

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345165</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>03/26/2026</b>
NAME OF PROVIDER OR SUPPLIER <b>Autumn Care of Marion</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1264 Airport Road , Marion, North Carolina, 28752</b>	
(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	<p>INITIAL COMMENTS</p> <p>A complaint investigation survey was conducted from 3/24/26 through 3/6/26. The following intakes were investigated: 2794622 and 2963831. One (1) of the 2 allegations resulted in a deficiency. Intake # 2794622 resulted in immediate jeopardy. Event ID# 22BA32-H1. Immediate Jeopardy was identified at:</p> <p>CFR 483.25 at tag F689 at a scope and severity (J)</p> <p>The tag F689 constituted Substandard Quality of Care.</p> <p>Immediate Jeopardy began on 3/02/2026 and was removed on 3/05/2026. A partial extended survey was conducted.</p> <p>04/14/26: 2567 amended to include a scope and severity for F842 that was left out on the original posting.</p>	F0000		04/16/2026
F0689 SS = SQC-J	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and interviews with Guardian, witnesses, resident, Psychiatric Provider, Nurse Practitioner (NP), and staff, the facility failed to provide the necessary supervision to prevent Resident #1 from exiting the facility unsupervised and without staff's knowledge through one of two doors that did not alarm when opened. Resident #1 was at risk for falls, her diagnoses included dementia, and she had been identified with a decline in cognition with signs of increased confusion and</p>	F0689	<p>1. How corrective action was accomplished for the resident found to have been affected by the deficient practice:</p> <p>On 3/2/2026, Resident #1 experienced an unsupervised exit from the facility through a side exit door and was observed off facility property by a family member, which alerted staff. The resident was immediately returned to the facility without injury by the Administrator, Director of Nursing, and Assistant Director of Nursing.</p> <p>The Administrator and Director of Nursing (DON) conducted an immediate review of the incident on 03/02/2026. The Administrator and DON determined the root cause to be that the side exit door did not have an alarm system installed that alerted staff to any opening of the door at the time of the incident, which allowed Resident #1 to exit the facility without staff awareness.</p> <p>Immediately upon the resident's return to the facility on 3/2/2026, the following actions were taken:</p> <p>The Administrator and DON contacted Resident #1's guardian, primary care provider, and Medical Director on 3/2/2026.</p>	03/27/2026

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	<p>Continued from page 1</p> <p>disorientation in the months prior to March 2026. Staff reported these signs included getting lost in the hallways, not being able to figure out how to get back to her room and forgetting that she required supervision to smoke. On 3/2/26 around 10:00 AM an unknown individual found Resident #1 outside of the facility in her wheelchair on the opposite side of the road as the facility, in the roadway, trying to self-propel up the road. Staff were unaware the resident had left the facility without supervision. In addition, not all staff were aware Resident #1 had exited the facility to understand the need for heightened awareness for her safety and whereabouts. Resident #1 was not injured; however, there was a high likelihood of serious harm, injury, or death with risks that included getting lost, falling with an inability to get out of harm's way, and/or getting hit by a car. Additionally, the facility failed to ensure staff were aware of Resident #1's unsupervised exit. The deficient practice affected 1 of 3 reviewed for accidents.</p> <p>Immediate Jeopardy began on 3/2/2026 when Resident #1 exited the facility unsupervised and without staff's knowledge. Immediate Jeopardy was removed on 3/5/2026 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure all staff and providers are aware of the elopement, education is completed and monitoring systems put into place are effective.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 11/28/18. Resident #1's diagnoses included dementia, hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) following cerebral infarction, anxiety and depression.</p> <p>The quarterly Minimum Data Set assessment dated 1/1/26 revealed Resident #1 was 69 years old and cognitively intact. She had age related nuclear cataracts (a slow-developing, common eye condition where the center [nucleus] of the eye's lens gradually hardens and yellows, causing blurry vision) and her vision was assessed as adequate with corrective lenses. Resident #1 had no functional limitations with range of motion and she utilized a wheelchair. She required partial/moderate assistance with upper body dressing and substantial/maximum assistance with lower body dressing, putting on/taking off footwear, and transfers. She was independent with self-propelling her</p>	F0689	<p>Continued from page 1</p> <p>Resident #1's nurse completed a head-to-toe nursing assessment on 3/2/2026, and no injuries were noted.</p> <p>The Administrator and Director of Nursing (DON) interviewed Resident #1. During the interview, Resident #1 verbalized a desire to go home to care for her son. The Administrator reassured Resident #1 that her son is cared for by a full-time caregiver.</p> <p>The Director of Rehabilitation Services completed a Brief Interview for Mental Status (BIMS) assessment on 3/2/2026, with a score of 8/15.</p> <p>Resident #1's nurse completed an elopement risk assessment on 3/2/2026, and Resident #1 was identified as high risk for elopement. At the time of identification as being high risk, the staff were notified via shift-to-shift report and resident was placed in the high-risk binder and through staff education.</p> <p>Assistant Director of Nursing (ADON) added Resident #1 to the facility's High Risk for Elopement binder located at the nurses' stations and reception desk to promote staff awareness. At the time of identification as being high risk, the staff are notified via shift-to-shift report and resident was placed in the high-risk binder and through staff education.</p> <p>The Director of Nursing applied a Wander Guard device to Resident #1's left ankle on 3/2/2026.</p> <p>The psychiatric provider, who was present in the facility, assessed Resident #1 and initiated new orders. The in-house provider also assessed Resident #1 on 3/2/2026, and in collaboration with the psychiatric provider implemented additional orders:</p> <p>Plavix (antiplatelet) 75 mg by mouth once daily.</p> <p>Memantine (used to treat Alzheimer's disease) 10 mg by mouth twice daily.</p> <p>Obtain Head computed tomography (CT) scan for evaluation for possible Cerebrovascular Accident (CVA) or vascular changes.</p> <p>Apply wander guard monitoring device.</p> <p>Monitor wander guard function and placement every shift.</p>	

