STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwell Park Rehabilitation and Healthcare Center	**1930 West Sugar Creek Road , Charlotte, North Carolina, 28262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted on 09/04/25, additional information was obtained offsite on 09/05/25 therefore the exit date was 09/05/25. The following intakes were investigated 2581945 and 2594253. Intake 2594253 resulted in immediate jeopardy. 1 of the 3 complaint allegations resulted in a deficiency. Immediate Jeopardy was identified at past noncompliance at: CFR 483.25 at tag F689 at a scope and severity (J). The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 07/17/25 and was removed on 07/19/25. An extended survey was conducted. The amended compliance date is 07/26/25.	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, resident, and Medical Director interviews, the facility failed to ensure the necessary supervision was provided to prevent a cognitively impaired resident who was care planned as having a history of attempting to leave the facility, who wandered aimlessly and had impaired safety awareness from exiting the building at night	F0689	"Past Noncompliance - no plan of correction required"	

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

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

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F0689 SS = SQC-J	Continued from page 1 without staff knowledge. On 07/17/25, the resident was last seen at 9:00 PM. At approximately 9:30 PM Nurse Aide (NA) #1 was unable to locate Resident #1. Staff members searched the building before checking the back doorway employee entrance, which required a keycode for exit. Resident #1 was found outside lying on his left side with his wheelchair on top of his lower back area. Resident #1 had traveled approximately 30 feet out of a back employee entrance down a sidewalk that led to a dark dumpster area which was approximately 5 feet from where Resident #1 was found and that staff sometimes used as a parking area. The area of sidewalk where Resident #1 was found was noted to have a large crack in the pavement. The resident was brought back into the building at approximately 10:10 PM. This deficient practice had the high likelihood to cause serious harm or serious bodily injury to Resident #1 including serious head injury, fractures, or internal injuries. The deficient practice affected 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 03/27/2025 with diagnoses of heart failure, metabolic encephalopathy and non-Alzheimer's dementia. A current care plan initiated on 04/01/25 revealed a focus area for Resident #1 as an elopement risk/wanderer related to disorientation to place, history of attempts to leave the facility unattended, and impaired safety awareness. Resident #1 was noted to wander the facility aimlessly, significantly intruding on the privacy or activities of other residents. The goal was for Resident #1's safety to be maintained through the next review date. Interventions included distracting the resident from wandering, identifying the pattern of wandering, increased supervision and a wanderguard bracelet (bracelet that causes the door to alarm if a resident exits a door that was equipped with wanderguard alarm sensor) to the resident's ankle. Resident #1's admission Minimum Data Set (MDS) assessment dated 04/03/25 revealed he was severely cognitively impaired and required moderate assistance of one staff member for sit to stand transfers and chair to bed transfers. Wandering behavior not exhibited during the assessment reference period. Resident #1 used a wheelchair as an assistive device and had no functional impairments with range of motion to the upper or lower extremities. He did not receive an anticoagulant during the assessment period. Resident #1 used a wander/elopement alarm daily.	F0689		

