STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345563	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion Health Center at Brightmore	**10011 Providence Road West , Charlotte, North Carolina, 28277**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted on 12/04/25. The survey team went back to the facility to validate the facility's corrective action plan on 12/09/25. Therefore, the exit date was changed to 12/09/25. The following intake was investigated: 2681627. Intake 2681627 resulted in immediate jeopardy. 1 of the 1 complaint allegation resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/22/25 and was removed on 11/26/25. A partial extended survey was conducted.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, video footage, observations, and interviews with family members, staff, the Medical Director, Police Officer, and Fire Captain, the facility failed to supervise a severely cognitively impaired resident (Resident #1) from exiting the facility without staff knowledge on 11/22/25 (Saturday) at approximately 10:28 AM on foot for 1 of 3 residents reviewed for supervision to prevent accidents. Resident #1 who had a primary diagnosis of toxic encephalopathy	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0689 SS = SQC-J	Continued from page 1 (neurological disorder caused by exposure to toxic substances, leading to diffuse brain dysfunction) exited from the facility without staff's knowledge for over two hours on the morning of 11/22/25. Resident #1 walked on the sidewalk on Providence Road (Providence Road is a heavily trafficked road in the city of Charlotte), fell and was assisted by strangers who placed the resident into their private vehicle and drove across town where the strangers dropped Resident #1 off at a fire department 20 miles away from the facility. The fire department called medics who transported Resident #1 to the hospital. Resident #1 was noted to have an abrasion and mild swelling over the right maxilla (upper jawbone) and abrasions on posterior aspect of bilateral hands from a reported fall on Providence Road where the facility was located. This had the high likelihood of causing serious harm and/or injury. The findings included: Resident #1 was admitted to the facility on 11/8/25 with diagnoses that included toxic encephalopathy, cardiac arrest, atherosclerotic heart disease (coronary artery disease caused by the buildup of fats, cholesterol and other substances in and on the walls of the heart arteries) and chronic kidney disease. A review of the Interdisciplinary Risk Assessment (this assessment is completed during admission to determine a resident's risk factors in the areas of pressure ulcer, wandering, falls, malnutrition and dehydration) for Resident #1 dated 11/8/25 and completed by the admitting nurse indicated Resident #1 did not have a history of wandering per family or other medical notes, did not have a history of elopement, had not been noted to wander, and did not have a diagnosis of dementia. The assessment also indicated Resident #1 had the following risk factors for fall: confusion/disorientation/impulsivity and altered elimination which meant he was frequently incontinent of both urine and bowel. Resident #1's care plan initiated on 11/10/25 indicated Resident #1 was at increased risk for falls due to confusion, poor balance and poor communication/comprehension and that he had impaired cognitive function or impaired thought processes. Interventions included to anticipate and meet needs as much as possible, to check on the resident frequently throughout the shift and to cue, reorient and supervise the resident as needed. Resident #1 did not have a care plan for wandering behaviors or risk for elopement.	F0689		

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F0689 SS = SQC-J	Continued from page 2 The admission Minimum Data Set assessment dated 11/14/25 indicated Resident #1 was severely cognitively impaired and did not exhibit wandering behaviors during the assessment period. Resident #1 did not have any range of motion impairments, used a wheelchair, and required partial/moderate assistance with most activities of daily living including walking 10 feet. Resident #1 did not have any falls since admission. A nursing progress note dated 11/21/25 at 6:36 AM documented by Nurse #2 indicated Resident #1 was resistive to personal care per staff. Nurse with nurse aide encouraged Resident #1 to allow staff to change soiled brief. Resident #1 showed confusion with understanding the need for changing and his ability to do it himself. The nurse explained to Resident #1 several times that they were there to help him due to his weakness displayed and unsteady gait. Resident #1 allowed staff to change him. Confusion noted throughout the personal care. Resident #1 placed legs into brief and attempted to ambulate alone. Nurse had to keep Resident #1 from falling while ambulating. A review of an Incident Report dated 11/22/25 prepared by the Director of Nursing indicated at approximately 11:30 AM, staff suspected that Resident #1 was missing from the building after they were unable to locate him when his (family member) came to visit. The Weekend Supervisor initiated the Code Pink protocol for missing residents. (Code Pink protocol meant a resident was missing and was used by the facility to alert staff to start searching for the missing resident.) Before the incident, staff interaction with the resident included a Nurse Aide who served him breakfast at approximately 8:15 AM, and his assigned Nurse Aide who picked up his tray at approximately 9:30 AM and observed him still lying in bed. Staff conducted an extensive search of the facility and surrounding areas, including neighboring buildings, the street, nearby bushes and drainage ditches but could not locate the resident. The Weekend Supervisor reported the incident to the Director of Nursing and Administrator and notified law enforcement. Upon arrival at the facility, staff provided the police with all relevant identifying information of the resident. The Weekend Supervisor notified the resident's listed family members of Resident #1 missing. At approximately 12:55 PM, law enforcement notified the facility that they had located the resident and contacted Emergency Medical Services to transport the resident to the Emergency Department for medical evaluation as precautionary measure. A phone interview with Family Member #2 on 12/4/25 at 5:11 PM revealed he tried to get in touch with Resident	F0689		