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F0689 SS = SQC-J	<p>Continued from page 2 wheelchair.</p> <p>The active care plan as of 3/1/26 revealed Resident #1 was care planned for requiring supervised leave of absences and her mental function varied over the course of the day related to medical conditions. Resident #1's care plan also included the risk for decreased/ impaired vision and the risk for falls secondary to decreased mobility, abnormal gait, muscle weakness. There were no interventions documented for the for care planned problem areas.</p> <p>Resident #1's active physician orders as of 3/1/26 included Namenda (used to treat moderate to severe dementia) 5 milligrams (mg) two times a day.</p> <p>An interview with Nurse #2 was conducted on 3/24/26 at 1:57 PM. Nurse #2 reported that Resident #1 has had a decline the last couple of months prior to March 2026 with increased episodes of confusion and increased anxiety, as well as several urinary tract infections beginning sometime in January 2026. Nurse #2 explained that Resident #1 would get lost in the hallways some days and could not figure out how to get back to her room. She further explained that the resident would forget she required supervision when she went out to smoke. Nurse #2 reported that Resident #1 was changed from independent to supervised smoking in late January due to her not being able to hold the cigarette well. Nurse #2 reported she was not aware of any changes to Resident #1's supervision except with smoking.</p> <p>An interview with Nurse #3 on 3/24/26 at 12:54 pm revealed she had been caring for Resident #1 for about five years and knew her pretty well. Nurse #3 reported that Resident #1 had been declining over the last several months prior to March 2026. She indicated the resident had been seen by the psychiatric provider and the Nurse Practitioner (NP) and her dementia medications had been adjusted. Nurse #3 went on to say that Resident #1 would get confused and disoriented while moving down the hallway and would become anxious and have to be redirected. Nurse #3 reported that it had become more difficult to redirect Resident #1 in the last several weeks. Nurse #3 explained that in several instances Resident #1 did not remember she now required supervision to smoke and would become angry when she asked to go out and the staff had to remind her she had to wait for someone to take her. Nurse #3 reported that Resident #1 was changed from independent to supervised smoking in late January due to her not being able to hold the cigarette well.</p>	F0689	<p>Continued from page 2</p> <p>Resident #1's comprehensive care plan was reviewed and revised on 3/2/2026 to include interventions related to elopement risk, including Wander Guard placement, increased staff awareness, behavioral monitoring, and redirection when verbalizing a desire to leave the facility. Minimum Data Set (MDS) nurse added this to the care plan and resident profile. Floor nurse was made aware by the DON and other floor Staff are notified via shift-to-shift report and placed in high-risk binder.</p> <p>The DON initiated and communicated on 3/2/2026 to the nurses that Resident #1 was placed on every 15 minute visual checks. Resident #1 was placed on increased behavior monitoring for 72 hours following the incident. The nurses caring for Resident #1 were responsible for completing these checks and documenting on the frequent visual check log.</p> <p>The door through which Resident #1 exited was placed under continuous staff monitoring by the Business Office Manager (BOM)/designees until an alarm system could be installed. The door was monitored from 10am until 4pm when the Maintenance Director installed the alarm. Visualization of the door monitor was observed by the Administrator and DON. The BOM also completed a form stating they completed the assigned task of monitoring the door.</p> <p>On 3/2/2026, the Maintenance Director installed an alarm device on the side exit door to ensure the door alarmed when opened. Staff were educated on the placement of the new alarm via all staff education.</p> <p>Elopement drills were conducted by the Business Office Manager (or designee) to reinforce staff response procedures:</p> <p>Second shift – 3/2/2026</p> <p>Third shift – 3/3/2026</p> <p>First shift – 3/3/2026</p> <p>On 3/3/2026, the DON (or designee) interviewed nursing staff who had cared for Resident #1 within the previous 72 hours to determine whether Resident #1 had verbalized a desire to leave or demonstrated</p>	

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F0689 SS = SQC-J	<p>Continued from page 3</p> <p>During an interview with Nurse Aide (NA) #1 on 3/24/26 at 1:14 PM she stated that Resident #1 had become more confused over the last several months, had episodes of increased anxiety, and became more difficult to redirect. NA #1 indicated that Resident #1 would often become disoriented when she was out on the halls and when she (NA #1) would attempt to redirect her the resident became upset. NA #1 reported she had made the nurse responsible for Resident #1 aware anytime she noticed a change in Resident #1, she stated she did not remember which nurses she told.</p> <p>A progress note written by the Director of Nursing (DON) on 3/2/26 at 10:30 AM indicated Resident #1 attempted elopement and was intercepted. The resident continually stated, "I just want to go home." The DON indicated reorientation to the resident's situation was attempted without success. The Psychiatric Provider was in the facility and assessed the resident. The Nurse Practitioner (NP) was also in the facility and assessed the resident with new orders given. A wanderguard (electronic wander management bracelet) was placed on Resident #1 for safety and her guardian was made aware. The note indicated Resident #1 had never attempted to show any signs that she would attempt elopement.</p> <p>An interview with the DON on 3/24/2026 at 2:58 PM revealed on the morning of 3/2/2026 management staff were in the morning meeting and Witness #2 came into the conference room telling them a resident was outside. He reported that the staff in the morning meeting immediately left the conference room to locate the resident. The DON stated that they (staff) were all shocked when they discovered it was Resident #1, as this was not normal for her. He reported that when they found Resident #1, she was on the road just past the gravel parking lot. He stated Resident #1's "mentation was altered, she was what I would describe as manic." He reported that it was difficult to make the resident understand the danger she was in on the road and why she needed to return to the facility. The DON reported Resident #1 was difficult to convince to come back to the facility, as she kept attempting to propel herself via wheelchair further up the hill on the road stating she needed to go and take care of her son. He indicated they were able to get Resident #1 back to the facility and the Psychiatric Provider was in the facility, so he asked her to assess Resident #1. The DON stated that during the assessment Resident #1 was not making a lot of sense and referred to her adult son as a baby. The DON revealed that he was aware Resident #1 had</p>	F0689	<p>Continued from page 3 exit-seeking behaviors. Any concerns identified were immediately addressed.</p> <p>2. How the facility identified other residents who had the potential to be affected by the same deficient practice</p> <p>Immediately upon discovery of the unsupervised exit on 3/2/2026, the Director of Nursing conducted a head count of all residents, and all residents were accounted for.</p> <p>On 3/2/2026, the Maintenance Director evaluated all exit doors in the facility to ensure alarms were present and functioning properly. All alarms were confirmed to be operational.</p> <p>On 3/2/2026, the Director of Nursing (or designee) reviewed elopement risk assessments for all residents to ensure accuracy and confirm appropriate interventions were in place. No additional residents were newly identified as being at risk.</p> <p>On 3/2/2026 the DON (or designee) also reviewed progress notes for all residents for the previous seven days to identify any behavioral changes or exit-seeking behaviors. No additional concerns were identified.</p> <p>On 3/3/2026, the DON (or designee) interviewed nursing, housekeeping, and therapy staff to determine whether any resident had verbalized a desire to leave the facility or demonstrated behavioral or cognitive changes that could contribute to exit-seeking behavior. Any identified concerns were immediately reported to the Administrator and DON for follow-up.</p> <p>On 3/3/2026, the DON (or designee) reviewed residents who had experienced a gradual dose reduction (GDR) of antipsychotic or anxiolytic medications within the previous 30 days to determine whether increased behaviors were present that could contribute to exit-seeking behavior. This was accomplished by reviewing all orders for the above medications and also reviewed progress notes for the entire facility to identify any affected residents. No additional concerns were identified.</p> <p>3. Measures put into place and systemic changes to ensure the deficient practice does not recur</p> <p>On 3/2/2026, the Maintenance Director permanently installed an alarm system (screamer alarm) on the side</p>	

