STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhaven Health and Rehabilitation Center	**801 Greenhaven Drive , Greensboro, North Carolina, 27406**

(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
E0006 SS = J	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan.	E0006	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 8/5/25 The Administrator notified law enforcement that Resident #1 could not be located. The police department notified the Administrator on 8/5/25 that the resident was located, and The Director of Nursing (DON) and Nursing Assistant #2 went to the location of the resident and brought the resident back to the facility. An assessment was completed by the assigned hall nurse and revealed a laceration approximately one inch to the right cheek and a ¾ inch abrasion above both knees with treatment provided. Emergency Medical System (EMS) arrived to evaluate the resident and found the resident to be stable. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 8/8/25, nursing progress notes for the last 30 days were reviewed by the Assistant Director of Nursing (ADON) to identify any resident with an unsupervised exit from the facility to ensure the staff immediately reported the exit and emergency preparedness procedures were followed to include reporting to the police within 15 minutes of discovering the resident missing. There were no other unsupervised exits identified. On 8/12/25, incident reports for the last 30 days were reviewed by the Director of Nursing to identify any resident with an unsupervised exit from the facility to ensure the staff immediately reported the exit and emergency preparedness procedures were followed to include reporting to the police within 15 minutes of discovering the resident missing. There were no other unsupervised exits identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 8/8/25, the Regional Vice President educated the Administrator and DON on the Emergency Preparedness procedures for elopement with emphasis on the Administrator's and DON's responsibility to ensure the	09/09/2025

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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E0006 SS = J	Continued from page 1 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on observations, record review, and staff, physician, family and law enforcement interviews, the facility failed to implement their Emergency Preparedness (EP) Plan for a missing person when staff did not limit the initial search to 15 minutes and upon the lapse of 15 minutes failed to call 911 and report a missing severely cognitively impaired resident to the local police. Medication Aide #1 realized Resident #1 could not be found during the evening medication pass approximately 8:15 pm or 8:20 pm on 08/5/25 and notified Nurse #1. Nurse #1 stated she became aware that Resident #1 could not be located at 8:45 pm on 08/05/25 and called a Code Orange (missing person). Nurse #1 conducted 3 separate search attempts at 8:55 pm, 9:13 pm, and 9:20 pm. She had notified the Director of Nursing (DON) on 08/05/25 at 8:55 pm that the resident was missing. The DON notified the Administrator who arrived at the facility on 08/05/25 at 9:15 pm. Staff members continued to search the inside and outside of the building and in surrounding neighborhoods. The Administrator called 911 on 08/05/25 at 9:49 pm to report a missing person. In addition, the Maintenance Director, who was responsible for completing missing person drills with the staff, and the DON and Administrator all stated they were unaware	E0006	Continued from page 1 local police is contacted with a report within 15 minutes of a resident missing. Additionally utilizing the emergency preparedness missing resident template as a reference to ensure all appropriate steps are taken. On 8/12/25, a missing resident checklist on bright colored paper was posted at each nurse's station for nurses to utilize as a guide for steps to take in an event of a missing resident. The check list includes notification to the local police department if a resident cannot be located after a 15-minute search. On 8/12/25, the DON initiated an, in service with all staff including dietary staff and agency staff regarding the Emergency Preparedness Plan/Policy for elopements. The education on the policy includes (1) activation of the emergency preparedness plan for a missing resident (2) immediately notifying the Administrator and Director of Nursing of a missing resident (3) the initial search for the resident should be limited to a period of 15 minutes (4) if the resident remains missing after a 15-minute search, the local police department must be notified. Additionally, the missing resident checklist posted at the nurse's stations was reviewed with all nurses during the education and the location of the emergency preparedness binders. Education was completed with all staff by 9/8/25, any staff member who has not received the in-services will receive education prior to the employee starting their assignment on their next scheduled work shift. /All newly hired staff, including agency will be in-serviced by the Staff Development Coordinator (SDC) during orientation regarding the Emergency preparedness procedures for elopements. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. An unsupervised exit drill will be conducted by the Administrator, DON, Unit Manager, or Maintenance Director weekly x 8 weeks then monthly x 1 month, utilizing the Unsupervised Exit Drill Form, to ensure staff successfully respond to what to do when there is an unsupervised exit to include reporting to the local police if the resident remained missing after a 15-minute search. Unsupervised Exit Drill will be conducted to include all three shifts. Staff will be retrained for any concerns identified during the drills. The Administrator or DON will review and initial the drills weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately. The Unit Managers will review progress notes and	

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E0006 SS = J	Continued from page 2 the facility's EP policy for a missing resident included calling 911 if a resident could not be located in 15 minutes and reporting a missing resident to the local police. On 08/05/25 Resident #1 was located by local law enforcement at 10:37 pm (approximately 1.0 mile away from the facility.) He was found lying in the road on a five-lane main street where the I-40 interstate east and west on and off ramps are located at the intersection of Randleman Road and Teague Street. He was returned to the facility by the Director of Nursing and Nurse Aide #2 in Nurse Aide #2's private vehicle. Emergency Medical Services (EMS) personnel assessed Resident #1 at 11:41 pm on 08/05/25 at the facility. He had a right facial cheek laceration approximately 2.5 inches long with controlled bleeding and band aids on his knees placed by Nurse #1 during first aid care. EMS presumed Resident #1 had fallen and they informed the family of the risks of an intracranial hemorrhage (brain bleed) after a fall and the risks of the family transporting the resident themselves. The family took Resident #1 directly to a regional hospital where he was diagnosed with a left 1 cm (centimeter) subdural hematoma (brain bleed), a right 7 mm (millimeter) subdural hematoma (brain bleed), a 3 mm midline shift of the ventricle (when the brain moves past it's center line) due to the subdural hematoma (brain bleed), a right maxillary sinus fracture (beside the nose/beneath the eye), a right orbit fracture (bone around the eye), and a right zygomatic arch fracture (cheek). He was transferred to a higher level trauma hospital for treatment. The Trauma Medical Center Physician stated Resident #1 had been transferred to their trauma unit from an affiliated regional medical center because the size of his brain bleed was too large for the other hospital to manage in accordance with their hospital protocol and the injuries Resident #1 presented with were life threatening. This was for 1 of 3 residents reviewed for accidents (Resident #1). Immediate Jeopardy began on 08/05/25 when Resident #1 exited the facility unsupervised from the facility at approximately 8:30 PM and the facility failed to notify local law enforcement when the search for Resident #1 exceeded 15 minutes in accordance with the facility Emergency Preparedness policy. Immediate jeopardy was removed on 08/13/25 when the facility implemented an acceptable removal plan of immediate jeopardy. The facility will remain out of compliance at a scope and severity of D to ensure education is completed and monitoring systems are in place and are effective. Findings included:	E0006	Continued from page 2 incident reports 5 times a week x 8 weeks then monthly x 1 month to include weekends, on the Progress Note & Incident Report Audit Tool . This audit is to identify any incidents of elopement to ensure the Emergency Preparedness plan was activated when the resident was discovered missing to include notification to the local police department if the resident remained missing after a 15-minute search. All identified areas of concern will be addressed during the audit to include reeducation with staff. The DON will review the progress note audit 5 times a week x 8 weeks to ensure all concerns were addressed. The Administrator will forward the results of the Unsupervised Exit Drill Form to the QA Committee monthly x 3 months for review and determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Director of Nursing will forward the results of the progress notes and incident reports audit to the QA Committee monthly x 3 months for review and determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Compliance: 9/9/2025	