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F0689 SS = SQC-J	Continued from page 3 #1 on 11/22/25 at 10:30 AM by calling the phone that was in his room at the facility but Resident #1 did not pick up the phone. Family Member #2 stated he decided to go ahead and come to the facility and he arrived around 11:00 AM. He stated that when he got there, Resident #1 wasn't in the room, so he asked the nurse aide where Resident #1 was. He said the nurse aide thought Resident #1 was in his room but when she saw he wasn't in his room, she searched for Resident #1 in the rehabilitation room, but he wasn't there either. Family Member #2 further stated that the nurse aide told the nurse that she couldn't find Resident #1, so they started looking in other rooms. When they didn't find Resident #1, the nurse told the Weekend Supervisor who called a code pink over the intercom. Family Member #2 stated that at that point, he got in his car and drove around the block searching for Resident #1, and then he called Family Member #1. Shortly after, police arrived and they wanted to know what time Family Member #2 arrived at the facility. After about 2 hours and 15 minutes, police told them that Resident #1 was at the fire station across town and that he was picked up by somebody down the street from the facility where he fell and they took him to the fire station. He also stated that Resident #1 was sent to the hospital when the medics arrived at the fire station because he couldn't answer questions. Family Member #2 further stated that he either visited or called Resident #1 almost every day and Resident #1 had always been confused ever since his last hospitalization. Whenever Family Member #2 visited Resident #1 at the facility, he assisted him with walking and sitting up front and outside, but Resident #1 never talked to him about going home or leaving. Family Member #2 stated that he did not think Resident #1 should be left to walk by himself because he wasn't steady walking and he could not make decisions on his own. A phone interview with Nurse Aide (NA) #1 on 12/4/25 at 1:01 PM revealed she last saw Resident #1 on 11/22/25 around 9:30 AM when she picked up his breakfast tray. NA #1 stated that Resident #1 was still in bed at that time, and he did not want to get up. NA #1 stated that Resident #1 was lying in bed underneath his blankets, so she didn't see what he was wearing that day. NA #1 stated Resident #1 never left his room by himself, and he did not usually walk unassisted because he was not steady whenever he walked. NA #1 further stated that Resident #1 was confused per baseline, and he usually needed help with putting his shoes on. NA #1 stated that when Family Member #2 arrived at around 11:00 AM and asked her where Resident #1 was, she looked in his room, and he was not there. They looked in the therapy gym, but he wasn't there either. They then began	F0689		