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F0689 SS = SQC-J	<p>Continued from page 4 experienced a decline over the last several months and had several medication changes. He explained that Resident #1 had become more confused and had been changed from an independent to supervised smoker back in January due to the increased confusion. He reported that when Resident #1 was returned to the facility on 3/2/26 he asked Nurse #4 to place a wanderguard on Resident #1 and do an elopement assessment. The DON stated he told Nurse #4 to use the progress note he completed (completed by the DON on 3/2/26 at 10:30 AM) as a resource to complete the elopement assessment. The DON was unable to explain why he wrote in the progress note that Resident #1 attempted elopement and was intercepted by staff. The DON reported that Resident #1 did elope and was found down the road below the gravel parking lot. He reported that he felt sure he had verbally reported to all staff that Resident #1 had actually left the facility and went down the road and had not just attempted elopement. He revealed he did not keep track of the staff he verbally reported this information to. He reported that he felt that it was important for all staff to know that Resident #1 had actually left the building and went down the road and not that she just attempted to elope because an attempt to elope is a lot less dangerous than an actual elopement. The DON spoke about how Resident #1 exited the facility on 3/2/26. He indicated it was determined that Resident #1 exited out the side door of the facility. He explained that the side door of the facility and the front door of the facility were the only two exterior doors that did not alarm when opened. He further explained that the side door had a wanderguard alarm on it only prior to Resident #1's unsupervised exit on 3/2/26 and Resident #1 did not have a wanderguard in place until after the unsupervised exit. The DON indicated the side door was the only door that could not be easily visualized by the receptionist.</p> <p>An observation of the facility was conducted on 3/24/26 at 4:30 PM. The facility was a one-story construction that visitors could enter via the paved or the gravel parking lot. Immediately outside of the side door of the facility was an approximately 50-foot wheelchair ramp that led by the side of the front porch to the front of the facility and into the main paved parking lot of the facility. At the end of the wheelchair ramp to the right led to a paved hill that was used to enter and exit the paved parking lot. The entrance/exit to the paved parking lot had ditches filled with six-to-eight-inch jagged rocks and led out into a well-traveled main road that had a posted speed limit of 35 miles per hour and had blind curves on each side</p>	F0689	<p>Continued from page 4 exit door through which the resident exited. This is the only door that is affected.</p> <p>Beginning 3/2/2026 through 3/4/2026, the Director of Nursing (or designee) re-educated all facility staff on the facility's Elopement Prevention Policy.</p> <p>Education included the following procedures:</p> <p>Upon discovery that a resident cannot be located, an immediate head count will be conducted.</p> <p>If the resident remains missing, Code Green will be announced via the facility paging system.</p> <p>The clinical supervisor will notify the Administrator, Director of Nursing, and attending physician.</p> <p>The highest-ranking staff member on duty will assume the role of team leader and coordinate the search.</p> <p>The team leader will maintain documentation throughout the search process.</p> <p>The facility floor plan will be used to ensure a thorough interior search.</p> <p>If the resident is not located inside the facility, staff will initiate an external search and notify the resident's family or legal representative.</p> <p>If the resident remains missing, the Administrator will notify local emergency response agencies.</p> <p>Staff were also re-educated that staff nurses are to complete elopement risk assessments:</p> <p>Upon admission</p> <p>Quarterly</p> <p>With any significant change in condition</p> <p>As needed</p> <p>Staff were instructed to immediately report new or increased behaviors, including verbalizations of wanting to leave the facility or changes in mental status, to nurse management.</p>	

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F0689 SS = SQC-J	<p>Continued from page 5 of the facility's driveway, which made it difficult to see any oncoming traffic. To the left of the wheelchair ramp led back to the front of the facility. Straight ahead of the wheelchair ramp led across the paved parking lot and into a gravel parking lot of the facility. Resident #1 was found on the opposite side of the road from the facility on the two-lane road</p> <p>Review of weather data from Weather Underground for 3/2/26 at 10:00 AM revealed the recorded temperature was 56 degrees Fahrenheit with light winds and no precipitation.</p> <p>Review of google earth revealed that there was 47 feet from the side door of the facility to the end of the wheelchair ramp, 157 feet from the end of the wheelchair ramp to the main road and 258 feet from facility parking lot to where Resident #1 was found. The slope out of the parking lot was 8.9 degrees.</p> <p>An interview with Assistant Director of Nursing (ADON) #1 revealed that on the morning of 3/2/26 management staff were in the conference room for morning meeting when Witness #2 came into the room and reported that a resident was out on the road. ADON #1 reported that everyone in the room went out to find the resident. She indicated that when they found Resident #1 she was just past the gravel parking lot and was on the opposite side of the road from the facility, in her wheelchair, in the road. ADON #1 stated Resident #1 was upset, not easy to console, and was adamant that she must continue down the road and not go back to the facility when staff got to her. She reported Resident #1 was stating she wanted to go home to see her son. ADON #1 reported they wheeled Resident #1 back into the building, assessed her and she began to calm down. ADON #1 recalled that Resident #1 did not have any injuries. ADON #1 reported Resident #1 had not indicated in the past that she wanted to leave the facility. ADON #1 stated Resident #1 had experienced a decline over the last several months prior to 3/2/26 and was not safe to be outside without supervision.</p> <p>A telephone interview with Witness #1 on 3/24/26 at 2:00 PM revealed that on the morning of 3/2/26 she was on the front porch of the facility and remembered seeing Resident #1 coming down the ramp beside the front porch of the facility and observed her go out into the paved parking lot in front of the facility. Witness #1 reported she assumed the resident was going outside to enjoy the morning. Witness #1 reported she</p>	F0689	<p>Continued from page 5</p> <p>Residents identified as being at risk for elopement will be listed in the facility's High Risk for Elopement binders, located at the reception desk and nurses' stations, to promote staff awareness. The ADON/designee is responsible for ensuring the elopement binders are updated and accurate. The DON communicated this responsibility to the ADON upon orientation/training. Staff are educated about the High-risk for elopement binder upon hire/orientation and are instructed to look at the binder to identify any newly added residents if a lapse in days worked has occurred. This is also accomplished via shift-to-shift report, care plan updates and resident profile updates. Nurses are also aware as there are orders to check the function and location of the wander guard every shift that shows up on the Electronic Treatment Record.