 2/8/2022, revealed Resident #1 participated in the Elopement Management Program. Review of the facility's timeline dated 2/10/2022, revealed Resident #1 left the facility at 9:02 AM in a transportation van for an appointment. The transportation driver escorted Resident #1 into the appointment office and left the resident unattended. The transportation driver returned to the office at 2:45 PM, the building was dark, the door to the office was locked, and Resident #1 was not present. The facility was notified. Staff left the facility to search for Resident #1. At 4:15 PM, a facility staff member reported Resident #1 was at a Community Center, approximately 2.2 miles from the facility but had walked away from the center about 20 minutes before staff arrived. At 4:48 PM, Resident #1's sister called the facility and stated she had received a call from Resident #1. He was using a stranger's phone. He said he was at an intersection that was approximately 4.1 miles from the facility and was going to a (Named) Store where he had previously worked, that was located approximately 7.1 miles from the facility. The facility staff arrived at the (Named) store at 5:41 PM. Resident #1 was drinking vodka from a bottle and smoking a cigarette. The facility staff escorted Resident #1 back to the facility at 6:04 PM. The outside temperature was noted to be 61 degrees at that time. Resident #1 was wearing capri length pants, a t-shirt, and a button up shirt with mid length sleeves, socks, and tennis shoes. The facility failed to ensure a secure and safe environment for Resident #1 when the facility was unaware the resident was missing from the appointment until 5 hours and 43 minutes later, when the transport van driver notified the facility. The facility was unaware of Resident #1's location for approximately 8 hours and 39 minutes. Resident #1 was located 7.1 miles from the facility, at a convenience store drinking alcohol and smoking a cigarette. (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 2/14/2022 at 5:15 PM, Resident #1 stated, .I went to an appointment .the Social Worker made arrangements for them to take me .my sister told me she was not coming, she had to work [the resident did not tell the facility this] .the appointment only lasted 10 minutes, I went outside to look for my ride, and the driver was not there, he was gone .I sat and talked to the homeless people, and they gave me cigarettes. I got tired of waiting . I went back into the office they told me to wait outside. I went outside and sat on the steps .I walked to a friend's house that lived in the area, he was not there so I came back [to the appointment location] and went and asked again where my ride was .they told me to go outside so the driver could see me. I waited until I started to get cold and hungry. I walked back to my friend's house, he was home, and he took me to East [part of the city where he lived]. I called my sister and told her to come and get me and that's when she told me the [facility] had been calling her looking for me. I was at [named streets in the city]. I got a house in that area .I fed my dogs .then I went to the place I used to work, [named store] they were glad to see me, they said they thought I was dead. My friends gave me some vodka and cigarettes .I was outside drinking .when the police, I mean nurses pulled up .my girlfriend came up there too .she wanted us to go to the house .she said she had some liquor and cigarettes and some food .My friend at the store gave me some food to eat .didn't do any drugs .nurses caught me when I was turning the bottle up drinking my friends gave me 2 small bottles [of alcohol] and I put it in my pocket .I drank them on the way back. I told them I didn't want to come back .I'm trying to get out of here .I don't belong here .I was hungry and sleepy . just having a good time . During the interview, Resident #1 was looking at the windows in the Conference Room. Resident #1 stated, .do you think those windows would open .if they open, then you could get out of them . Observation downstairs at the vending machine on 2/15/2022 at 12:30 PM, revealed Resident #1 standing near the vending machines that were located near an exit door. A wander guard bracelet was noted on his left ankle. Resident #1 stated, .I'll go out that door, jump over that fence and go home . During an interview on 2/15/2022 at 3:36 PM, Registered Nurse (RN) #1 stated, .I heard he [Resident #1] was missing when the driver went to get him .everyone [driving around] looking for him .the resident's sister was called .she said he was walking to the [Named] convenience store .another nurse and I went to the [Named] store .when we arrived to the store he was sitting on a milk crate outside talking to some other people .drinking a bottle of liquor .he said 'I'm not ready to go' I told him we'd been looking for him all afternoon .he had liquor, he drank the rest of it .he had a small bottle of liquor in his pocket he drank it on the way back to the facility .I don't know if he had done any drugs I didn't ask . (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 2/15/2022 at 3:54 PM, Licensed Practical Nurse (LPN) #1 stated, .I was informed transport had called and said the resident wasn't at the office when he went back to pick him up .