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F0689 SS = SQC-J	Continued from page 4 searching for Resident #1. NA #1 stated that she did not know how Resident #1 got out of the facility, but she heard that a housekeeper saw him walking in the hallway right before he got out. NA #1 also stated that she remembered it being warm that day because she went outside to search for Resident #1. NA #1 stated that the Weekend Supervisor called the police who told them eventually that Resident #1 had been found. A phone interview with Housekeeper #1 on 12/4/25 at 2:40 PM revealed she saw Resident #1 in the middle of the hallway in front of the dining area on 11/22/25, but she did not remember the time. Housekeeper #1 stated that Resident #1 was walking towards the main entrance without any assistive device, and that he was wearing a white shirt, pants and shoes. Housekeeper #1 stated that she remembered asking Resident #1 where he was going and Resident #1 told her that he was going to the porch. Housekeeper #1 stated Resident #1 was normally in his room and that this was the first time she saw him walking out in the hallway. A phone interview with Nurse #1 on 12/4/25 at 11:16 AM revealed she was assigned to Resident #1 on 11/22/25 from 7:00 AM to 3:00 PM. Nurse #1 stated she saw Resident #1 on 11/22/25 when she gave him his morning medications, but she could not recall the exact time. Nurse #1 stated that Resident #1 was lying in bed, and that she had to wake him up to take his medications. Nurse #1 stated that she didn't recall what Resident #1 was wearing that day. Nurse #1 further stated that Resident #1 did not do well with ambulating on his own, and that he walked with assistance from staff. Nurse #1 stated that NA #1 told her around 11:15 AM that Resident #1 was not in his room, so they started looking for him in all the rooms on her hall. When they could not locate Resident #1, Nurse #1 spoke with the Weekend Supervisor, and they started a more thorough search including the surrounding area outside the facility. Nurse #1 stated that they continued to look for Resident #1 even when the police came. Later on, Nurse #1 heard from the police that Resident #1 was found and that he was safe. Nurse #1 shared that they had cameras inside the facility, all the other doors were kept locked and that the only way to go in and out was through the front door where there should be a receptionist even on the weekends. Nurse #1 stated there was a receptionist on 11/22/25. Nurse #1 further reported that she hadn't seen Resident #1 ambulate by himself, and that Resident #1 was confused and was not able to communicate his specific needs. A phone interview with the Weekend Supervisor on 12/4/25 at 11:31 AM revealed she did not see Resident	F0689		

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F0689 SS = SQC-J	Continued from page 5 #1 on 11/22/25. The Weekend Supervisor stated that Nurse #1 told her around 11:15 AM that they were looking for Resident #1 and could not find him inside the facility. She stated that she called a code pink over the intercom which alerted all staff that a resident was missing and that all staff members should start looking for the missing resident. She stated that they started searching for Resident #1 from both inside and outside the facility. At 11:25 AM, the Weekend Supervisor called the Administrator and the DON and notified them of Resident #1's elopement and that search was in progress. The Weekend Supervisor informed them that staff had been searching every single area inside the building, the grounds, buildings next door, by the street, bushes and ditches close by. At 11:25 AM, the Weekend Supervisor called the police and the police arrived at 11:30 AM. The Weekend Supervisor gave the police information about Resident #1 and provided details and his face sheet. The Weekend Supervisor also called Resident #1's family members listed on his face sheet to inform them of Resident #1 being missing. Around 12:50 PM, she was notified that police found Resident #1. She stated that she couldn't remember who told her that Resident #1 had been located. A review of the Emergency Department Provider Notes dated 11/22/25 for Resident #1 indicated a chief complaint of altered mental status. Resident #1 was found walking on street and was taken to the firehouse. He was also reported missing two hours ago per family. Abrasion and mild swelling over the right maxilla (jawbone) and inferior to the right orbit (bony socket in the skull that houses and protects the eyeball). CT (computed tomography) scan of the head was negative for acute bleeds. Abrasions present on the posterior aspect of bilateral hands. Resident #1 was unsteady on his feet and unable to walk without assistance. Resident #1 was alert and oriented to person and date of birth. He was not oriented to time, place or recent events. Resident #1 was admitted and remained in the hospital while waiting for another skilled nursing facility placement. A phone interview with Receptionist #1 on 12/4/25 at 1:09 PM revealed she worked as the receptionist on 11/22/25 from 8:00 AM to 8:00 PM. Receptionist #1 stated that she did not remember Resident #1 going out through the front door on 11/22/25, but she did not know what Resident #1 looked like. Receptionist #1 stated that if she needed to step away from her desk, she usually got coverage but if she couldn't, she would run quickly and come back as soon as she could. She stated that she did not remember if she left her reception desk unattended on 11/22/25. Receptionist #1	F0689		