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F0689 SS = SQC-J	Continued from page 2 A physician order dated 04/27/25 revealed Resident #1 had a wanderguard. Nursing staff were to check placement of the bracelet to left ankle every shift and monitor the wanderguard each shift. Review of Resident #1's Medication Administration Record dated July 2025 revealed an order for staff to check placement of the bracelet to left ankle every shift and monitor the wanderguard each shift. The order was initialed as completed on each shift by the nursing staff. Review of Resident #1's medical record from June 2025 to July 2025 revealed no progress notes that mentioned Resident #1's wandering behaviors or tendencies. An incident report dated 07/17/25 revealed Resident #1 was found by Nurse #1 on the ground by the employee entrance. Resident #1 stated he was going to the kitchen. The resident was assessed by Nurse #1 and noted to have no injuries at the time of the fall. Resident #1 was assisted into his wheelchair by two staff members The note revealed Resident #1's vital signs were at baseline, range of motion was within normal limits and a head-to-toe skin assessment revealed his skin was intact. Neurological monitoring was initiated. The incident report was completed by Nurse #1. An elopement risk evaluation dated 07/17/25 completed by Nurse #1 revealed Resident #1 scored a level 6 and was labeled as a low risk for potential elopement. A nursing note dated 07/17/25 at 11:16 PM written by Nurse #1 revealed Resident #1's vital signs were the following: blood pressure 164/74 (normal range 120/80), pulse 65 (normal range 60-90), respirations 18 (normal range 12-20) and oxygen saturation level 97% (normal range greater than 92%). Resident #1 was noted to have had a fall from his wheelchair. He was placed back into his wheelchair by two-person assistance with neurological monitoring in place. The residents Responsible Party was notified as well as the on-call provider. On 09/04/25 at 10:04 AM an interview was conducted with Nurse #1. During the interview Nurse #1 stated she was responsible for Resident #1 on 07/17/25 during the 3:00 PM to 11:00 PM shift. Nurse #1 stated Resident #1 was alert but confused and would often wander around the facility in his wheelchair. She stated on 07/17/25 she had administered his nighttime medications at 9:00 PM. Nurse Aide (NA) #1 went to check on Resident #1 at 9:30	F0689		

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F0689 SS = SQC-J	Continued from page 3 PM and noticed he was not in his room. NA #1 went to Nurse #1 and stated she could not find the resident. Nurse #1 stated the facility staff completed the rounds around the inside of the facility. On the first round they checked the hallways, on the second round they checked the resident rooms and on the third round they checked in the resident bathrooms but were unable to locate Resident #1. She stated each staff member in the building was assigned an area to look and she decided to look out of the backdoor which was the employee entrance. The interview revealed the door required a key code to get out of the building and into the building. Nurse #1 stated she entered the key code number and stepped outside of the door, yelling Resident #1's name and heard a response of "yeah." The interview revealed it was dark outside, and she could not initially see Resident #1. Nurse #1 stated she walked to the end of the sidewalk to find Resident #1 lying on his left side with the wheelchair on top of his lower back. Nurse #1 stated the time frame of Resident #1 being missing and her finding the resident was approximately 15 minutes. She stated she yelled for staff assistance and Nurse Aide #2 came outside. Nurse #1 assessed Resident #1 and noted him to have no injuries therefore Nurse #1 and NA #2 assisted the resident back into his wheelchair. Nurse #1 stated Resident #1 was smiling and laughing at the situation while they rolled him back into the facility around 10:10 PM. Nurse #1 stated she had to put in the key code to get back into the facility while pushing the resident. Resident #1 stated to Nurse #1 he did not know how he had gotten out of the door and that he was trying to find the kitchen. Resident #1 was placed into his bed and put on every 15-minute monitoring. A one-on-one staff member was placed with the resident once he was back into bed because the facility had an extra nurse that night. Nurse #1 stated she notified the residents Responsible Party, on-call provider and the Director of Nursing. Resident #1 was wearing a t-shirt, pants and non-slip socks with slide on shoes at the time of the elopement. Nurse #1 stated she completed the elopement assessment along with the Director of Nursing and kept the residents score low because he intentionally did not elope from the facility. Resident #1 was confused and was looking for the kitchen. An observation and interview were conducted on 09/04/25 at 10:09 AM with Nurse #1. The observation started at the back door employee exit/entrance and continued outside to where Resident #1 was located the night he exited the facility. The staff time clock was on the wall on the right side of the wall door. Nurse #1 used a keycode located on the inside of the door to open the	F0689		