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E0006 SS = J	Continued from page 3 The facility Emergency Preparedness policy dated 02/2025 for a Missing Resident was reviewed. The policy states: “3. The highest ranking will assume the Incident Commander position and implement the Missing Resident policy; #10. The initial search is to be limited to a period of 15 minutes. All search teams must meet with the Incident Commander within 15 minutes with a report during that time; and # 11. Upon the lapse of 15 minutes, the Incident Commander will contact the local Police with a report of a missing resident by calling 911.” Resident #1 was admitted to the facility on 08/04/25 for respite care (temporary institutional care of a sick, elderly, or disabled person, providing relief for their usual caregiver). He entered the facility from home. Diagnoses included Alzheimer’s disease, low back pain, chronic kidney disease stage 1, Type 2 Diabetes Mellitus, major depressive disorder, hypothyroidism, and essential hypertension. A Nursing Admission/Re-entry Evaluation assessment completed by Nurse #2 on 08/04/25 was reviewed. Resident #1 needed setup or clean-up assistance with dressing and personal hygiene. He needed moderate assistance with showering. He was independent with eating. He was independent with mobility, transferring, and ambulation. He did not use any assistive devices for mobility. He could communicate with some difficulty. He wore glasses. He had no falls within the past 30 days of admission. He had a serious intellectual mental health diagnosis. His admission to the facility was for short-term placement. An interview was conducted with Medication Aide #1 on 08/12/25 at 9:50 pm by telephone. Medication Aide #1 stated when she went to give Resident #1 his evening medications 08/05/25 he was not in his room. She reported it was 8:17 pm when she noticed he was not in his room. Medication Aide #1 explained she instructed two Nurse Aides to look up and down the 300 and 400 hallways because he did wander. The Nurse Aides could not find him, so the 100 and 200 halls were searched. Medication Aide #1 stated she could not find the resident in the facility. The search exhausted all areas he might have been and when she realized the resident might have exited the building, Medication Aide #1 notified Nurse #1 immediately. She could not remember what time she told Nurse #1 that the resident was missing. She stated Nurse #1 called a “Code Orange” (missing person) as soon as she told her. Medication Aide #1 concluded she had locked her medication cart and participated in the search but did not find the resident.	E0006		

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E0006 SS = J	Continued from page 4 An interview was conducted with Nurse #1 on 08/12/25 at 1:55 pm by facetime. Nurse #1 stated she was told that Resident #1 could not be located at 8:45 pm by Medication Aide #1 on 08/05/25. She explained she immediately called a “code orange” (missing person). She stated she had kept notes and written down times regarding the three searches she conducted. Nurse #1 recorded the following times: the first search was at 8:50 pm; the Director of Nursing (DON) was called at 8:55 pm, the second search was at 9:13 pm, and the third search was at 9:20 pm. All searches included inside and outside the facility. She stated at 9:25 pm she got in her personal car to search the surrounding area. She stated she went to the left when she turned out of the parking lot because she thought he would have gone that way because there were more lights, but she couldn’t find him. Nurse #1 noted she continued to search for him until the police arrived at the facility. She stated that when the resident returned to the facility she helped the family change his clothes and provided first aide to a laceration on his face and abrasions on both his legs above his knees. Nurse #1 noted that EMS came to the facility and were able to assess the resident. During the interview she provided a copy of the notations she had made regarding the times mentioned above along with a screen shot of the phone record that indicated the time she reported to the DON that Resident #1 was missing. Nurse #1 stated she was not aware of the Emergency Preparedness Policy for a missing person and could not recall ever seeing the policy. She explained she was not aware that if a resident could not be found after 15 minutes that 911 was to be called. An interview was conducted with Medication Aide #2 on 08/12/25 at 10:16 am. She started her shift at 5:00 pm on 08/05/25 and recalled around 9:00 pm an Agency Nurse Aide approached her and asked if she had seen Resident #1 and stated staff could not find him. She stated she began to look for him and had searched the salon, bathroom, and laundry room but was unable to find him. As she was looking for him another Nurse Aide told her she had seen him on the 300-hall pulling at the exit door, but she did not know the nurse aide’s name. She explained she went to the 300-hall to search for him. She checked all the doors on the 300-hall, and they were all locked. She stated she had not heard any door alarms sound during her shift. A telephone interview was conducted with Nurse Aide #2 on 08/12/25 at 4:39 pm. Nurse Aide #2 stated she was not involved in the search for Resident #1 except to drive the DON to the site to retrieve the resident.	E0006		

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E0006 SS = J	Continued from page 5 Nurse Aide #2 explained she had just arrived to work third shift after the resident was found. Nurse Aide #2 stated it was about 10:40 pm on 08/05/25 when she and the DON went in her personal car to pick up Resident #1 from where he had been found by the police. Nurse Aide #2 recalled Resident #1 was shaking because he was cold and wet. She added that it had been raining that night. When they arrived, she noticed Resident #1 had some blood on his face. She stated she checked to see if his wanderguard bracelet was on and she found it on his left foot. Nurse Aide #2 recalled she talked to Resident #1 while they waited for EMS to arrive, and it calmed him. They were at the intersection of Randleman Road and Teague Street. The resident was rambling on about his mom and dad. He told her, “They fought me, but they didn’t win.” She stated when EMS arrived the resident would not let them assess him. Resident #1 did allow EMS to eventually take his blood pressure and oxygen saturation percentage because she held his arm for them. Nurse Aide #2 stated EMS would not transport the resident because they could only take him to the hospital and the family wanted him returned to the facility, so the DON and herself took Resident #1 back to the facility in her personal car. Weather conditions reported by customweather.com for the Greensboro area on 08/05/25 documented the outside temperature to be between 66 degrees Fahrenheit at 7:54 pm and 63 degrees Fahrenheit at 10:54 pm. The conditions were mostly cloudy with light rain and fog. Two incident reports by EMS were reviewed: Incident #1 dated 08/05/25 at 11:05 pm documented the nursing home staff would not let EMS fully assess the patient who wanted to be taken back to the facility at the family’s request; and Incident #2 dated 08/05/25 at 11:41 pm documented that EMS was called back to the facility to assess the resident. EMS personnel assessed Resident #1 at 11:41 pm on 08/05/25 at the facility. The EMS report documented Resident #1 had a blood pressure of 136/100 millimeters of mercury, a heart rate of 100 beats per minute, a respiratory rate of 18, and an oxygen saturation reading of 96% on room air. He had a right facial cheek laceration approximately 2.5 inches long with controlled bleeding. He had band aids on his knees placed by Nurse #1 during first aide care. Resident #1’s mental status was oriented to person only. EMS presumed Resident #1 had fallen and they informed the family of the risks of an intracranial hemorrhage after a fall and the risks of transporting the resident themselves. EMS left the resident with his family to transport him to the hospital at their request and advised the family to call 911 for any changes.	E0006		

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E0006 SS = J	Continued from page 6 The law enforcement Incident/Investigation report was reviewed. The date and time of the report was 08/05/25 at10:37 pm. The location of the incident was 2501 Randleman Road and Teague Street. The victim was Resident #1. A second police officer assisted the responding officer on the scene. The responding law enforcement officer documented: “On 08/05/2025 at 2237 (10:37 pm) hours, I responded to Randleman Rd. and Teague St. in reference to a suspicious activity. The investigation is ongoing at this time.” Hospital records from the Regional Medical Center dated 08/06/25 at 1:01 am were reviewed. Resident #1 was diagnosed with a left 1 CM (Centimeter) subdural hematoma (brain bleed), a right 7 mm (millimeter) subdural hematoma (brain bleed), a 3 mm midline shift of the ventricle (when the brain moves past it's center line) due to the subdural hematoma (brain bleed), a right maxillary sinus fracture (beside the nose beneath the eye), a right orbit fracture (bone around the eye), and a right zygomatic arch fracture (cheek). He was transferred to a higher-level trauma medical center for treatment. A telephone interview with the Regional Medical Center Hospital physician was conducted on 08/15/25 at 4:09 pm. He stated Resident #1 was not able to tell him what had happened due to his advanced dementia but that the injuries he had to his face were caused from blunt force trauma and could have been the result of a fall. He reported that he thought the subdural hematomas he currently had could be a mix of an old subarachnoid brain bleed from January 2025 but that two of the subdural hematomas were acute meaning they had occurred within the last 24 hours. He explained he did not have anything else to offer, that Resident #1 had been transferred to a trauma hospital and the family was happy with the care Resident #1 had received at the Regional Medical Center. A telephone interview was conducted with the Trauma Medical Center physician on 08/21/25 at 10:30 am. He stated Resident #1 had been transferred to their trauma unit from an affiliated regional medical center because the size of his brain bleed on 08/06/25 was too large for the other hospital to manage in accordance with their hospital protocol. He stated the injuries Resident #1 presented with were life threatening and “very reasonably” were caused from a fall. He stated he examined the brain scan results and noted both the subdural hematomas were new and had occurred within the previous 12 hours. The Trauma Center physician explained that Resident #1 had a previous brain bleed in January 2025 which he reviewed and noted that the	E0006		