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F0689 SS = SQC-J	Continued from page 6 further stated that she knew the long-term residents well and also recognized the short-term residents. However, if the resident did not have a walking device, she stated that she would not think they would be a resident at the facility. Receptionist #1 stated that if she was uncertain, she was supposed to verify whether the person was a visitor or a resident by asking for their name and checking the sign-in sheet. A phone interview with Family Member #1 on 12/4/25 at 10:13 AM revealed she saw Resident #1 at the hospital looking scratched up with a pump knot (a lump or swelling usually from a blow) on his cheek. Family Member #1 reported that when she asked facility staff how Resident #1 got out of the building, they told her that they didn't know how he got out, and that nobody knew what happened or how it happened. She also reported that she asked Resident #1 what happened to him while he was away from the facility, but he did not remember anything and could not tell her what happened to him. Family Member #1 stated that Resident #1 has had some memory loss after he had a heart attack the last time he was hospitalized, and that she did not think it was safe for him to be walking by himself especially on the sidewalk outside the facility. Family Member #1 stated that she visited Resident #1 often and she assisted him to walk and sit outside, but Resident #1 had never mentioned to her about wanting to leave the facility or go home. An observation was made with the Administrator on 12/4/25 at 2:21 PM of the lobby and front area of the facility where Resident #1 walked. The Administrator stated Resident #1 walked out of the lobby and out the front door towards a chair on the left side right outside the therapy gym. The distance from the front door to the chair was approximately 150 feet. It was another 125 feet from the chair to the sidewalk outside the facility. Right outside the facility was Providence Road which was a 2-lane road with a posted speed limit of 35 miles per hour. The sidewalk was along Providence Road where the facility was located. A review of the weather conditions per the Weather Underground website revealed the following data for Charlotte, North Carolina on 11/22/25 at 10:33 AM: 70 degrees Fahrenheit with no precipitation, Southeast wind speed at 13 miles per hour (mph) with a gust of 20 mph. The video footage was viewed with the Administrator and the Quality Assurance Nurse Consultant on 12/4/25 at 2:25 PM, and it revealed the following caught on camera on 11/22/25:	F0689		

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F0689 SS = SQC-J	Continued from page 7 10:28 AM – Resident #1 walked into the lobby and straight out through the front door. Receptionist #1 was at her desk, but she was observed talking to a visitor. Resident #1 was observed walking with a limp and an exaggerated swaying of both arms alternatively. He kept on walking out the front door and almost stumbled against the curb from an island right outside the door. Resident #1 regained his balance and started walking to a chair on the left side right outside the therapy gym. 10:29 AM – Resident #1 sat at a chair outside the therapy gym while a car was observed driving in through the facility's driveway. 10:36 AM – Resident #1 stood up and started walking towards the sidewalk outside the facility. 10:37 AM – Resident #1 stopped on the left side of the driveway and stood there for a minute. 10:38 AM – Resident #1 resumed walking and crossed the driveway to the brick wall at the facility entrance and towards the right sidewalk while walking with an ataxic gait (uncoordinated, clumsy, staggering walk with poor balance, characterized by wide-based steps, irregular foot placement, and a tendency to veer or fall, often resembling drunkenness). 10:39 AM – Resident #1 went out of view of the camera/video footage. An interview with the Director of Nursing (DON) on 12/4/25 at 1:38 PM revealed after he was notified by the Weekend Supervisor at around 11:25 AM about Resident #1's elopement on 11/22/25, he came to the facility. The DON stated by the time he got to the facility, the police had already left. He stated that he received report from the Weekend Supervisor that the police told her that they had located Resident #1, that they called the medics and then sent Resident #1 to the hospital. He further stated that he had not seen Resident #1 ambulate by himself at the facility, and that most of his interaction with him was while he was lying in bed, so he did not know if he had balance or gait issues. The DON shared that Resident #1 might have walked out of the building through the front door, but he was not aware if there was a camera at the front lobby. The DON stated that he would not say that it would be safe for Resident #1 to be walking unsupervised outside the facility. An interview with the Administrator on 12/4/25 at 2:12	F0689		