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F0689 SS = SQC-J	Continued from page 4 door, no alarm sounded. The door slowly closed behind the surveyor and Nurse #1 in a time frame a resident could have put his foot in the door to stop it. A "STOP" sign with education to check your surroundings before exiting the facility was observed on the inside of the door. Once the door was shut, there was a sidewalk leading to the back alley of the facility in an "S" shape. The kitchen was observed to be straight across from the back door. Nurse #1 explained she could not see Resident #1 immediately when she went out of the door because she could not completely visualize where the sidewalk ended from standing directly on the outside of the door and it was dark outside. Nurse #1 stated she had to walk a couple of feet before being able to visualize the resident lying on the ground with the wheelchair on top of him approximately 30 feet from the door of the facility. Resident #1 was found on the slope leading down from the sidewalk where the sidewalk met the pavement. There was large crack in the sidewalk at the end of the sidewalk where Nurse #1 explained Resident #1's wheelchair must have gotten caught causing it to turn over. A dumpster was located out of the back kitchen area and was approximately 5 feet from where the resident was found lying in the dark. There were no cars parked during the observation however, the back alley-way led to the employee parking lot. A weather report dated 07/17/25 revealed the low for the area was 79 degrees on the night Resident #1 was found outside of the facility. The weather report also indicated the sun set at 8:37 PM. On 09/04/25 at 10:37 AM an observation and interview were conducted with Resident #1. During the interview he stated he did not recall ever going out of the back entrance of the facility or experiencing a fall. He stated he did not remember the incident. Resident #1 was observed lying in bed at the time of the interview. On 09/04/25 at 10:45 AM an interview was conducted with NA #1. NA #1 stated she had worked the 7:00 PM to 7:00 AM shift on 07/17/25 and was responsible for Resident #1. The interview revealed NA #1 had picked up Resident #1's meal tray at 8:30 PM. She stated she went back to check on Resident #1 at 9:30 PM, however she was unable to locate him in his room. NA #1 stated Resident #1 would typically roll around the facility in his wheelchair, so she thought he was probably on the other side of the building, so she started to immediately look for him. NA #1 told Nurse #1 she was unable to locate Resident #1 and Nurse #1 stated," he isn't far, I just gave him his medication at 9:00 PM". The interview revealed the facility staff started checking all resident rooms and bathrooms. By the time everyone	F0689		

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F0689 SS = SQC-J	Continued from page 5 in the building was looking for Resident #1, Nurse #1 had gone out of the facility's back entrance and found Resident #1 outside. NA #1 stated when she came back around the building Nurse #1 and NA #2 had the resident in his wheelchair and back inside of the facility. NA #1 stated Resident #1 was smiling and laughing about the situation and did not seem in any distress. Resident #1 was placed into his bed around 10:15 PM and every 15-minute monitoring was initiated. The facility had an extra staff member that came in on the night of the incident and was assigned to Resident #1 for one-on-one supervision. NA #1 stated Resident #1 had been wandering around the facility in his wheelchair per his usual self that night and she had not observed him attempting to exit any of the facility doors. On 09/04/25 at 11:00 AM an interview was conducted with the Director of Nursing (DON). During the interview the DON stated she and the Assistant Director of Nursing (ADON) had been in the facility on 07/17/25 and had clocked out at 9:46 PM and exited the facility together through the back door employee entrance of the facility. The DON stated she used the keycode to exit the door. The interview revealed the DON had parked her vehicle at the back entrance of the facility. The interview revealed there were no residents near the door when she exited the building, nor did she see any residents in the hallway. She stated she received a call from Nurse #1 shortly after leaving around 10:10 PM stating Resident #1 had gotten out of the back door employee entrance and experienced a fall off of the sidewalk. The DON stated she immediately turned around and returned to the facility to assess the situation. She stated once back at the facility she assessed Resident #1 herself and noted no injuries. The DON explained Resident #1 would sometimes follow staff around the building and felt like he had trailed behind someone as they went out the door that night and the staff hadn't seen him. The DON noted she did not see him when she exited the facility at 9:46 PM. She stated she had an extra staff member that night, so they were placed on one on one with Resident #1 and every 15-minute monitoring was initiated. Resident #1's wanderguard was in place at the time of the elopement however the back door employee entrance does not have a wanderguard alarm system, it was a key code only door. The DON explained Resident #1's elopement risk score remained low because she felt like he wasn't trying to elope from the facility, but was confused and looking for the kitchen as he stated. A review of the facility time sheet revealed on 07/17/25 at 9:46 PM the Director of Nursing clocked out of the facility. The Assistant Director of Nursing	F0689		