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E0006 SS = J	Continued from page 7 previous brain bleed was a very different type of bleed than the current subdural hematomas. The comparison showed the January 2025 brain bleed was from a different area of the brain and only had trace bleeding-unlike the current subdural hematomas that had a large amount of bleeding. He also noted that the January 2025 test results showed no facial fractures. He stated all of the facial fractures were also from this episode. The Trauma Medical Center physician stated that Resident #1 was fortunate to be in stable condition and that he had been discharged home with his family. An interview was conducted with the Maintenance Director on 08/13/25 at 12:30 pm. The Maintenance Director stated that (3) Missing Person drills had been conducted by himself on 12/27/24, 03/21/25, and 04/29/25. He explained the drills always had a full resident count and did not address if a resident was missing. The drills did not include a post test for staff understanding. The Maintenance Director explained the drills only included staff who were on duty when the drill was performed and staff who were not on duty at the time missed it. He did not provide any additional drills to include staff who were not on duty when the drill was conducted. The Maintenance Director was not aware of the Emergency Preparedness Plan directive to call 911 if a resident was not located after searching for 15 minutes and explained the drills he conducted only covered how to initiate and organize the search for a presumed missing resident. In the drills he conducted, the resident was always found safe within the facility. An interview was conducted with the DON on 08/11/25 at 1:26 pm. The Administrator was also present. The DON stated Nurse #1 had called her on 08/05/25 at 8:55 pm and reported that staff could not find Resident #1. She was told that Resident #1 had been seen 15 to 20 minutes earlier on the top of the 400 hall. She stated that she told Nurse #1 to stop everything and look for the resident. She asked Nurse #1 if any doors were alarming, if there were any visitors in the building, and did anyone let anyone out of the front door. She noted she got the first call at 8:55 pm. She explained she then called the Administrator to let him know Resident #1 could not be found. She recalled the Administrator came to the building about 9:15 pm. She started another search “high and low.” She left the building in her personal car and went up and down the road in her car but did see anything. She recalled the Administrator came and started searching outside about 9:45 pm. Maintenance was called to the building to check the doors. She went back outside and searched the	E0006		

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E0006 SS = J	Continued from page 8 surrounding area to the left of the facility, then the Administrator called her back to the building. She recalled the Administrator had called the police and the family to explain the resident was missing. The Administrator showed on his cell phone that he had placed the call to 911 on 08/05/25 at 9:49 pm to report a missing person (Resident #1). The Administrator explained he had not been aware that 911 was to be called if a missing resident was not found after a period of 15 minutes. He concluded that was where the facility had “gone wrong” in the search for Resident #1 and noted had the facility followed the Emergency Preparedness Plan and called 911 after 15 minutes that the outcome of the situation may have been different and possibly caused less harm to Resident #1. The DON stated when the police arrived at the facility, they spoke to her and the Administrator and searched the facility. She heard the police officer get a call that the resident had been found. The DON explained they wanted to be sure the person the police found was Resident #1, so she and Nurse Aide #2 went in Nurse Aide’s #2’s personal car to the corner of Randleman and Teague Street at 10:52 pm. Two officers were present, 2 bystanders were there, along with Resident #1. She put Resident #1 in the back of Nurse Aide #2’s car and called the Administrator. She recalled Resident #1 was confused and the police lights were agitating him. The resident was asking for momma and daddy and was confused. The DON recalled he had dirt on his pants and was wet, but it was not raining at the time she picked him up, although it had been raining earlier in the evening. Nurse #1 took Resident #1 to his room. She noted EMS did arrive and went to the resident’s room where Nurse #1 was assessing the resident and providing first aide. The DON stated she was not aware of the EP plan to call 911 after 15 minutes if the resident had not been found. She explained she had not actually reviewed the Emergency Preparedness Plan for a missing resident. The Administrator was notified of immediate jeopardy on 08/12/25 at 5:35 PM. The facility provided the following credible allegation of Immediate Jeopardy removal: · Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 8/5/25, at approximately 8:30 pm, Medication Aide #1 attempted to administer Resident #1’s, evening medications but was unable to locate him. A	E0006		

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E0006 SS = J	Continued from page 9 facility-wide search was immediately initiated, and at approximately 8:55 pm, a code orange (code used to notify all staff of a missing resident) was announced by Nurse #1 and the Director of Nursing (DON) was notified. At approximately 9:15 pm, the Director of Nursing notified the Administrator that Resident #1 could not be located. Facility staff continued to search for Resident #1 inside the facility, around the facility perimeter/property, and in the surrounding community areas in their personal vehicles. At approximately 9:49 pm the Administrator notified law enforcement that Resident #1 could not be located, which was longer than the required time of 15 minutes to notify law enforcement in the emergency preparedness manual. The Administrator wanted to confirm that all areas of the facility had been searched prior to contacting law enforcement. At approximately 10:45 pm, the police department notified the Administrator that the resident was located 0.9 miles away from the facility. The Director of Nursing and Nursing Assistant #2 went to the location of the resident and brought the resident back to the facility, where the family was onsite upon the resident's return. An assessment was completed by the assigned hall nurse and revealed a laceration approximately one inch to the right cheek and a ¾ inch abrasion above both knees with treatment provided. Emergency Medical System (EMS) arrived to evaluate the resident and found the resident to be stable. The family decided to discharge the resident from the facility Against Medical Advice (AMA) and take the resident to the emergency room (ER) via their personal vehicle. The staff did not refer to and did not implement the Emergency Preparedness plan when Resident #1 was discovered missing. On 8/8/25, nursing progress notes for the last 30 days were reviewed by the Assistant Director of Nursing (ADON) to identify any resident with an unsupervised exit from the facility to ensure the staff immediately reported the exit and emergency preparedness procedures were followed to include reporting to the police within 15 minutes of discovering the resident missing. There were no other unsupervised exits identified. On 8/12/25, incident reports for the last 30 days were reviewed by the Director of Nursing to identify any resident with an unsupervised exit from the facility to ensure the staff immediately reported the exit and	E0006		

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E0006 SS = J	Continued from page 10 emergency preparedness procedures were followed to include reporting to the police within 15 minutes of discovering the resident missing. There were no other unsupervised exits identified. · 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. On 8/8/25, the Regional Vice President educated the Administrator and DON on the Emergency Preparedness procedures for elopement with emphasis on the Administrator's and DON's responsibility to ensure the local police is contacted with a report within 15 minutes of a resident missing. Additionally, the education included to utilize the emergency preparedness policy for missing resident as a reference to ensuring all appropriate steps are taken. On 8/11/25, the Administrator developed a new Unsupervised Exit Drill Form, aligned with the Emergency Preparedness Policy, to document observations during unsupervised exit drills. The policy will also be attached and referenced during each drill. On 8/12/25, the Administrator educated the Maintenance Director on the newly implemented Unsupervised Exit Drill Form. The education included (1) the requirement of completing the form weekly on various shifts, days, and times (2) completion of the form which indicates to ensure staff respond following steps of the emergency preparedness policy when a resident exits the facility (3) using a sample missing resident for staff to locate (4) verification that Emergency Preparedness protocols were followed, including notifying the local police department if a resident cannot be located after a 15-minute search, as part of validating staff response. On 8/11/25, the Administrator made the decision to oversee the first unsupervised exit drill to validate the Maintenance Director's knowledge and understanding of how to conduct the drills and to ensure the Maintenance Director is competent to perform the emergency preparedness drill for unsupervised exits and provide education to staff that requires re-training. The purpose of the Unsupervised Exit Drill Form is to validate staff knowledge and understanding of the emergency preparedness policy of what to do for a missing resident. The form included the following: (1) date (2) time (3) to include an attachment of staff who participated in the drill (4) If the alarm is sounding (5) Staff checked that potential residents exited facility and responded per the emergency preparedness	E0006		