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F0689 SS = SQC-J	Continued from page 8 PM revealed she was on leave during Resident #1's elopement incident on 11/22/25, but she found out that Resident #1 walked out of the facility through the front door. The Administrator stated that the front doors were unlocked, and they were usually unlocked because there was a receptionist at the front desk. However, the receptionist did not know that Resident #1 was a resident. She also stated that Resident #1 did not have safety awareness and for some reason, he wanted to get out of the door that day. She shared that prior to the incident, Resident #1 had only stayed in his room, and had not demonstrated any signs that he would attempt to get out of the facility unassisted. An interview with the Rehabilitation Manager on 12/4/25 at 12:31 PM revealed Resident #1 needed supervision when ambulating by himself because of balance and gait issues. The Rehabilitation Manager stated that it was safe for Resident #1 to walk with a family member or a staff member, but she would not recommend for him to be walking by himself. She stated that somebody needed to keep an eye on him because it was not safe for him to walk by himself, and he could fall or get hurt especially with his confusion. A phone interview with the Medical Director on 12/4/25 at 1:18 PM revealed a severely cognitively impaired resident like Resident #1 should not be outside without supervision. The Medical Director stated that if Resident #1 was just sitting outside, it would not have been a problem but if he got out to the main road, he could get lost, and that it was definitely a problem especially with him being gone for over two hours. A phone interview with the Police Officer on 12/4/25 at 12:20 PM revealed Resident #1 was located walking along the road on the sidewalk by some folks driving by in a car, and Resident #1 asked for a ride to a location that was supposed to be his friend's house. The Police Officer stated that when they arrived at the address, Resident #1 said it did not look familiar, so they decided to drop him off at the fire station. He stated that they did not have information about the people who picked Resident #1 up, and that he did not know what road Resident #1 was walking on before he got picked up. He also stated that from what he could remember, there was no report of any medical emergencies, but they called the medics to come and check him out and an ambulance took Resident #1 to the hospital. The Police Officer further stated that he was not sure what time Resident #1 was located walking on the road, but he knew that from the time he was last seen at the facility to the time he was located was within a two to two and a half hour period. He also shared that they	F0689		

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F0689 SS = SQC-J	Continued from page 9 did not file a police report because there was no crime but only filed a missing person report to document about Resident #1 being missing from the facility. A phone interview with the Fire Captain on 12/4/25 at 4:41 PM revealed they had no information regarding the people who dropped Resident #1 off at the fire station. The Fire Captain stated that the people who dropped him off said that they saw him fall while he was walking down on Providence road where the facility was located and so they picked him up, but the address Resident #1 gave them was not familiar to him, so they decided to drop him off at the fire station which was 20 miles away from the facility per GPS (global positioning system). The Fire Captain stated that he saw Resident #1, but he couldn't remember what he was wearing and all he could remember was that he was confused and unable to answer any questions. The Administrator was notified of immediate jeopardy on 12/4/25 at 5:44 PM. The facility provided the following corrective action plan: How will corrective action be accomplished for those residents found to have been affected by the deficient practice? · On 11/22/25 at approximately 10:30 AM, Resident#1 was observed by Visitor#1 walking out of facility and then walking to chair in front of therapy gym and sitting down. Approximately 5 minutes later, Resident #1 was observed by Visitor #1 getting up from chair and walking up sidewalk towards brick wall at facility front entrance driveway. Visitor #1 observed resident speaking to persons in a white Nissan Rogue who instructed Resident #1 to walk down to stoplight where they would pick him up. Resident #1 observed by Visitor #1 getting into a white Nissan Rogue. Staff were unaware that Resident #1 had exited the facility. Visitor #1 was standing outside on sidewalk at facility entrance driveway and noted Resident #1 walking towards a white Nissan Rouge occupied by a male and a female who instructed Resident #1 to walk down the sidewalk towards stoplight and they would pick him up. Visitor #1 stated he was unaware that Resident #1 was a resident of the facility. · On 11/22/25, at approximately 11:00 AM, Resident #1's cousin arrived at the facility to visit Resident #1 and notified staff that resident was not in his room. Resident #1 was seen by Housekeeper #1 at 10:20 AM walking up 400 hall towards dining room. Staff	F0689		

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F0689 SS = SQC-J	Continued from page 10 immediately began initial search in the facility and parking lot for Resident #1. · On 11/22/25, at approximately 11:10 AM Nurse Supervisor #1 instructed Receptionist #1 to initiate a Code Pink (Missing Resident Search) via overhead paging system and staff continued to search in and on facility grounds, Assistant Living Facility next door, and local streets, and surrounding areas including wooded areas behind the facility. · On 11/22/25, at approximately 11:25 AM, police were notified. Police arrived at the facility at approximately 11:30 AM and were provided with a detailed description of Resident #1 (resident wearing white shirt, jeans and white sneakers) and information provided by Visitor #1 who observed resident getting into white a vehicle. Face sheet with resident's picture was also provided. Temperature outside at time of incident was 67 degrees. · On 11/22/25, at approximately 11:25 AM, Nurse Supervisor #1 notified the Director of Nursing and Administrator. · On 11/22/25, at approximately 11:30 AM, Responsible Party and Medical Director were notified of the incident by the nurse supervisor. · On 11/22/25, at approximately 12:55 PM, Resident #1 was located and transported to the hospital for evaluation and treatment as a safety precaution. Regional Director of Operations and police notified Resident #1's family who were on site that Resident #1 had been located by a bystander near North Lake mall who witnessed resident fall and assisted him to a nearby fire station who then notified police and Emergency Medical System. · On 11/22/25, Quality Assurance (QA) Nurse Consultant reviewed Resident #1's care plan with no updates at this time. Care plan to be updated related to exit seeking behaviors upon readmission. · On 11/22/25, at approximately 1:45 PM, family notified staff that they would be packing up residents' belongings and that he would not be returning to facility. Staff assisted family with gathering resident's belongings. · On 11/25/25, video footage of the front entrance was reviewed by the Administrator. At approximately 10:30 AM, Resident #1 who walked with a limp was noted walking out the front entrance door and walked towards	F0689		