</p> <p>On 3/2/2026, nurse management received additional education from the Regional Director of Clinical Services regarding the review of new or increased behaviors during the daily clinical morning meeting to determine whether a new elopement risk assessment is warranted. This is completed by reviewing the Facility Activity report (24-hour report) during the morning meeting. Any negative finding will be addressed at that time. The activity report flows from each individual residents chart to the activity report. This consist of all progress notes, observations completed, new events initiated and any new orders written.</p> <p>Starting on 3/2/26 the Maintenance Director (or designee) was assigned by the Administrator to conduct daily checks of all door alarm systems to ensure proper function. Any issues will be immediately reported to the administrator and addressed at time of discovery.</p> <p>The Administrator instructed the Scheduler to ensure all agency staff complete this education prior to working in the facility, and Human Resources (HR) will ensure all newly hired staff receive this education during orientation. The scheduler and HR were educated on this process on 3/2/2026 by the Administrator.</p> <p>No staff member will be permitted to work until this education has been completed.</p> <p>4. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?</p> <p>On 3/3/2026, the interdisciplinary team reviewed the incident and implemented monitoring through the facility's Quality Assurance and Performance</p>	

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F0689 SS = SQC-J	<p>Continued from page 6 (Witness #1) continued into the facility to get her family member who she was visiting and came back out to the porch where they were joined by Witness #2. Witness #1 stated she didn't remember seeing Resident #1 when she returned to the front porch of the facility. Witness #1 reported there may have been five to eight minutes between her seeing Resident #1 and when another visitor came to the porch to tell Witness #2 and her (Witness #1) that someone (Resident #1) was in a wheelchair down the road. Witness #1 stated that Witness #2 went inside to tell the staff about Resident #1 being in the road. Witness #1 reported that a lot of the staff came out of the facility and went down the road, and a few minutes later came back pushing Resident #1 in her wheelchair.</p> <p>A telephone interview with Witness #2 on 3/24/26 at 1:49 PM revealed she was sitting on the front porch of the facility on 3/2/26 around 10:00 AM with Witness #1 and someone, who Witness #2 assumed was a family member of another resident, came up onto the porch and told her there was a lady in her wheelchair across the road heading up around the curve. Witness #2 reported she went inside the facility and when she saw no one at the front desk she went to the conference room to let the staff know that Resident #1 was out in the road in her wheelchair. Witness #2 reported all the staff in the conference room went out to get Resident #1 and she observed a passerby standing with Resident #1 on the opposite side of the road down past the gravel parking lot.</p> <p>An interview with Nurse #2 conducted on 3/24/26 at 1:57 PM revealed she was at the morning meeting with all department heads on 3/2/26. She reported that on the morning of 3/2/26 she was sitting on the side of the table in the conference room where she could see out the windows into the hallway. She stated she saw Resident #1 come down the hall self-propelling in her wheelchair around 10:00 AM, which was not unusual for Resident #1 as she frequently visited the front desk. Nurse #2 reported that several minutes later Witness #2 came into the conference room and said Resident #1 was outside. Nurse #2 stated everyone in the conference room ran out to get Resident #1. She stated the resident was found just past the gravel parking lot area, on the opposite side of the road as the facility in the roadway trying to self-propel herself via wheelchair up the road. Nurse #2 reported there was a passerby outside with the resident trying to get her out of the road when she (Nurse #2) arrived. Nurse #2 did not know who the passerby was.</p>	F0689	<p>Continued from page 6 Improvement (QAPI) program for 12 weeks to ensure sustained compliance.</p> <p>Elopement Drills</p> <p>Beginning the week of 3/3/2026:</p> <p>Weekly drills for four weeks</p> <p>Monthly drills for two additional months</p> <p>Drills will be conducted on all shifts and weekends.</p> <p>The Business Office Manager (or designee) is responsible for conducting and documenting these drills.</p> <p>Beginning the week of 3/9/2026, for 12 weeks, the Director of Nursing (or designee) will:</p> <p>Audit progress notes during the daily clinical morning meeting to identify new or increased behaviors that could lead to exit-seeking behavior.</p> <p>Interview three random staff members weekly to determine awareness of residents who have verbalized a desire to leave the facility or have experienced behavioral or cognitive changes that could contribute to elopement risk.</p> <p>Review residents who have had recent gradual dose reductions of antipsychotic or anxiolytic medications for increased exit-seeking behaviors. This information is obtained by reviewing the facility activity report.</p> <p>Elopement Risk observations are reviewed in the clinical morning meeting as part of the Facility Activity Report (24-hour report.) Any concerns identified are addressed at that time.</p> <p>Any concerns identified will be addressed immediately, and the interdisciplinary team will review and implement additional interventions as indicated.</p> <p>Audit results will be reviewed weekly during the clinical meeting and monthly during the QAPI meeting.</p> <p>At the conclusion of the 12-week monitoring period, the QAPI committee will evaluate the results and determine whether additional monitoring is necessary to ensure</p>	

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F0689 SS = SQC-J	<p>Continued from page 7</p> <p>An interview with NA #1 on 3/24/26 at 1:14 PM indicated she was familiar with the elopement on 3/2/26 involving Resident #1 and was her assigned aide on that day. NA #1 revealed Resident #1 was sitting at the nurse's station around 9:30 AM on the morning of 3/2/26. NA #1 reported that was Resident #1's normal routine as she waited at the nurse's station for someone to take her out to smoke. NA #1 stated that a while later she noticed Resident #1 was no longer at the nurse's station. She was unable to recall the time but reported she was still doing morning rounds so it was sometime before 10:30 AM. She indicated the next time she saw Resident #1 she (the resident) was being pushed down the hall in her wheelchair by the DON. NA #1 reported she was made aware by one of the nurses, she could not recall which one, that Resident #1 had attempted elopement from the facility but didn't succeed. NA #1 stated she was not aware through present date that Resident #1 had gotten out of the building and went down the road. NA #1 reported she was not aware of any other occasions where Resident #1 had tried to elope, and Resident #1 had never said anything to her about wanting to leave or needing to care for her adult son.