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F0689 SS = SQC-J	Continued from page 6 clocked out of the facility at 9:45 PM. No other staff members locked out during the time frame of 9:00 PM to 9:45 PM. On 09/04/25 at 10:50 AM, 11:15 AM and 2:31 PM an interview was attempted with Nurse Aide #2 with no return phone call received. On 09/04/25 at 3:13 PM an interview was conducted with NA #3. During the interview he stated he had seen Resident #1 in his wheelchair on the night of the incident, but he was not attempting to exit any of the doors that night. NA #3 explained he was working on a different unit than where Resident #1 resided. The interview revealed NA #3 had visualized him trailing close behind staff members in the past, close to the doors and always being in the hallway near the door but did not specifically see him with that behavior on the night of 07/17/25. NA #3 stated all staff in the facility were looking for Resident #1 on the night of the incident and had looked in resident rooms and bathrooms. He stated it wasn't long after the search began that Resident #1 was found outside of the back door employee entrance. NA #3 stated Resident #1 did not seem like he was in distress or hurt when he saw him. He stated the resident was smiling. On 09/04/25 at 3:18 PM an interview was conducted with the Scheduler. During the interview she stated she was not working on the night of 07/17/25 but had observed Resident #1 following staff around closely while they left the building and had experienced him following her. She stated she knew he had a wanderguard bracelet on and she would always turn around to ensure the door closed once she exited the building. The interview revealed that all staff members knew Resident #1 would wander around the building in his wheelchair. On 09/04/25 at 11:54 PM an interview was conducted with the Medical Director. During the interview he stated he was told about the incident the next day by the Director of Nursing. Resident #1 tried to get around the facility himself and he unfortunately snuck out of the back door. The Medical Director stated, "there was no harm to it". Resident #1 knew what he was doing when he followed a staff member out of the door and managed to fool the facility staff. The Medical Director explained that Resident #1 was probably having a good day mentally and was able to exit the building. When the Medical Director was asked if Resident #1 was safe to be outside by himself after dark the Medical Director replied that was a "trick question, it was a slight problem but not a huge problem." The Medical Director stated he did not "expect perfection from the	F0689		

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F0689 SS = SQC-J	Continued from page 7 nursing home staff. It was unfortunate but it wasn't the nursing home's fault he got out of the door." On 09/04/25 at 12:31 PM an interview was conducted with the Administrator. He stated he was not in the facility when the incident occurred, however, remembered hearing about it the day after. The interview revealed the Director of Nursing had gone back to assist staff that night on 07/17/25. The Administrator stated it was his understanding Resident#1 was missing for approximately 15 minutes from the facility when he was found outside of the back door employee entrance. He stated the facility had assumed he had followed a staff member out of the door but interviewed all staff members the night of the incident and nobody had seen him behind them when going out of the door. The interview revealed Resident #1 was wearing a wanderguard and all of the other doors in the facility would have alarmed except for the back employee entrance. There was no alarm that night and based on his location it was assumed that he went out through the back door. The interview revealed Resident #1 had not eloped from the facility prior to 07/17/25 or after. The Administrator was notified of the immediate jeopardy on 09/04/25 at 1:39 PM. The facility provided the following corrective action plan with a compliance date of 07/19/25. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. · On 7/17/2025, at approximately 9:30 PM Nursing Aide (NA) noted that Resident #1 could not be located. The Nurse Aide (NA) reported to Resident #1's nurse that Resident #1 was missing. Resident #1's Nurse verbally alerted the staff nurse on the other nursing unit that Resident #1 was missing and staff on both units immediately began searching for Resident #1 in all rooms, closets, under beds and in bathrooms, shower rooms, clean and soiled utility rooms, day rooms, nursing stations, employee lounge, dining area, kitchen, lobby, and common areas within the center and as well as the outside of the center front, sides and back of the center and parking areas. Resident #1 was located outside the employee exit door on the sidewalk approximately 30 feet from the exit door. Resident #1 had fallen, and his wheelchair was tipped over on top of him.	F0689		