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E0006 SS = J	Continued from page 11 policy. The Maintenance Director will carry and review the emergency preparedness policy for missing residents during the drills to ensure staff are compliant with the following to include but not limited to: · Validating that staff are aware of notifying the police department when a resident cannot be located within 15 minutes. The incident command will designate who will notify the police. · Validating that staff know how to properly conduct a search for a missing resident. · Validating that staff understand who the incident command is during a missing resident · If staff do not respond appropriately during the drill, document on the unsupervised exit drill form what education was provided. On 8/12/25, the Administrator made the decision to post a missing resident checklist on bright colored paper at each nurse's station for nurses to utilize as a guide for steps to take in an event of a missing resident. The check list includes notification to the local police department if a resident cannot be located after a 15-minute search per the facility emergency preparedness plan for missing resident. On 8/12/25, the DON initiated an in person verbal in-service with all staff including the Maintenance Director and agency staff regarding the Emergency Preparedness Plan/Policy for elopements. The education on the policy includes (1) activation of the emergency preparedness plan for a missing resident (2) designating the highest level individual as incident command (3) immediately notifying the Administrator and Director of Nursing of a missing resident (4) the initial search for the resident should be limited to a period of 15 minutes (5) if the resident remains missing after a 15-minute search, the local police department must be notified (6) all search teams must meet with the Incident Command within 15 minutes with a report during that time (7) location of the emergency preparedness policy notebook which includes steps in the event of an emergency to include a missing resident. Additionally, the missing resident checklist located at the nurse's stations for assigned hall nurse to utilize in the event of a missing resident was reviewed with all nurses during the education. 8/12/25, any staff member who has not received the in-services will receive education prior to the employee starting their assignment on their next scheduled work shift. All newly hired staff, including agency will be	E0006		

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E0006 SS = J	Continued from page 12 in-serviced by the Staff Development Coordinator (SDC) during orientation regarding the Emergency preparedness procedures for elopements. The Staff Development Coordinator will monitor the completion of staff in-services. The education will also be completed annually. Staff were not educated that the Unsupervised Exit Drills would be conducted as they were intended to be surprised drills. On 8/12/25, the Administrator notified the SDC of responsibility to monitor completion of staff in-services. Alleged date of immediate jeopardy removal: 8/13/25 The removal plan of the Immediate Jeopardy was validated on 09/04/25. A sample of staff including the Administrator, Director of Nursing, nurses, nurse aides and were interviewed regarding in-service training received related to the deficient practice. All staff interviewed stated they had been in-serviced regarding the elopement/unsupervised exit action checklist that included if a resident cannot be located after 15 minutes of searching 911 must be called. An audit to review progress notes for behaviors was completed on 08/08/25. The Administrator and Director of Nursing were educated by the Regional Vice President on 08/08/25 to call 911 after 15 minutes if a resident is not located. An audit of incident reports was completed on 08/12/25. An audit to ensure the “Action Checklist for Unsupervised Exits” for Nursing Staff was posted at each nursing station. The new Unsupervised Exit Drill form was reviewed. Drills have been conducted on 08/12/25, 08/14/25, 08/21/25, 08/24/25, 08/29/25, and 09/04/25 across various shifts and times. The Administrator have overseen the drills. The Emergency Preparedness policy is included in each training to be followed. Law enforcement is to be called if a search for a missing resident exceeds 15 minutes. The facility Administrator provided a written statement declaring Emergency Preparedness to include missing resident and elopement prevention would be discussed at the next Quality Assurance meeting on August 21, 2025. The IJ removal date of 8/13/25 was validated.	E0006		
F0000	INITIAL COMMENTS A complaint investigation was conducted on-site on	F0000		09/09/2025

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F0000	Continued from page 13 08/11/25 through 08/13/25. Additional information was received on 08/15/25, 08/21/25, 09/3/25 and 09/04/25. The revised allegation of immediate jeopardy removal was validated on 09/04/25. Therefore, the exit date was 09/04/25. Event ID# 1D413C-H1. The following intakes were investigated: 2583335, 2563155, 865310, 2582485, 2582629, and 2588146. 4 of the 10 allegations resulted in deficiency. Intakes 865310, 2582485, 2582629, and 2588146 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.73 at tag E0006 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/05/25 and was removed on 08/13/25. 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 observations, record review, and staff, physician, family and law enforcement interviews, the facility failed to supervise a severely cognitively impaired resident from exiting the facility without supervision. On 08/05/25 at approximately 8:30 pm Resident #1 followed Dietary Aide #1 out of the employee exit door and exited the facility. Resident #1 did have a wanderguard bracelet (component of a wander management system) on his left ankle; however, the door	F0689	"Past Noncompliance - no plan of correction required"	09/09/2025

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F0689 SS = SQC-J	Continued from page 14 Resident #1 exited did not have a transmitter sensor and the magnetic lock was released when Dietary Aide #1 entered a code on the door keypad. Dietary Aide #1 believed Resident #1 to be a visitor (because he was wearing street clothes, had a hat on, and was walking unassisted) and had directed him to exit through the front door and did not realize Resident #1 had followed him out the door until he saw him walking outside the building toward the front as he was driving away. On 08/05/25 Resident #1 was located by local law enforcement at 10:37 pm (approximately 1.0 mile away from the facility.) He was found lying in the road on a five-lane main street where the I-40 interstate east and west on and off ramps are located at the intersection of Randleman Road and Teague Street. When law enforcement arrived, a bystander was trying to help Resident #1 get out of the street. It appeared to law enforcement that Resident #1 had fallen over the median and was lying face down on the pavement in the middle of the busy road. It was raining and he was shaking, cold, and wet. He was returned to the facility by the Director of Nursing and Medication Aide #1 in Medication Aide #1's private vehicle. Emergency Medical Services (EMS) personnel assessed Resident #1 at 11:41 pm on 08/05/25 at the facility. Resident #1's mental status was oriented to person only and EMS presumed Resident #1 had fallen. EMS left the resident with his family to transport him to the hospital at the family's request. The family took him directly to a regional hospital where he was diagnosed with a left 1 cm (centimeter) subdural hematoma (brain bleed), a right 7 mm (millimeter) subdural hematoma (brain bleed), a 3 mm midline shift of the ventricle (when the brain moves past it's center line) due to the subdural hematoma (brain bleed), a right maxillary sinus fracture (beside the nose/beneath the eye), a right orbit fracture (bone around the eye), and a right zygomatic arch fracture (cheek). He was transferred to a higher-level trauma hospital for treatment. The Trauma Medical Center Physician stated Resident #1 had been transferred to their trauma unit from an affiliated regional medical center because the size of his brain bleed was too large for the other hospital to manage in accordance with their hospital protocol and the injuries Resident #1 presented with were life threatening. This was for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: A history and physical assessment completed by Physician #1 on 05/28/25 for Resident #1 (when Resident #1 was previously admitted to the facility for a 5-day respite stay) was reviewed. Resident #1 was assessed to have severe chronic dementia. He required assistance	F0689		

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F0689 SS = SQC-J	Continued from page 15 with bathing and was continent of bowel and bladder. He was without untoward behaviors or overt agitation. He had a subtle anxious affect, with a tendency toward wandering. Resident #1 was admitted to the facility on 08/04/25 for respite care (temporary institutional care of a sick, elderly, or disabled person, providing relief for their usual caregiver). He entered the facility from home. Diagnoses included Alzheimer's disease, low back pain, chronic kidney disease stage 1, Type 2 Diabetes Mellitus, major depressive disorder, hypothyroidism, and essential hypertension. A Nursing Admission/Re-entry Evaluation assessment completed by Nurse #2 on 08/04/25 was reviewed. Resident #1 needed setup or clean-up assistance with dressing and personal hygiene. He needed moderate assistance with showering. He was independent with eating. He was independent with mobility, transferring, and ambulation. He did not use any assistive devices for mobility. He could communicate with some difficulty. He wore glasses. He had no falls within the past 30 days of admission. He had a serious intellectual mental health diagnosis. His admission to the facility was for short-term placement. A Wandering Risk Evaluation completed by Nurse #2 on 08/04/25 was reviewed. Nurse #2 documented Resident #1 had no known history of attempts to leave home or facility or wander. His mood and behavior was complacent. He was ambulatory and/or self-mobile. He had a diagnosis of Alzheimer's dementia or severe cognitive impairment. He never or rarely made decisions. He rarely/never understood or was understood when communicating. He made verbal statements of a desire or intent to leave the facility. Resident #1 scored 13 on the assessment (a resident who scores greater than 5 is at risk for wandering.) A progress note written on 08/04/25 at 4:25 pm documented Resident #1 arrived at the facility on 08/04/25 at 12:00 noon from PACE (a program of all-inclusive care for the elderly) for Respite Care accompanied by family. He had a wanderguard on his left leg. Resident #1 was a participant in the PACE of the Triad program under the primary care of the PACE physician. In an interview with the Pace Program Physician on 08/11/25 at 9:49 am she stated Resident #1 had been a participant in the Pace program since 05/01/25. She explained he wandered and was often agitated. She stated he was not "okay" to be outside by himself. She	F0689		