</p> <p>During an interview on 3/24/26 at 10:50 AM with Resident #1 she stated she left the building in her wheelchair (on 3/2/26) and went down the hill of the paved parking lot and up the road. She reported she did not go through the gravel parking lot because she knew she could not push her wheelchair through the gravel. Resident #1 stated she was wearing a sweatshirt, long pants, socks and shoes, and her toboggan (winter hat). Resident #1 reported she felt like something was wrong with her adult son and she needed to be the one caring for him. Resident #1 indicated she wasn't sure why she felt she needed to leave on 3/2/26 to go take care of her son, she just felt like her son needed her and she should be the one caring for him. She stated she did not let anyone know that she was leaving the facility and was unsure why she didn't tell anyone. Resident #1 indicated she had gotten out to the road via wheelchair and had passed the gravel parking area when two people, who she thought were from the nearby church, stopped her and told her they were afraid she was going to get hit by a car. Resident #1 reported she didn't remember where those people went, she reported she thought they stayed there with her until the Administrator and DON got there. Resident #1 stated that the Administrator and DON came and got her and brought her back to the facility. She stated she liked it at the facility but was concerned about her adult son and who was taking</p>	F0689	<p>Continued from page 7 sustained compliance.</p> <p>Alleged Date of Compliance: 3/27/2026</p>	

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F0689 SS = SQC-J	<p>Continued from page 8 care of him.</p> <p>During a follow-up interview on 3/24/26 at 5:03 PM with Resident #1 she stated she did not have a cell phone to call for help on 3/2/26 if she needed it and was not wearing a coat because she did not think she needed a coat.</p> <p>An interview was conducted with Resident #1's State Appointed Guardian on 3/24/26 at 10:04 AM. The Guardian reported that she had been made aware by the facility that Resident #1 had been having increased confusion and increased anxiety prior to March 2026. She reported she had noticed Resident #1 was repeating herself a lot during their visits and was more concerned about the well-being of her adult son. The Guardian reported that these changes had led her to begin the process of filing for full guardianship. She explained that full guardianship gave her the ability to make all decisions regarding personal, care, residence, medical treatment and financial affairs for Resident #1. She further explained that at the time of the 3/2/26 incident she had limited guardianship which gave the guardian limited power only in areas where the person could not make decisions. Resident #1's State Appointed Guardian reported that she obtained guardianship over Resident #1 because the resident had not demonstrated the ability to make sound decisions, and there was no family member who could make sound decisions on Resident #1's behalf. Resident #1's State Appointed Guardian reported that Resident #1 had a son that was blind and Resident #1 had previously been his primary caregiver and the Guardian believed that this contributed to Resident #1 wanting to leave the facility on 3/2/26.</p> <p>Interview with Nurse #4 on 3/24/26 at 12:57 PM revealed she was asked by the DON and the ADON #1 on 3/2/26 to put a wanderguard on Resident #1. Nurse #4 reported the DON also asked her to fill out an elopement assessment on Resident #1 on 3/2/26, and to read his 3/2/26 progress note about the attempted elopement for the information she would need to complete the assessment. Nurse #4 stated the progress note did not have a location as to where Resident #1 was found. She explained that she made the DON aware that the progress note did not include a location and the DON stated he would complete that part of the assessment. Nurse #4 reported she spoke with Resident #1 before completing the assessment on 3/2/26 and Resident #1 stated she wanted to go home and take care of her son. Nurse #4 reported that Resident #1 was crying and repeating she was sorry for leaving when Nurse #4 spoke to her. Nurse</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 9</p> <p>#4 stated she was not given any details on the elopement or attempted elopement of Resident #1 by the DON or by Resident #1. Nurse #4 reported she did not know through present date (3/24/26) that Resident #1 had left the building on 3/2/26. She explained that the progress note completed by the DON led her to believe it was an attempted elopement and the resident had been intercepted by staff.</p> <p>An interview with Nurse #5 on 3/24/26 at 12:41PM indicated she had given Resident #1 her medications between 7:45 and 8:00 AM on the morning of 3/2/26 and she noted no concerns with Resident #1 at that time. She reported Resident #1 was in her room in her wheelchair at the time and she was dressed. Nurse #5 reported the next time she saw Resident #1 was at approximately 11:00 AM when Nurse #4 was putting a wandguard bracelet on her. Nurse #5 reported the DON and Assistant Director of Nursing (ADON) #1 explained to Nurse #5 that Resident #1 had attempted to leave the facility. Nurse #5 reported that to present date (3/24/26) she had not been made aware that Resident #1 had left the building. Nurse #5 stated Resident #1 had never told her (Nurse #5) that she wanted to leave the facility and had never expressed needing to leave to care for her adult son.</p> <p>A Psychiatric Provider note dated 3/2/26 indicated Resident #1 was seen for psychiatric follow up due to staff request. Per the DON, Resident #1 attempted elopement, and was intercepted by staff. Resident #1 was continually stating "I just want to go home." The DON stated Resident #1 was placed on every 15-minute checks for 24 hours due to attempted elopement. Per the DON, Resident #1 had no prior history of exit seeking behavior. Resident #1 was followed for a known history of depression, anxiety, and a recent diagnosis of dementia. Per staff, Resident #1 had ongoing confusion. Resident #1 was a fair historian. Resident #1 was assessed after attempted elopement and she stated, "I just wanted to go home." Staff discussed with resident she was not safe to go home and needed help with activities of daily living. Resident #1 stated "I know, I know I can't go, there's no one to take care of me." She then repeated, "I just want to go home." She stated, "I need to care for my child, he needs me, it should be me taking care of him." Resident #1 was referring to her grown son who had impaired vision. She stated they were good to her at facility, but she did not like being away from home. When asked if there was any trigger or inciting event, Resident #1 initially stated "no." She later stated she was upset that she</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 10 could not go outside and smoke when she wanted to. Resident #1 was a supervised smoker. The resident stated, "I know I shouldn't have done that; I won't do it again." The Psychiatric Provider indicated she discussed Resident #1 with the NP who stated she was ordering a head computed tomography scan (CT scan) to evaluate for possible CVA (cerebrovascular accident) or vascular changes due to history of past CVA. Also discussed increasing Namenda for dementia. Resident #1 now had a wanderguard in place.</p> <p>An interview with the Psychiatric Provider on 3/24/26 at 2:12 PM revealed she was at the facility on 3/2/26 when it was reported to her that Resident #1 had attempted to leave the facility and was intercepted by staff. The Psychiatric Provider revealed that to present date (3/24/26), she did not recall anyone reporting to her that Resident #1 actually left the building. The Psychiatric Provider reported the staff had already interviewed the resident prior to her assessment on 3/2/26, however, during the interview with the Psychiatric Provider the resident told her a very different story than what she had told the facility staff. The Psychiatric Provider could not remember the details of what Resident #1 told her. The Psychiatric Provider stated that it was out of the ordinary for Resident #1 to attempt to leave the facility and she found Resident #1 to be very confused and tearful on 3/2/26. The Psychiatric Provider indicated Resident #1 had been treated for a UTI, so she assumed that played a part in her disposition on 3/2/26, although she was not being treated for an active infection. The Psychiatric Provider reported Resident #1 had been experiencing increased confusion and depression over the last three months prior to 3/2/26 and her Cymbalta (a medication used to treat depression) had been increased. The Psychiatric Provider indicated that she has had no further concerns with Resident #1 since 3/2/26.