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F0689 SS = SQC-J	Continued from page 8 · On 7/17/2025 at 10:10 pm the Licensed Nurse completed a head-to-toe skin assessment, including neurological checks and range of motion for Resident #1. No concerns were identified. · On 7/17/2025 The Director of Nursing notified the on-call Nurse Practitioner at 11:13 pm. · On 7/17/2025 The Director of Nursing notified Resident #1's responsible party. · On 7/17/2025 the Regional Clinical Director reviewed the care plan for Resident #1 to ensure the care plan reflected use of wanderguard and wandering/elopement status. No concerns were identified. · On 7/17/2025 the Regional Clinical Director reviewed Resident #1's physician orders to ensure orders were in place to check placement of wanderguard and to verify battery function. No concerns were identified. · On 7/17/2025 the Director of Nursing verified all doors were secure and locked, including performance test of wanderguard door. No concerns were identified. · On 7/17/2025 the Director of Nursing completed an elopement risk assessment for Resident #1 with a score of 6 (low risk). · On 7/17/2025 the Director of Nursing verified the wanderguard was in place and the battery was functioning properly for Resident #1. No concerns were identified. · On 7/17/2025 Resident #1 was placed on 1:1. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. · All residents with wandering behaviors have the potential to be affected.	F0689		

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F0689 SS = SQC-J	Continued from page 9 · On 7/17/2025 the Director of Nursing/Designee completed a 100% resident count to ensure all current residents were present in the facility. No concerns were identified. · On 7/17/2025 the Director of Nursing/Designee verified all residents with wanderguards had wanderguards in place and they were functioning properly. No concerns were identified. · On 7/17/2025, the Policy and procedure for Wandering and Elopement was reviewed by the Regional Clinical Director and the Director of Nursing. · On 7/18/2025 the Maintenance Director checked all exit doors to ensure proper functioning, including the performing a function test on the wanderguard door. No concerns were identified. · On 7/18/2025 the Maintenance Director placed signs stating to “stop” on all exit doors to provide a visual reminder for residents to stop and not exit. This is also a reminder for staff to ensure the door is closed, and residents do not exit doors behind them. · On 7/18/2025 the Director of Nursing/Designee completed elopement assessments for all residents. Any residents identified as being at risk for elopement were immediately evaluated for proper interventions, including need for wanderguard, or referral to a memory care/dementia unit. · On 7/18/2025 the Regional Clinical Director reviewed/updated care plans and NA’s kardex’s for all residents at risk for elopement/with a wanderguard. · On 7/18/2025 the Regional Clinical Director reviewed physician orders for all residents with wanderguards to ensure orders were in place to check placement of wanderguard and to verify function. No concerns were identified. · On 7/18/2025 the Assistant Director of Nursing reviewed and updated the elopement books, as indicated with pictures of residents assessed to be at risk for	F0689		