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F0689 SS = SQC-J	Continued from page 16 noted PACE staff often calmed Resident #1 down by singing hymns to him. She reported that he acted out in non-violent ways and was resistant to care. Review of a skin assessment dated 08/04/25 at 6:07 pm by the Treatment Nurse was reviewed. Resident #1 had no abrasions or cuts on his body on admission. A progress note written on 08/04/25 Nurse #1 at 11:35 pm documented, in part, that on admission Resident #1's skin was dry and warm to touch with no lesions noted, that he was ambulatory, wandered around and needed frequent redirection. Review of the care plan for Resident #1 initiated on 08/04/25 revealed the following focus areas: Wandering and or at risk for unsupervised exits from facility related to cognitive impairment and at risk for falls characterized by a history of falls/actual falls, injury and multiple risk factors. The goals were: 1) The whereabouts will be known to staff as demonstrated by no events of leaving the facility unsupervised, 2) Will have no episodes of unsupervised exits from the facility, and 3) The resident will remain free of injury as evidenced by no falls or accidents through the next review. Interventions included to place familiar objects in resident surroundings, Wanderguard alarm bracelet to the resident's left ankle, have commonly used articles within easy reach, and keep the call light within reach and answer timely. The following physician orders were reviewed: WANDERGUARD-Verify location and expiration every day and night shift for Safety (start date 08/05/25); and Check Wander Device Transmitter to ensure proper functioning every day and night shift for Safety/Monitoring (start date 08/05/25). A telephone interview was conducted with Nurse Aide #1on 08/12/25 at 10:29 pm. She stated she had cared for Resident #1 on 08/04/25 and 08/05/25 on day shift. She recalled on 08/04/25 he had been looking for his mama and asked her where she was. She told him that his mama wasn't there. She remembered she had seen him walking up and down the hall several times but had not seen him pushing on any exit doors. An interview was conducted with Medication Aide #2 on 08/12/25 at 10:16 am. She started her shift at 5:00 pm on 08/05/25. She recalled Resident #1 was sitting in a chair on the 400 hall and did not appear to be upset and he was calm. He was still sitting in the chair when the dinner carts came to the hall at approximately 5:30 pm. She stated at approximately 6:30 pm she saw	F0689		

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F0689 SS = SQC-J	Continued from page 17 Resident #1 walking up and down the 300 and 400 halls. Medication Aide #2 recalled when she was providing care to another resident, Resident #1 approached her and asked her where the door was to get out. She stated she told him, “No”, and directed him to his room, but he replied, “I already paid my money and I’m going to see my mother and father” and he walked away. In a telephone interview with Nurse Aide #1 on 08/12/25 at 10:29 pm she stated on 08/05/25 Resident #1 ate his meals in the hallway because he did not want to be in his room. She noted that he had refused to allow her to take him to the bathroom during her shift. A telephone interview was conducted with Nurse Aide #3 on 08/12/25 at 11:25 am. She stated she worked at the facility through an agency. She reported that she had arrived at work around 3:00 pm on 08/05/25. She observed Resident #1 walking around the facility and wandering in and out of rooms. She recalled he would swing his arms at staff who approached him. He was difficult to redirect and continued wandering in and out of rooms and hallways during the shift. Around 6:30 pm she helped pass out meal trays on the hall. At that time Resident #1 was wandering in the hallway. She had attempted to redirect him to his room for his meal, but he refused. She recalled she had taken a break at 7:30 pm. She reported that during her break she had been sitting in her car that was parked in the front of the building, and she did not see any resident leave the building while she was on break. An interview was conducted with the Dietary Aide on 08/12/25 at 9:42 am by telephone. He stated that on the night Resident #1 exited the building without staff knowledge on 08/05/25 he had worked the evening shift in the kitchen. He stated he clocked out at approximately 8:17 pm. He reported that when he approached the first set of double doors that lead to the employee exit door, he noticed a man (Resident #1) behind him. He stated Resident #1 was dressed in street clothes, had a hat on, and was walking unassisted and looked like a visitor, so he told him that visitors exited the building in the front and directed Resident #1 to go to the front and sign out. He noted the man kept saying, “I paid my money. My parents are coming to pick me up.” He thought Resident #1 had walked away. He stated his ride arrived; he punched in the code for the employee exit door and left the building. He recalled he was almost to the car when he noticed the employee exit door was open and alarming, so he went back to the building and secured the door. He stated he did not see Resident #1 exit the building; however, when he was leaving the parking lot, he had seen Resident #1	F0689		

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F0689 SS = SQC-J	Continued from page 18 outside of the building walking toward the front. He explained he believed Resident #1 to be a visitor who was going to the front of the building to catch a ride, so he did not intervene. An interview was conducted with Medication Aide #1 on 08/12/25 at 9:50 pm by telephone. She stated when she went to give Resident #1 his evening medications on 08/05/25, he was not in his room. She reported it was 8:17 pm when she noticed he was not in his room. She explained she instructed two Nurse Aides to look up and down the 300 and 400 hallways because he did wander. The Nurse Aides could not find him, so the 100 and 200 halls were searched. Medication Aide #1 stated she could not find the resident in the facility. The search exhausted all areas he might have been and when she realized the resident might have exited the building, she notified Nurse #1. She could not remember what time she told Nurse #1 that the resident was missing. She stated Nurse #1 called a “Code Orange” (missing person) as soon as she told her. Medication Aide #1 concluded she had locked her medication cart and participated in the search but did not find the resident. An interview was conducted with Nurse #1 on 08/12/25 at 1:55 pm by facetime. Stated she was told that Resident #1 could not be located at 8:45 pm by Medication Aide #1 on 08/05/25. She explained she immediately called a “code orange” (missing person). She stated she had kept notes and written down times regarding the three searches she conducted. She recorded the following times: the first search was at 8:50 pm; the Director of Nursing (DON) was called at 8:55 pm, the second search was at 9:13 pm, and the third search was at 9:20 pm. All searches included inside and outside the facility. She stated at 9:25 pm she got in her personal car to search the surrounding area. She stated she went to the left when she turned out of the parking lot because she thought he would have gone that way because there were more lights, but she couldn’t find him. She noted she continued to search for him until the police arrived at the facility. She stated that when the resident returned to the facility she helped the family change his clothes and provided first aide to a laceration on his face and abrasions on both his legs above his knees. She noted that EMS came to the facility and were able to assess the resident. She stated she was never able to perform a head-to-toe assessment on the resident because the family wanted to take him home. She concluded that the last time she interacted with the resident he had been sitting in a chair with his family in the front lobby. During the interview she provided a copy of the notations she had made regarding the times mentioned above along with a screen shot of	F0689		