</p> <p>Interview with the NP on 3/24/26 at 1:50 PM revealed she was made aware on 3/2/26 that Resident #1 had gotten out of the building on the morning of 3/2/26 and someone found her outside in the gravel parking lot. The NP reported she had had no concerns about Resident #1 leaving the facility prior to 3/2/26. The NP indicated Resident #1's cognition had been declining, which included increased confusion and depression, and she had been treated for several UTI's in the last three months prior to 3/2/26. The NP stated she had consulted with the Psychiatric Provider after the elopement and increased Resident #1's Namenda (a</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 11 medication used to treat dementia). The NP indicated that after the elopement she also ordered a CT scan and it did show Resident #1 to have encephalomalacia, (softening of the brain tissue consistent with dementia). The NP reported she spoke with Resident #1 after the incident on 3/2/26 and the resident was apologetic for leaving but could not tell the NP why she left, only that she wanted to go home. The NP reported she did not know who found Resident #1 or how long she had been outside the facility. The NP reported she had not had any new concerns since the incident on 3/2/26. The NP reported that due to Resident #1's increased confusion, decreased mobility and being wheelchair bound her risk of being outside the facility unassisted included turning the wheelchair over and sustaining an injury, getting lost, or kidnapped and/or being hit by a car. The NP stated Resident #1 should not have been outside unassisted.</p> <p>An interview with the Maintenance Director on 3/24/26 at 2:08 PM revealed he was unsure if the side door that Resident #1 went out of was locked during business hours prior to 3/2/26. He reported the door did not alarm when Resident #1 went out because it only had a wanderguard alarm on it and Resident #1 did not wear a wanderguard bracelet at that time. He reported that the only exterior door that did not have an alarm now was the front door. He reported that the front door was monitored all day by the front desk receptionist or a member of management and then was locked at 5:00 PM when the management staff went home.</p> <p>During an interview with Nurse #3 on 3/24/26 at 12:54 pm she reported that she had been off for several days prior to 3/2/26 and upon returning to work she was reading thru the recent progress notes of the residents in her care and found the progress note completed by the DON alerting her to Resident #1's "attempted elopement." Nurse #3 revealed that to present date (3/24/26) no one had told her that Resident #1 had actually left the facility.</p> <p>An interview with the Administrator on 3/24/26 at 3:20 PM revealed that on 3/2/26 the morning meeting was being held in the conference room, and the meeting was about over when Witness #2 came into the room to let staff know that a resident was in the road. The Administrator reported that she and the staff were able to catch up to Resident #1 and that she was across the road from the facility, just past the gravel parking lot, sitting in her wheelchair in the road. The</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 12</p> <p>Administrator stated the staff were able to get Resident #1 back into the building. She reported that Resident #1 had never indicated that she wanted to leave the facility prior to 3/2/26 and the staff were surprised by this event. The Administrator explained that Resident #1 did worry about her blind son a lot and she (the Administrator) had discussed with Resident #1's guardian that the adult son lived right down the road with other family members. The Administrator indicated she was aware that Resident #1 had started having some increased confusion a few months ago and a lot of diagnostics were completed, such as labs and scans, as well as medication changes, but she was unsure what medications had been changed. The Administrator revealed that the Psychiatric Provider and the NP both were able to assess Resident #1 on 3/2/26. The Administrator reported that Resident #1 went out the side door of the facility and that prior to 3/2/26 the side door did not alarm unless there was a wanderguard close by. The Administrator further stated the Maintenance Director put an alarm on the side door that sounded anytime the door was opened on 3/2/26 after Resident #1 was returned to the facility and management also put signs out at the nurses' station to make the nursing staff aware of the alarm. The Administrator reported that a wanderguard was placed on Resident #1's ankle for safety. The Administrator stated she was not sure why all staff did not know that Resident #1 had actually got out of the building and she would need to speak to the DON about his progress note on 3/2/26 that indicated the elopement was attempted as she was unsure why the DON would have written that. The Administrator reported she felt that it was important for all staff to know that Resident #1 had actually left the building and went down the road and not that she just attempted to elope. She explained that an actual elopement presented much more danger than just an attempted elopement. The Administrator indicated that it was not safe for Resident #1 to be out of the facility unsupervised.</p> <p>The Administrator was notified of immediate jeopardy on 03/24/26 at 6:00 PM.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;</p> <p>On 3/2/2026, Resident #1 experienced an unsupervised exit from the facility through a side exit door and was</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 13 observed off facility property by a family member, which alerted staff. The resident was immediately returned to the facility without injury by the Administrator, Director of Nursing, and Assistant Director of Nursing.</p> <p>The Administrator and Director of Nursing (DON) conducted an immediate review of the incident on 03/02/2026. The Administrator and DON determined the root cause to be that the side exit door did not have an alarm system installed that alerted staff to any opening of the door at the time of the incident, which allowed Resident #1 to exit the facility without staff awareness.