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F0689 SS = SQC-J	Continued from page 11 the therapy gym and sat down in a chair. Resident #1 sat in the chair for approximately 5 minutes and then Resident #1 was noted walking with unsteady gait up the sidewalk towards a brick wall in front of the facility entrance and then turned right and went out of view. How will the facility identify other residents having the potential to be affected by the same deficient practice? · On 11/22/25, a head count was completed by Nurse Supervisor #1 for 100% of residents. All residents in facility were accounted for with no issues identified. · On 11/22/25, the Director of Nursing reviewed clinical alerts dashboard and nursing notes for all residents for the past 30 days to identify any exit seeking behaviors. No issues identified. · On 11/22/25, the Director of Nursing audited 100 % of residents wandering risk assessments. All resident with low wandering risk were reviewed for changes in condition/function that may put them at risk to exit the facility. No issues identified. Risk assessments are completed upon admission by the admitting nurse, quarterly and any time a change of condition is noted by staff nurse or nurse manager. · Additionally, on 11/22/25, all residents at high-risk for wandering charts were reviewed by the Director of Nursing to ensure that they had appropriate wander prevention strategies in place to include wander guard bracelet in place and functioning properly, daily battery checks and every shift placement checks were present on the MAR and that care plan was current and appropriate interventions were on the care plan. The results of the audit revealed all residents that were assessed as high risk for wandering were noted to have elopement prevention measures in place and up to date care plans. · On 11/22/25, the Nurse Supervisor checked 100% of current residents with wander guards for placement and function by observing that wander guard was on resident's person and utilized the wander guard checker device to ensure proper function. No issues were noted. · On 11/22/25, all exit doors were checked by the Director of Nursing and Nurse Supervisor #1 to ensure they were functioning properly. · On 11/22/25, staff interviews were initiated for all staff by the Director of Nursing to identify any exit seeking behaviors. Interviews identified no other new	F0689		

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F0689 SS = SQC-J	Continued from page 12 onset of exit seeking behaviors. · On 11/22/25, the QA Nurse Consultant rechecked all entrance/exit doors to include door with wander guard system, squealer boxes and on/off switches for mag lock doors (doors with keypad entry/exit) and all were functioning properly. No issues were identified. · On 11/22/25, a Quality Assurance Performance Improvement meeting held with the Interdisciplinary Team members which included the Director of Nursing, Regional Director of Operations, Social Worker, Nurse Supervisor, Business Office Assistant, Unit Manager, QA Nurse Consultant and Human Resources Director to discuss incident findings and plan to correct. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? · On 11/22/25, the Director of Nursing began education of all full time, part time, and as needed staff including agency on the following topics: Elopement Prevention and Missing Person Policy. Education included what to do if resident was exhibiting wandering/exit seeking behaviors especially for those residents who normally stayed in their rooms. Staff educated to stop and communicate with the resident and redirect, ensure safety of the resident and immediately notify the nurse. As of 11/25/25, 25% of staff had not attended the Elopement Prevention and Missing Person Policy in-service. The Administrator will ensure that any of the above identified staff who did not complete the in-service training by 11/25/25 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff and will be provided by the Staff Development Coordinator during orientation and prior to working in patient care areas. · On 11/25/25, the Administrator educated all receptionists that all visitors will need to sign in and out and wear a badge to identify them as a visitor when entering the facility through main entrance designated for visitor entry. All other exit doors are locked with signage above directing visitors to go to the main entrance to enter and exit the facility. Additionally, all receptionists and nurses were educated by the Administrator that receptionists are to lock the main entrance door upon leaving front desk for any reason and nurses are to let visitors into and out of facility in receptionist's absence from receptionist area. Receptionists were educated to have all persons	F0689		