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F0689 SS = SQC-J	Continued from page 19 the phone record that indicated the time she reported to the DON that Resident #1 was missing. In an interview conducted with Medication Aide #2 on 08/12/25 at 10:16 am she recalled sometime around 9:00 pm on 08/05/25 an Agency Nurse Aide approached her and asked if she had seen Resident #1 and stated staff could not find him. She stated she began to look for him and had searched the salon, bathroom, and laundry room but was unable to find him. As she was looking for him another Nurse Aide told her she had seen him on the 300 hall pulling at the exit door, but she did not know the Nurse Aide's name. She explained she went to the 300 hall to search for him. She checked all the doors on the 300 hall, and they were all locked. She stated she had not heard any door alarms sound during her shift. The following written statement made by Nurse Aide #4 on 08/06/25 was reviewed. She had documented, in part, that she witnessed Resident #1 push the exit door handle on the 300 hall at approximately 8:00 pm on 08/05/25. She also documented that she had seen the resident around 8:45 pm. She had told him that the door was locked, and he walked back up the 300 hall towards the nursing station. She wrote that he stated he was "looking for his mom and dad." An interview was conducted with Nurse Aide #4 on 8/12/25 at 3:11 pm. She stated that her written statement was not correct. She reported she thought her first interaction with the resident was at 8:00 pm on 08/05/25 but she had heard some other staff member say "8:45" so that's what she documented. She denied she had seen him push the door handle and had only heard him say he wanted to "get out to see him mom and dad." In a telephone interview conducted with Nurse Aide #3 on 08/12/25 at 11:25 am she remembered that when she returned to the building after her break on 08/05/25 she was told that Resident #1 was missing. She stated she really wasn't sure what time she returned to the building. She noted she joined in the search for the resident and recalled some staff members used their personal cars to search in surroundings neighborhoods. She stated when she punched out around 11:05 pm the resident had not been found. The law enforcement Incident/Investigation Report was reviewed. The date and time of the report was 08/05/25 at10:37 pm. The location of the incident was 2501 Randleman Road and Teague Street. The victim was Resident #1. A second police officer assisted the responding officer on the scene. The responding law	F0689		

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F0689 SS = SQC-J	Continued from page 20 enforcement officer documented: “On 08/05/2025 at 2237 (10:37 pm) hours, I responded to Randleman Rd. and Teague St. in reference to a suspicious activity. The investigation is ongoing at this time.” A return telephone call from the responding Law Enforcement Officer was received on 08/12/25 at 10:20 pm. He explained he had responded to a call at the location of Randleman Road and Teague Street on 08/05/25 for an incident of simple physical assault. He stated when he arrived a bystander was standing over the resident trying to get him up and out of the street. Two young ladies had pulled over after exiting the I-40 ramp and were yelling aggressively at the bystander who was trying to help Resident #1. He stated when he interviewed the 2 young ladies they told him they thought the bystander was assaulting the resident but had never seen him or anyone hit the resident. The bystander explained to him that he had been walking by with his girlfriend, saw the resident lying in the middle of the road and was trying to help him. The responding Law Enforcement Officer stated the traffic on Randleman was heavy that night on the 5-lane road. He reiterated that no one was seen beating up the resident. He commented that it was a very busy area and if someone was getting beat up there would have been more than one call to 911. He concluded it appeared that Resident #1 had fallen over the median and was lying face down on the pavement in the middle of the busy road and the bystander was trying to help him get out of the road. The responding Law Enforcement Officer concluded that the investigation was ongoing. Weather conditions reported by customweather.com for the Greensboro area on 08/05/25 documented the outside temperature to be between 66 degrees Fahrenheit at 7:54 pm and 63 degrees Fahrenheit at 10:54 pm. The conditions were mostly cloudy with light rain and fog. A telephone interview was conducted with Nurse Aide #2 on 08/12/25 at 4:39 pm. She stated it was about 10:40 pm on 08/05/25 when she and the DON went in her personal car to pick up Resident #1 from where he had been found by the police. She recalled Resident #1 was shaking because he was cold and wet. She stated that it had been raining that night. When they arrived, she noticed Resident #1 had some blood on his face. She stated she checked to see if his wanderguard bracelet was on and she found it on his left foot. She recalled she talked to Resident #1 while they waited for EMS to arrive, and it calmed him. They were at the intersection of Randleman Road and Teague Street. The resident was rambling on about his mom and dad. He told her, “They fought me, but they didn’t win.” She stated	F0689		

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F0689 SS = SQC-J	Continued from page 21 when EMS arrived the resident would not let them assess him. Resident #1 eventually allowed EMS to take his blood pressure and oxygen saturation percentage because she held his arm for them. She stated EMS would not transport the resident because they could only take him to the hospital and the family wanted him returned to the facility, so she and the DON took Resident #1 back to the facility in her personal car. An interview was conducted with the DON on 08/11/25 at 1:26 pm. The Administrator was also present. The DON stated Nurse #1 had called her and reported that staff could not find Resident #1 on 08/05/25. She was told that Resident #1 had been seen 15 to 20 minutes earlier on the top of 400 hall. She stated that she told Nurse #1 to stop everything and look for the resident. She asked Nurse #1 if any doors were alarming, if there were any visitors in the building, and did anyone let anyone out of the front door. She noted she got the first call at 8:55 pm. She explained she then called the Administrator to let him know Resident #1 could not be found. She recalled the Administrator came to the building about 9:15 pm. She started another search “high and low.” She left the building in her personal car and went up and down the road in her car but did see anything. She recalled the Administrator came and started searching outside about 9:45 pm. Maintenance was called to the building to check the doors. She went back outside and searched the surrounding area to the left of the facility, then the Administrator called her back to the building. She recalled the Administrator had called the police and the family to explain the resident was missing. She stated when the police arrived at the facility, they spoke to her and the Administrator and searched the facility. She heard the police officer get a call that the resident had been found. The DON explained they wanted to be sure the person the police found was Resident #1, so she and Nurse Aide #2 went in Nurse Aide #2’s personal car to the corner of Randleman and Teague Street at 10:52 pm. Two officers were present, 2 bystanders were there, along with Resident #1. She put Resident #1 in the back of Nurse Aide #2’s car and called the Administrator. She recalled Resident #1 was confused and the police lights were agitating him. The police officers had called EMS before she got there. Resident #1 would not go to the EMS truck, and he wouldn’t allow EMS to assess him. She notified the Administrator and explained the resident would not go with EMS. The family had arrived at the facility and requested she come back to the facility with the resident. The family met them at the front door when they returned. The resident was asking for momma and daddy and was confused. The DON recalled he had dirt on his pants and	F0689		

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F0689 SS = SQC-J	Continued from page 22 was wet, but it was not raining at the time she picked him up, although it had been raining earlier in the evening. Nurse #1 took Resident #1 to his room, and she suggested to the family that EMS be called, and they agreed. EMS and the provider were called. She noted EMS did arrive and went to the resident's room where Nurse #1 was assessing the resident and providing first aid aide. The Administrator interjected that the family and EMS came to him and reported that the resident did not want to leave with EMS and the family member told the resident that he did not have to be at the facility and that they would take him home. The Administrator explained that the family left the facility with the resident. He noted that the resident had appeared to have fallen because he had dirt on his clothing. Resident #1 was wearing his glasses that did not appear to be damaged. The Administrator stated that the resident was fully dressed when he returned to the facility wearing black sweatpants, dark gray shoes, a black t-shirt, a dark blue zip up jacket and a black hat. An incident report by EMS dated 08/05/25 at 11:05 pm was reviewed. The report documented that the nursing home staff would not let EMS fully assess the patient at the scene of Randleman Road and Teague Street because they wanted him to be taken back to the facility at the family's request. An EMS Incident report dated 08/05/25 at 11:41 pm documented that EMS was called back to the facility to assess the resident. EMS personnel assessed Resident #1 at 11:41 pm on 08/05/25 at the facility. The EMS report documented Resident #1 had a blood pressure of 136/100 millimeters of mercury, a heart rate of 100 beats per minute, a respiratory rate of 18, and an oxygen saturation reading of 96% on room air. He had a right facial cheek laceration approximately 2.5 inches long with controlled bleeding. He had band aids on his knees placed by Nurse #1 during first aid care. Resident #1's mental status was oriented to person only. EMS presumed Resident #1 had fallen and they informed the family of the risks of an intracranial hemorrhage after a fall and the risks of transporting the resident themselves. EMS left the resident with his family to transport him to the hospital at their request and advised the family to call 911 for any changes. In an interview with a family member on 08/11/25 at 4:08 pm she stated the family took Resident #1 straight to the regional hospital after removing him from the facility. The regional hospital then sent him to the trauma center in Winston-Salem for treatment of a brain bleed. She stated Resident #1 was doing better but that	F0689		