[Named Social Worker] and I went to the building where the appointment was . the door was locked to the office .rode around grocery store parking lot .then came back to the facility .I got in my car and started looking in a different area .tried to call his sister, she called and gave me the address of his former home .the sister had not heard anything from him .I went to the address the sister had given me and looked around .didn't see him .I was notified that he had called his sister and said he was at a bus stop .the Police were here and Administrator said he's my responsibility we'll go get him. I got in the car and the Administrator called and said he was at the [Named] store and the staff at the store was going to hold him there until we got there. When we got there, he was sitting on a milk crate in the front of the store. He was drinking alcohol when he seen us, he turned the bottle up. He had 2 cigarettes behind each ear and he was smoking a cigarette and said, ' .oh lord it's the police .' he had a fifth of vodka in his hand and he drank it all .asked him how did you get out here .he said I caught the bus .he didn't say from where .just said he had friends .he's always had a wander guard on .always asks when am I getting out of here . During an interview on 2/15/2022 at 5:10 PM, the Social Worker (SW) stated, .[Named Resident #1]'s sister had requested transportation to be set up for an appointment because she didn't want to take him in her car because she said he would jump out of the car and take off .he asked me several times if we had transportation set up for the appointment .when I got to work the morning of the appointment .he was already dressed and ready to go, pacing around .transport came and got him took him to the appointment .the transport driver called around 2:45 PM and notified me that the resident wasn't at the medical office when he returned pick him up .everyone started looking for him .in our cars looking at the library, the grocery store . hoping we'd see him walking around .it was scary .didn't consider him an elopement risk .verbalizes he wants to go home that's why the wander guard is still on . During an interview on 2/15/2022 at 6:12 PM, the Administrator stated, .when he [Resident #1] left the facility to go to the appointment he was wearing a wander guard .we did not know he had left the appointment until the transport driver went back to pick him up .we didn't know where he was going .he knew where he was going and how to get there but he is still our responsibility .for his safety he is going to keep the wander guard on . During an interview on 2/16/22 at 11:18 AM, the Nurse Practitioner (NP) stated, .notified he [Resident #1] had gone to an appointment and didn't return .when he got back he was intoxicated I ordered some prn [as needed] medications .he was looking to get out .meet with friends he didn't think it was a big deal .I have concerns because of the history of a brain bleed .he wouldn't be safe .he has a history of alcohol abuse .that [alcohol] is what he was after .not capable of making good decisions that are safe for him . (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 2/16/2022 at 11:27 AM, the transport driver stated, .picked [Named Resident #1] up around 9:00 AM .took him to the appointment address .I noticed he had an ankle monitor on, I wondered about it .on the way to the appointment he talked about where he was from, said his sister was going to meet him at the appointment, talked about his history of alcohol and what he was going to eat for lunch. I walked upstairs with him to the office and left .when I came back around 2:45 PM to pick him up, the whole building was dark, the doors were locked, didn't see him. I called [Named Social Worker] and told her he wasn't there .she asked me to look for him, so I drove to south [area of the city] looking around because that's where he said he was from around 5:00-6:00 PM that evening I found out he had been located . During an interview on 2/16/2022 at 12:02 PM, the Social Worker stated, .he's [Resident #1] not safe because of his drinking and drug history and his primary concern was drinking .he wasn't fearful .he should've had an escort . During an interview on 2/16/2022 at 5:05 PM, LPN #2 stated, .notified me that a resident is missing .went to the Community Center, a lady that works at the Community Center said he was there earlier .she showed me the video. He walked in the Community Center looked around and walked back out, walked toward [Named Street] .I called the facility and told them he had been at the Community Center .I looked around the area near the Community Center .police were looking .sister was on the phone .I called the [Named] store and talked to a staff member .they asked me if I was talking about the person with an ankle bracelet, I said yes that's him, they said he was he was walking down the street .I asked him [staff member] to get him back to the store . I talked to him [Resident #1] on the phone he said, 'how did you find me' guess he ate, got some alcohol. I told him to stay there .he had the wander guard on like it would do anything over there at the appointment . Observation in the resident's room on 2/16/2022 at 5:35 PM, revealed Resident #1 was lying in bed with a wander guard bracelet noted on his left ankle. Resident #1 stated to the surveyor, .are you coming to get me out of here? The surveyor stated, .no .the Social Worker is working on it . Resident #1 stated, .she's [the Social Worker] not going to do anything .all I need is a ladder and a rope . During a telephone interview on 2/17/2022 at 10:35 AM, the Appointment Secretary stated, .he [Resident #1] arrived to the appointment about 9:15 AM .he went to the hall where patients wait .he left the office probably about 10:10 AM .around 11:45-12:00 I was straightening up the office and I looked up and he was standing at the desk .I told him he couldn't be here .told him to go outside and wait on his ride, he walked out .I left the office about 12:30 PM saw him sitting at a bus stop .I guess he went on a joy ride/walk . During a telephone interview on 2/17/2022 at 11:55 AM, the Medical Director stated, . notified Thursday night that he [Resident #1] went to an appointment and left the appointment .went to a liquor store .he was intoxicated .no he is not safe to go by himself .he was supposed to have family meet him . During a telephone interview on 2/17/2022 at 12:10 PM, a Governing Body member stated, .he [Resident #1] was intoxicated when he was brought back to the facility .it is an unfortunate incident . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445165	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Health and Rehabilitation Center	3549 Norriswood Memphis, TN 38111

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/18/2022 at 2:58 PM, the DON stated, .residents with a wander guard should be supervised when going out to an appointment .alcohol affects decision making if they drink enough .because of his [Resident #1] drinking and drug history and verbalizing he wants to go home .he is an elopement risk . don't know if we can trust him . The facility's corrective action plan included the following: 1. On 2/10/2022, an investigation of the incident was initiated. The surveyors reviewed the facility's investigation, interviewed the DON, Administrator, and facility staff. 2. On 2/10/2022, an Adhoc (as needed)/Quality Assurance Performance Improvement (QAPI) meeting was conducted with the Medical Director, Administrator, DON, and Director of Social Services participating in the meeting. The meeting was held to notify and discuss the incident and receive input from the Medical Director. During this meeting, a new policy was developed and implemented that no residents are to go to appointments without a facility staff member escort. The surveyors reviewed the AdHoc sign in sheet and interviewed the Medical Director, Administrator, DON, Social Worker, and facility staff. The surveyors reviewed the new policy for transport. 3. On 2/10/2022, in-service education regarding the new policy was completed with the Social Worker. The surveyors interviewed the Social Worker and reviewed the in-service sign in sheets. 4. Beginning on 2/10/2022, after this incident, Resident #1 was educated daily by the Psychiatrist, Nurse Practitioner (NP), DON, and Social Services that he does not need to attempt to leave on his own because the facility needs to be aware of where he is for his own safety. The surveyors interviewed the NP, DON, Social Services, and Resident #1 about the education provided. The surveyors reviewed the medical record for documentation of the education. 5. On 2/11/2022, the DON, Administrator, and Registered Nurse (RN) #1 initiated education to all staff regarding the new policy for resident transport. The education is ongoing. Staff will be in-serviced prior to their first shift to work. The surveyors interviewed facility staff on all shifts and reviewed the in-service sign in sheets. 6. On 2/11/2022, all Elopement Risk Evaluation scores were reviewed for accuracy. Two residents were no longer an elopement risk and wander guards were removed. Orders were checked to ensure nursing is alerted on Medication Administration Record (MAR) to check wander guards for placement and functioning on all residents (Elopement Risk Evaluation) with a score of 10 or higher and requiring wander guards. Wander guards were noted to be in place and functioning. The wander guard binder was audited to ensure all high risk for elopement residents' pictures and face sheets were present. The surveyors reviewed the audit form, the medical records, and reviewed the wander guard binders. 7. On 2/11/2022, all appointments made in the last 30 days were audited to ensure the facility did not fail to provide adequate supervision to prevent an incident of elopement of a moderately impaired vulnerable resident wearing a wander guard bracelet with a history of alcohol and cocaine abuse. The outcome of audit of the audit revealed no appointments were noted. The surveyors reviewed the audit form and interviewed the facility staff. 8. On 2/10/2022, all new employees will be in-serviced during orientation on the transportation escort policy going forward. The surveyors interviewed the DON regarding new employee education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445165	A. Building B. Wing	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Health and Rehabilitation Center	3549 Norriswood Memphis, TN 38111

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On 2/10/2022, education for family members was provided regarding the new transportation escort policy regarding scheduled appointments and is ongoing. The surveyors interviewed the DON, the Administrator, and the Social Worker regarding family education. 10. The Administrator will review appointment sheets weekly to ensure the facility is providing an escort and is providing adequate supervision to prevent an incident of elopement of a vulnerable resident from an appointment. Review of the appointment sheets will be done weekly for 4 weeks, bi-weekly for 30 days, monthly for 1 month, and then quarterly. Findings will be reported to Quality Assurance (QA) monthly for 3 months then quarterly. The surveyors reviewed the audit tool for appointments and interviewed the Administrator regarding the monitoring.