</p> <p>Immediately upon the resident's return to the facility on 3/2/2026, the following actions were taken: The Administrator and DON contacted Resident #1's guardian, primary care provider, and Medical Director on 3/2/2026. Resident #1's nurse completed a head-to-toe nursing assessment on 3/2/2026, and no injuries were noted. The Administrator and Director of Nursing (DON) interviewed Resident #1. During the interview, Resident #1 verbalized a desire to go home to care for her son. The Administrator reassured Resident #1 that her son is cared for by a full-time caregiver. The Director of Rehabilitation Services completed a Brief Interview for Mental Status (BIMS) assessment on 3/2/2026, with a score of 8/15 (a score of 8 indicates moderate cognitive impairment). Resident #1's nurse completed an elopement risk assessment on 3/2/2026, and Resident #1 was identified as high risk for elopement. At the time of identification as being high risk, the staff were notified via shift-to-shift report and resident was placed in the high-risk binder and through staff education. Assistant Director of Nursing (ADON) added Resident #1 to the facility's High Risk for Elopement binder located at the nurses' stations and reception desk to promote staff awareness. At the time of identification as being high risk, the staff are notified via shift-to-shift report and resident was placed in the high-risk binder and through staff education. The Director of Nursing applied a Wander Guard device to Resident #1's left ankle on 3/2/2026. The psychiatric provider, who was present in the facility, assessed Resident #1 and initiated new orders. The in-house provider also assessed Resident #1 on 3/2/2026, and in collaboration with the psychiatric provider implemented additional orders: Plavix (antiplatelet) 75 mg by mouth once daily. Memantine (used to treat Alzheimer's disease) 10 mg by mouth twice daily. Obtain Head computed tomography (CT) scan for evaluation for possible Cerebrovascular Accident (CVA) or vascular changes. Apply wander guard monitoring</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 14 device. Monitor wander guard function and placement every shift. Resident #1's comprehensive care plan was reviewed and revised on 3/2/2026 to include interventions related to elopement risk, including Wander Guard placement, increased staff awareness, behavioral monitoring, and redirection when verbalizing a desire to leave the facility. Minimum Data Set (MDS) nurse added this to the care plan and resident profile. Floor nurse was made aware by the DON and other floor Staff are notified via shift-to-shift report and placed in high-risk binder. The DON initiated and communicated on 3/2/2026 to the nurses that Resident #1 was placed on every 15 minute visual checks. Resident #1 was placed on increased behavior monitoring for 72 hours following the incident. The nurses caring for Resident #1 were responsible for completing these checks and documenting on the frequent visual check log. The door through which Resident #1 exited was placed under continuous staff monitoring by the Business Office Manager (BOM)/designees until an alarm system could be installed. The door was monitored from 10am until 4pm when the Maintenance Director installed the alarm. Visualization of the door monitor was observed by the Administrator and DON. The BOM also completed a form stating they completed the assigned task of monitoring the door. On 3/2/2026, the Maintenance Director installed an alarm device on the side exit door to ensure the door alarmed when opened. Staff were educated on the placement of the new alarm via all staff education. Elopement drills were conducted by the Business Office Manager (or designee) to reinforce staff response procedures: Second shift – 3/2/2026 Third shift – 3/3/2026 First shift – 3/3/2026 On 3/3/2026, the DON (or designee) interviewed nursing staff who had cared for Resident #1 within the previous 72 hours to determine whether Resident #1 had verbalized a desire to leave or demonstrated exit-seeking behaviors. Any concerns identified were immediately addressed.</p> <p>Immediately upon discovery of the unsupervised exit on 3/2/2026, the Director of Nursing conducted a head count of all residents, and all residents were accounted for.</p> <p>On 3/2/2026, the Maintenance Director evaluated all exit doors in the facility to ensure alarms were present and functioning properly. All alarms were confirmed to be operational.</p> <p>On 3/2/2026, the Director of Nursing (or designee) reviewed elopement risk assessments for all residents to ensure accuracy and confirm appropriate interventions were in place. No additional residents were newly identified as being at risk.</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 15</p> <p>On 3/2/2026 the DON (or designee) also reviewed progress notes for all residents for the previous seven days to identify any behavioral changes or exit-seeking behaviors. No additional concerns were identified.</p> <p>On 3/3/2026, the DON (or designee) interviewed nursing, housekeeping, and therapy staff to determine whether any resident had verbalized a desire to leave the facility or demonstrated behavioral or cognitive changes that could contribute to exit-seeking behavior. Any identified concerns were immediately reported to the Administrator and DON for follow-up.</p> <p>On 3/3/2026, the DON (or designee) reviewed residents who had experienced a gradual dose reduction (GDR) of antipsychotic or anxiolytic medications within the previous 30 days to determine whether increased behaviors were present that could contribute to exit-seeking behavior. This was accomplished by reviewing all orders for the above medications and also reviewed progress notes for the entire facility to identify any affected residents. No additional concerns were identified.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 3/2/2026, the Maintenance Director permanently installed an alarm system (screamer alarm) on the side exit door through which the resident exited. This is the only door that is affected.</p> <p>Beginning 3/2/2026 through 3/4/2026, the Director of Nursing (or designee) re-educated all facility staff on the facility's Elopement Prevention Policy.</p> <p>Education included the following procedures: Upon discovery that a resident cannot be located, an immediate head count will be conducted. If the resident remains missing, Code Green will be announced via the facility paging system. The clinical supervisor will notify the Administrator, Director of Nursing, and attending physician. The highest-ranking staff member on duty will assume the role of team leader and coordinate the search. The team leader will maintain documentation throughout the search process. The facility floor plan will be used to ensure a thorough interior search. If the resident is not located inside the facility, staff will initiate an external search and notify the resident's family or legal representative. If the</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 16 resident remains missing, the Administrator will notify local emergency response agencies. Staff were also re-educated that staff nurses are to complete elopement risk assessments: Upon admission Quarterly With any significant change in condition As needed Staff were instructed to immediately report new or increased behaviors, including verbalizations of wanting to leave the facility or changes in mental status, to nurse management.</p> <p>Residents identified as being at risk for elopement will be listed in the facility's High Risk for Elopement binders, located at the reception desk and nurses' stations, to promote staff awareness. The ADON/designee is responsible for ensuring the elopement binders are updated and accurate. The DON communicated this responsibility to the ADON upon orientation/training. Staff are educated about the High-risk for elopement binder upon hire/orientation and are instructed to look at the binder to identify any newly added residents if a lapse in days worked has occurred. This is also accomplished via shift-to-shift report, care plan updates and resident profile updates. Nurses are also aware as there are orders to check the function and location of the wander guard every shift that shows up on the Electronic Treatment Record.</p> <p>On 3/2/2026, nurse management received additional education from the Regional Director of Clinical Services regarding the review of new or increased behaviors during the daily clinical morning meeting to determine whether a new elopement risk assessment is warranted. This is completed by reviewing the Facility Activity report (24-hour report) during the morning meeting. Any negative finding will be addressed at that time. The activity report flows from each individual residents chart to the activity report. This consist of all progress notes, observations completed, new events initiated and any new orders written.</p> <p>Starting on 3/2/26 the Maintenance Director (or designee) was assigned by the Administrator to conduct daily checks of all door alarm systems to ensure proper function. Any issues will be immediately reported to the administrator and addressed at time of discovery.</p> <p>The Administrator instructed the Scheduler to ensure all agency staff complete this education prior to working in the facility, and Human Resources (HR) will ensure all newly hired staff receive this education during orientation. The scheduler and HR were educated on this process on 3/2/2026 by the Administrator.</p> <p>No staff member will be permitted to work until this</p>	F0689		