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F0689 SS = SQC-J	Continued from page 23 the hospital was keeping him for a couple extra days in a regular room to keep an eye on the brain bleed to make sure there were no further complications. An interview was conducted with the Maintenance Director on 08/13/25 at 12:30 pm. He stated on the night of 08/05/24 he was called back to the facility to check the doors after Resident #1 had exited the building without staff supervision. He explained that only the front exit was alarmed for the wanderguard system, and all other doors had a keypad. Each door that had a keypad had its own unique key sequence to unlock the door. He stated all doors at the facility including keypads and the front entrance were checked daily and logged in the maintenance electronic computer system. An observation of the employee exit door was made on 08/12/25 at 10:10 am. The door was equipped with a keypad to enter a specifically assigned code for that door. When left ajar, the door did sound a faint alarm. The door was not equipped with a wanderguard alarm. An observation of the routes Resident #1 may have taken was conducted by the survey team by driving both routes on 08/12/25 beginning at 8:15 pm. Whether the resident turned left or right when leaving the facility driveway, the location where he was found by police was measured by driving the routes as 1.0 miles either way. The road where the resident was found (the intersection of Randleman Road and Teague Street) had 5 lanes and was the hub for the on and off ramps for Interstate 40. Traffic was steady during the observation. There were streetlights that came on if the resident had turned right (Creek Ridge) but to the left the street was a dark industrial side road (Teague Street). Both routes were observed to be heavily wooded. A 35 mile per hour speed limit sign was observed on Randleman road where Resident #1 was found. Hospital records dated 08/06/25 at 1:01 am were reviewed. Resident #1 was diagnosed with a left 1 cm (centimeter) subdural hematoma (brain bleed), a right 7 mm (millimeter) subdural hematoma (brain bleed), a 3 mm midline shift of the ventricle (when the brain moves past it's center line) due to the subdural hematoma (brain bleed), a right maxillary sinus fracture (beside the nose/beneath the eye),a right orbit fracture (bone around the eye), and a right zygomatic arch fracture (cheek). He was transferred to a higher level trauma medical center for treatment. A telephone interview with the Hospital physician was conducted on 08/15/25 at 4:09 pm. He stated Resident #1	F0689		

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F0689 SS = SQC-J	Continued from page 24 was not able to tell him what had happened due to his advanced dementia but that the injuries he had to his face were caused from blunt force trauma and could have been the result of a fall. He reported that he thought the subdural hematomas he currently had could be a mix of an old subarachnoid brain bleed from January 2025 but that two of the subdural hematomas were acute meaning they had occurred within the last 24 hours. He explained he did not have anything else to offer, that Resident #1 had been transferred to a trauma hospital and the family was happy with the care Resident #1 had received at the Regional Medical Center. A telephone interview was conducted with the Trauma Medical Center Physician on 08/21/25 at 10:30 am. He stated Resident #1 had been transferred to their trauma unit from an affiliated regional medical center because the size of his brain bleed on 08/06/25 was too large for the other hospital to manage in accordance with their hospital protocol. He stated the injuries Resident #1 presented with were life threatening and “very reasonably” were caused from a fall. He stated he examined the brain scan results and noted both the subdural hematomas were new and had occurred within the previous 12 hours. The Trauma Center physician explained that Resident #1 had a previous brain bleed in January 2025 which he reviewed and noted that the previous brain bleed was a very different type of bleed than the current subdural hematomas. The comparison showed the January 2025 brain bleed was from a different area of the brain and only had trace bleeding-unlike the current subdural hematomas that had a large amount of bleeding. He also noted that the January 2025 test results showed no facial fractures. He stated all of the facial fractures were also from this episode. He stated that Resident #1 was fortunate to be in stable condition. He noted it was a shame this had happened when the family had only placed Resident #1 for respite care to free up their time to hold a birthday party for Resident #1’s wife. At the end of the interview the Trauma Center Physician reported that the resident had returned home with his family. The Administrator was notified of Immediate Jeopardy on 08/12/25 at 5:35 pm. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is alert but not oriented, with a Brief	F0689		

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F0689 SS = SQC-J	Continued from page 25 Interview for Mental Status (BIMS) of 3. Diagnoses included Alzheimer's dementia and major depressive disorder. He was admitted to the facility on 8/4/25 for respite care. On August 5, 2025, at approximately 8:15 pm, Dietary Employee #1 observed an unknown gentleman (Resident #1), presumed to be a visitor, walking down the service hallway of the facility. The employee redirected the individual toward the front entrance, assuming he was unfamiliar with the building layout and attempting to exit. Upon the dietary employee exiting the facility via the service hall door, the gentleman followed behind him and proceeded to walk around to the front of the building. The dietary employee ensured the service hall door was secured and then proceeded to leave the facility with his transportation, believing the gentleman who came out behind him was walking around the front to meet his own ride. At approximately 8:30 pm, Medication Aide #1 attempted to administer Resident #1's, evening medications but was unable to locate him. Medication Aide #1 notified Nurse #1 that Resident #1 could not be located. A facility-wide search was immediately initiated, and a code orange (code used to notify all staff of a missing resident) was announced by Nurse #1. The Director of Nursing (DON) and Administrator were notified that resident #1 could not be located. Staff continued to search for resident #1 inside the facility and in the surrounding areas in their vehicles. At approximately 9:49 pm, the Administrator notified law enforcement that Resident #1 could not be located. At approximately 10:00 pm, local law enforcement arrived onsite to begin searching for Resident #1. At approximately 10:36 pm, the Administrator notified the Resident Representative (resident's daughter) that resident #1 could not be located. At approximately 10:45 pm, the police department notified the Administrator that the resident was located 0.9 miles away from the facility. The Director of Nursing and a Nursing Assistant #1 went to the location of the resident. The resident was uncooperative with EMS, so the family was contacted by the DON and made the decision for the resident to be brought back to the facility. Resident #1 was brought back to the facility via the staff's private vehicle, where the family was onsite at arrival. The Director of Nursing discussed with the resident's family the need for the resident to be sent to the Emergency Room (ER). The family agreed, and EMS	F0689		

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F0689 SS = SQC-J	Continued from page 26 was notified. An assessment was completed by the assigned hall nurse and revealed a laceration approximately one inch to the right cheek and a ¾ inch abrasion above both knees. Treatment was provided to the areas along with resident care. EMS arrived to evaluate the resident and found the resident to be stable. The family decided to discharge the resident Against Medical Advice (AMA) and take the resident to the ER via their private vehicle. At approximately 11:32 pm, the physician services were notified by the DON of the incident and the family's decision to discharge the resident AMA. At approximately 12:00 pm, the resident left AMA with family. On 8/6/25, the Administrator completed a root cause analysis for Resident #1's unsupervised exit. The investigation identified the root cause to be that Resident #1 walked out behind a dietary aide, and the dietary aide did not intervene to prevent an unsupervised exit, thinking he was a visitor. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 8/5/25, the charge nurse and nursing assistants completed a 100% Head Count utilizing a census sheet. All other residents were present and accounted for. On 8/5/25, the Maintenance Director and DON completed a 100 % audit of all entrance/exit doors, windows, and wander guards in the facility to ensure all windows and doors were locked and all were functioning properly. There were no concerns identified. On 8/5/25, the DON completed a 100% audit of all residents at risk for wandering to ensure residents' photos were in the elopement book. There were no concerns identified during the audit. On 8/6/25, the Administrator made the decision to add a bright colored sign to the entrance of both sides of the service hall door that states "employee's only." Additionally, a bright colored sign was placed on the service hall exit door stating, "No residents or visitors are allowed to exit this door." On 8/5/25, the DON completed an audit of all residents' progress notes including Resident # 1 for the past 30 days. This audit is to identify any residents with exit seeking behaviors or an increase in exit seeking behaviors to include wandering in and out of resident's rooms, wandering around the facility, attempting to pry open exit doors, tampering or removing of wander	F0689		