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F0689 SS = SQC-J	Continued from page 13 exiting facility to be identified prior to them exiting by looking for visitor badge and asking person to identify themselves, checking sign in/out log for name and having them sign out once identified on sign in/out log prior to exiting facility to ensure they are not a resident displaying exit seeking behaviors. If the person is noted to be a resident, receptionist is to maintain resident safety and immediately notify nurse assigned to resident to come assist resident. The Administrator will ensure that any newly hired receptionist or nurse will receive this education prior to working and this in-service was incorporated into the new employee facility orientation for the above identified staff. · As of 11/25/25, the following changes were put in place to correct the deficient practice. Visitors will be required to sign in and out and wear visitor badge while in the facility. Additionally, receptionists were educated that they are to lock the main entrance door upon leaving front desk area for any reason and if no one is available to provide coverage until they return, they are to notify nursing staff via phone that they will be leaving front desk area prior to leaving. Upon hearing doorbell ringing, nurses are to go to front entrance area and let visitor into the facility, have visitor sign in and provide them with a visitor's badge. For visitors leaving facility, nurse is to identify person prior to them exiting by looking for visitor badge and asking person to identify themselves, checking sign in/out log for name and having them sign out once identified on sign in/out log prior to exiting facility. A receptionist is scheduled to work 7 days a week. In the event that there is no receptionist available, facility front entrance doors will be locked and nurses on duty will be responsible for allowing visitors entry or exit to facility. On 11/25/25, to alert visitor of need to sign in or out, signage was placed on front entrance door making visitors aware of the need to sign in and out at front desk upon entering and exiting the facility. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? · Beginning the week of 11/24/25, The Administrator or designee will monitor Elopement Process using the Quality Assurance Tools for Elopement and Low Risk Wandering. The monitoring will include interviewing 2 staff members to identify any exit seeking/ wandering behaviors, reviewing 5 residents' charts with low risk for wandering with BIMS 12 or less to identify exit seeking behaviors and checking all exit doors and	F0689		

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F0689 SS = SQC-J	Continued from page 14 squealer boxes to ensure functioning properly and monitoring receptionist area to ensure area is covered, door is locked if receptionist is not at desk, visitors signing in and out and if any exit seeking behaviors identified. This will be completed by making random observations of front entrance area throughout the week between the hours of 8am to 8pm, reviewing visitor logs to ensure visitors are signing out prior to leaving facility and asking receptionist if any exit seeking behaviors were identified. This will be completed weekly times 4 weeks then monthly times 2 months or until resolved by Quality Assurance (QA) Committee. Clinical team to continue reviewing 24-hour reports, clinical alerts dashboard and nurse's notes daily during clinical meeting Monday through Friday to identify any exit seeking behaviors. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Nurse Supervisor, Therapy and Social Worker. Completion date: 11/26/25 Validation of the facility's corrective action plan was conducted on 12/9/25 through record review and staff interviews. On 11/22/25, the DON audited all residents' risk assessments to ensure that they had accurate elopement risk assessments. A review of the facility's monitoring audits conducted on 11/25/25 through 12/1/25 indicated residents with low risk for wandering were reviewed for changes in condition and for possible increase in wandering/exit seeking behaviors and newly admitted residents' wandering risk scores were checked for accuracy. Audits included the reception desk being covered and whether the receptionist identified any exit-seeking behaviors from residents. Signage was observed on the front entrance door regarding visitors' need to sign in and out at front desk upon entering and exiting the facility. Interviews with the receptionists revealed they were educated regarding making sure all visitors sign in and out as well as having a visitor badge, and making sure the desk was covered or to lock the door if they were unable to keep the desk covered. Interviews with staff revealed they received education on elopement, what to do if a resident was exhibiting wandering/exit seeking behaviors especially for those residents who normally stayed in their rooms, to stop and communicate with the resident and redirect, ensure safety of the resident and immediately notify the nurse.	F0689		

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F0689 SS = SQC-J	Continued from page 15 The corrective action plan completion date and IJ removal date of 11/26/25 was validated.	F0689		