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F0689 SS = SQC-J	Continued from page 17 education has been completed.  Alleged Date of IJ Removal: 3/5/2026  On 3/26/26, the facility's credible allegation of immediate jeopardy removal effective 3/05/26 was validated by the following: In-service records and interviews with staff across all departments revealed they had been educated on ensuring safety with residents that exhibit wandering or exit seeking behaviors. All staff received elopement competencies, completed return demonstration to include quizzes of the education received. The Maintenance Director completed daily door alarm checks for all entrance and exit doors to ensure all doors were alarmed and in proper working condition. All staff were educated on the wandering binders kept at each nurse's station with the list of residents' names, pictures of residents, updated assessments, and the policies and procedures. Staff were made aware to notify their supervisor or administrative staff if they observe any changes with residents' behaviors or any safety issue incidents. Front door would be locked at 5:00 PM and side entrance would be utilized with use of pin pad code to enter and exit after 5:00 PM and on weekends. Licensed nursing staff were educated on completing accurate wandering assessments by reviewing previous assessments, MDS, care plans, progress notes, and completing accurate observations of residents. Interviews with the administrative staff revealed they had been educated to make sure all residents have updated, and accurate mental status completed, and staff were also completing accurate, updated wandering assessments. Any changes in condition or new behaviors pertaining to wandering residents were being documented and supervisors were made aware. All wandering binders were kept up to date with the status of each of the residents. Located at each nurse's desk were wandering binders that contained a list of names and pictures of any residents with wandering behaviors or who require wandering devices, along with the wandering policy and protocols.  The facility's immediate jeopardy removal date was validated as 3/05/26.	F0689		
F0842 SS = D	Resident Records - Identifiable Information  CFR(s): 483.20(f)(5),483.70(h)(1)-(5)  §483.20(f)(5) Resident-identifiable information.  (i) A facility may not release information that is resident-identifiable to the public.	F0842	State and Federal law requires preparation and submission of this Plan of Correction. This Plan of Correction does not constitute an admission of liability by the facility and does not establish agreement with the survey findings. The Plan of Correction is submitted to demonstrate the facility's plan of achieve and maintain compliance.  Step 1	04/16/2026

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F0842 SS = D	<p>Continued from page 18</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records.</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p>	F0842	<p>Continued from page 18</p> <p>The facility failed to maintain a complete and accurate medical record in regards to resident #1. The progress note has received an addendum to correct the verbiage in the resident record. This correction was completed by the DON on 4/10/2026.</p> <p>Step 2</p> <p>On 04/10/2026 The Administrator and DON reviewed the last 30 days of events to ensure accurate documentation with no negative findings noted.</p> <p>Step 3</p> <p>On 04/10/2026 the Regional Director of Clinical Services (RDCS) educated the Administrator, Director of Nursing (DON) and department managers on maintaining a complete and accurate medical record.</p> <p>The DON/designee educated 100% of Facility staff and current agency staff that perform documentation at the facility on maintaining a complete and accurate medical record. This education was completed on 04/15/26</p> <p>All newly hired staff and new agency staff will also receive this education upon orientation prior to working on the floor. This education will be completed by the DON/designee.</p> <p>Step 4</p> <p>The DON/Designee will audit event documentation in clinical morning meeting 5 times weekly for 4 weeks then 3 times weekly for 8 weeks. Any negative findings will be forwarded to the Administrator and DON to be addressed and corrected.</p> <p>Audits will be forwarded to the QAPI Committee for review and recommendations; any additional interventions will be implemented as needed.</p> <p>Date of Compliance: 04/16/2026</p>	

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F0842 SS = D	<p>Continued from page 19</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff and resident interview the facility failed to maintain a complete and accurate medical record when staff documented a resident attempted elopement and was intercepted by staff. This occurred for 1 of 3 residents (Resident #1) reviewed for accurate medical record</p> <p>The findings included:</p> <p>A review of a progress note dated 3/2/26 written at 10:30 AM by the Director of Nursing (DON) indicated that Resident #1 attempted elopement and was intercepted. The DON indicated in the note that reorientation was attempted to her situation without success.</p> <p>An interview with the DON on 3/24/2026 at 2:58 PM revealed on the morning of 3/2/2026 management staff were in the morning meeting a visitor came into the conference room telling them a resident was outside. He reported that the staff in the morning meeting immediately left the conference room to locate the resident. He reported that when they found Resident #1 she was on the road just past the gravel parking lot.</p>	F0842		

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F0842 SS = D	<p>Continued from page 20</p> <p>He stated Resident #1's "mentation was altered, she was what I would describe as manic." He reported that it was difficult to make the resident understand the danger she was in on the road and why she needed to return to the facility. The DON reported Resident #1 was difficult to convince to come back to the facility, as she kept attempting to propel herself via wheelchair further up the hill on the road stating she needed to go take care of her son. He indicated they were able to get Resident #1 back to the facility. The DON was unable to explain why he wrote in the progress note that Resident #1 attempted elopement and was intercepted by staff. The DON reported that Resident #1 did elope and was found down the road below the gravel parking lot.</p> <p>An interview with the Administrator on 3/24/26 at 3:20 PM revealed that on 3/2/26 the morning meeting was being held in the conference room and the meeting was about over when a visitor came into the room to let staff know that a resident was in the road. The Administrator reported that she and the staff were able to catch up to Resident #1 and that she was across the road from the facility, just past the gravel parking lot, sitting in her wheelchair in the road. The Administrator reported that Resident #1 went out the side door of the facility. The Administrator reported she was not sure why all staff did not know that Resident #1 had actually got out of the building and she would need to speak to the DON about his progress note on 3/2/26 that indicated the elopement was attempted as she was unsure why the DON would have written that. The Administrator stated she expected all information entered into a resident's medical record to be accurate.</p>	F0842		