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F0689 SS = SQC-J	Continued from page 27 guards, and making comments about exiting the facility to ensure appropriate interventions were put into place for the prevention of an unsupervised exit. The Director of Nursing addressed all concerns identified during the audit. The audit was completed on 8/5/25. On 8/6/25, the Assistant Director of Nursing (ADON) and Unit Managers initiated an audit of all wandering assessments to ensure assessments were completed accurately and to ensure all residents who triggered as at risk were care planned for wandering risk, had appropriate interventions in place, and that the resident had a secure guard in place per facility protocol. The DON addressed all concerns identified during the audit to include completing wander assessments as indicated, applying secure guard to residents at risk for wandering, and updating the care plan as indicated. The audit was completed by 8/6/25. On 8/6/25, the Staff Development Coordinator initiated an audit of behavior alerts in the last 30 days to identify residents with exit seeking behaviors to include an increase in exit seeking behaviors. The purpose of the audit was to ensure appropriate interventions are in place to prevent an unsupervised exit. All areas of concern were addressed during the audit. The audit was completed on 8/6/25. On 8/6/25, the Staff Development Coordinator initiated, in person, questionnaires with all staff regarding: (1) Do you know of any resident that has verbalized wanting to leave the facility, packed their bags, and/or is exit seeking or has increased exit seeking behaviors? (2). Have you seen any resident outside of the facility unauthorized or that you were unclear of the authorization status, that was not reported? The purpose of the questionnaires is to ensure that all residents identified as being at wandering risk, including those exhibiting an increase in exit seeking behaviors, have interventions in place to prevent unsupervised exits. Additionally, notifications have been completed for all residents that have been observed with an unsupervised exit and it was appropriately addressed. All identified areas of concern will be addressed by the Director of Nursing. The questionnaires were completed by 8/6/25 for all staff who worked. The Staff Development Coordinator will monitor the completion of staff questionnaires. After 8/6/25, staff who have not completed the questionnaire will complete it upon the next scheduled work shift. Address what measures will be put into place or systemic changes made to ensure that the deficient	F0689		

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(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
F0689 SS = SQC-J	Continued from page 28 practice will not recur. On 8/5/25, the DON initiated an, in person, in-service with all staff including agency regarding elopements (Unsupervised exits) to include (1) the definition (2) immediately reporting if exits are not functioning properly (3) immediately initiating an intervention if residents are exhibiting wandering behaviors or statements about exit seeking and document (4) increasing supervision as necessary if a resident has increased exit seeking behaviors (5) If a resident is seen outside of the facility without authorization or you are unsure if it is authorized or if it is a visitor, encourage the individual to return inside the facility with you. Immediately notify staff inside the facility via phone for assistance as needed. Always remain with the individual until assistance arrives. Leaving potential residents unattended poses a significant risk for further elopement or injury. Once the individual is returned inside of the facility, immediately notify the nurse of the incident. All in-services will be completed by 8/6/25. The Staff Development Coordinator will monitor the completion of staff in-services. After 8/6/25, any staff who has not worked or received the in-services will receive education prior to the next scheduled work shift. All newly hired staff including agency will be in-serviced by the Staff Development Coordinator (SDC) during orientation regarding prevention of elopements (unsupervised exits). On 8/6/25, the Staff Development Coordinator initiated in person quizzes with all staff including agency to validate knowledge and understanding of the elopement education. The questions included (1) What is an elopement (2) If a resident is trying to exit the facility or constantly commenting on leaving the facility, what are some things you should do? (3) When should you report to the nurse that a resident has exit seeking behaviors, commenting on leaving the facility, or actually exited the facility? (4) What should you do if you see a resident outside of the facility unauthorized, unsure of the authorization status, or unsure if it is a resident or visitor? Any staff who does not successfully pass the quiz will be immediately reeducated and will be required to retake the quiz at the time of administration until a successful passing score is achieved. The quizzes were completed by 8/6/25 for all staff who worked. The Staff Development Coordinator will monitor the completion of staff questionnaires. After 8/6/25, staff who have not completed the quiz will complete it upon their next	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

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Greenhaven Health and Rehabilitation Center	**801 Greenhaven Drive , Greensboro, North Carolina, 27406**

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F0689 SS = SQC-J	Continued from page 29 scheduled work shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 8/6/25, the decision was made by the Administrator to monitor the plan for prevention of unsupervised exits and presented to the Quality Assurance Performance Improvement (QAPI) committee to include the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development Coordinator, Medical Records, Social Worker, and Minimum Data Set Nurse on 8/6/25. Ten staff, including agency will be interviewed and quizzed regarding exit seeking behaviors/elopements weekly for 4 weeks then monthly x 1 month by the SDC utilizing the Staff Questionnaire-Unsupervised Exit Tool. The interviews and quizzes will be conducted across various departments and shifts, including weekends. The purpose of the interviews and quiz is to identify any resident that may be at risk for wandering, having increasing exit seeking behaviors, or had an unsupervised exit, and to ensure staff validate knowledge and understanding of what to do when a resident has increased exit seeking behaviors or a potential resident is outside unsupervised. The SDC will address all concerns identified during the audit to include updating the care plan, increasing supervision as necessary, placing a secure guard per facility protocol, reeducation to staff, and ensuring staff that does not successfully pass the quiz be immediately reeducated and retake the quiz at the time of administration until a successful passing score is achieved. The SDC was made aware of the responsibility to conduct the quizzes and interviews by the Administrator on 8/6/25. The Director of Nursing (DON) will review the staff questionnaires and quizzes weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Interdisciplinary team to include the Minimum Data Set (MDS) nurse, Social Worker, and Staff Development Coordinator will review progress notes and behavior alerts 5 times a week x 4 weeks then monthly x 1 month to include weekends. This audit is to identify residents with exit seeking behaviors and increasing exit seeking behaviors to include wandering in and out of resident's rooms, wandering around the facility, attempting to pry open exit doors, tampering, or removing of wander guards, and making comments about exiting the facility to ensure appropriate interventions were put into place for the prevention of	F0689		

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F0689 SS = SQC-J	Continued from page 30 unsupervised exit. All identified areas of concern will be addressed during the audit. The DON will review the progress note audit 5 times a week x 4 weeks to ensure all concerns were addressed. The interdisciplinary team was made aware of this responsibility by the Administrator on 8/6/25. The DON will forward the results of the Staff Questionnaire-Unsupervised Exit Tools and Progress Note Audit tools to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Date corrective actions completed: 8/7/25 Alleged date of IJ removal: 8/7/25 The corrective action plan was validated on 08/13/25. The following documentation was reviewed along with staff interviews and observations: A 100% head count dated 08/05/25, A 100% door audit dated 08/05/25, a 100% Wander Risk report dated 08/05/25, a sign at the employee exit door dated 08/06/25, an audit performed by the DON for exit seeking residents dated 08/05/25, an audit of wandering risk evaluations dated 08/06/25, an audit of behavior alerts dated 08/06/25, an audit of staff questionnaires dated 08/06/25, a root cause analysis dated 08/06/25, an elopement education to staff dated 08/05/25, and a weekly audit of staff that was to be initiated. An observation of a “Wander List” was posted at each nursing station that included resident names and room numbers. A random sample of staff across different disciplines and working varied shifts were interviewed on 08/13/25 to include elopement, missing resident, and the Emergency Preparedness policy. All of the staff members stated they had received the education. An observation of the hallway leading to the employee exit door was made on 08/11/25 at 11:50 am with the corporate Regional Vice President. A sign had been placed on the double doors leading to the employee exit door that read: “No residents or visitors allowed to exit this door.” An employee was seated at the double doors leading to the exit door to ensure only employees entered the hallway leading to the exit door. In an interview with the Regional Vice President, he stated the facility had stationed a staff member at the entrance to the employee exit door hallway 24 hours a	F0689		

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F0689 SS = SQC-J	Continued from page 31 day since 08/06/25. Additionally, an inspection of the front door alarm system revealed the door did alarm and lock when a Wanderguard bracelet was within 5 feet of the door. The Immediate Jeopardy removal date of 8/7/25 was validated.	F0689		