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F0689 SS = SQC-J	Continued from page 10 elopement. These books are located at each nurse's station and the reception desk at the front of the facility and are updated as needed with changes, including new residents at risk for elopement with wanderguard orders and when a wanderguard has been discontinued. These updates are the responsibility of the Director of Nursing/Designee. · On 7/18/2025 an elopement drill was completed by the Maintenance Director and the Director of Nursing using the facility "Elopement Drill Documentation Audit Form" with all staff on duty at the time of the drill. This audit form was provided to the nurses on duty and posted at each facility nurses' station as a guide to elopement protocol steps. This drill included: The Nurse alerts all staff of the missing resident with an announcement "Medical Alert- There is a missing Resident. The Resident was last seen on (UNIT)". This alerts all staff that a formal search is underway. Each unit sends a person to the unit that announced the code to learn the name and description of the missing residents. Each unit charge nurse directs in-house staff to search room to room and all areas of the center, including all resident rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, laundry, kitchen (including walk-in refrigerators and freezers) bathrooms, dayrooms/lounges, courtyards and employee lounges, outside building perimeter and grounds. Staff successfully responded to missing resident. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 7/18/2025, the Director of Nursing/Assistant Director of Nursing/Designee educated staff using the policy and procedure for Wandering and Elopement, including the Elopement Drill Documentation Audit Form, which also included the following: a. All staff were educated on ensuring residents are not sitting at exit doors- especially if staff are going out of the door: stop signs were placed at every exit door as a visual reminder for residents and staff. b. All staff were educated on ensuring that once outside, staff should make sure the door is closed and locked from the outside and that residents have not followed them outside, as well as check surroundings.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 11 c. All staff were educated on ensuring the whereabouts of residents with wandering tendencies routinely throughout the shift. d. All staff were educated on notifying the nurse, Unit Manager/Director or Nursing/Assistant Director of Nursing if residents have new wandering behaviors. e. Licensed Nurses were educated to complete elopement risk assessment, change in condition documentation, and notify the Physician/Nurse Practitioner/Responsible Party, and apply a wanderguard, implement appropriate interventions and update the elopements books located at each nurse's station and the receptionist desk as indicated or with new wandering behavior. f. Licensed Nurses were educated that new admissions/re-admissions should have a wandering/elopement assessment completed upon admission, with appropriate interventions implemented if high risk for elopement. g. Licensed Nurses were educated on verifying wanderguard function daily, including blinking pattern on wanderguard, which indicates proper function of the wanderguard when residents are not near the sensor box wanderguard door (front door). h. All staff were educated on notifying the Nurse/Unit Manager/Director of Nursing/Assistant Director of Nursing if residents are near a wanderguard door, and door does not activate or sound. i. Nursing Aides (NA's) were educated on reviewing kardex for each assigned residents each shift they work for any updates or changes to the residents kardex. j. All staff were educated on the process/policy on how to respond to elopement or missing person. This education was completed on 7/18/2025. Any employee who is not educated will receive this education prior to their next shift. The Director of Nursing/Designee will be responsible for this education. This education will be added to the facility orientation program for all new hires. The Director of Nursing/Designee will validate with the Human Resource Director that all new hires have received this education during the orientation process. · An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 7/18/2025 to discuss,	F0689		

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F0689 SS = SQC-J	Continued from page 12 review and approve the plan that had been initiated and implemented by the Regional Clinical Director and the Director of Nursing on 7/17/2025. The Quality Assurance Performance Improvement Committee also reviewed the policy and procedure for Wandering and Elopement residents as well as the “Elopement Drill Documentation Audit Form”. The decision to monitor the plan was also decided upon during the QAPI meeting on 07/17/25. Root Cause Analysis was completed and determined that Resident #1 likely trailed behind staff that was exiting out the employee entrance/exit door as Resident #1 validated this was the door that was exited, which was the employee door at the back of the facility and verified that the code was not known to Resident #1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. · The Director of Nursing/Designee and/or the Human Resources Director/Designee will randomly observe staff entering/exiting the 2 designated employee entrance/exit doors, which are not wanderguard protected, 3 times a week for 12 weeks. They will observe staff entering or exiting the designated employee entrances door to ensure that staff, during the observations are paying attention to their surrounds, ensuring no residents follow them out of the building, and ensuring the door closes and is locked appropriately. All other entrance/exit doors that are not wanderguard protected have alarms which alert staff when the door has been opened, which are emergency exit doors only and are not designated entrance/exit doors. · The Maintenance Director/Designee will perform door checks on all exit doors, including verifying stop signs are in place as well as performing a function test on the wanderguard door 5 times a week for 12 weeks to ensure doors/including wanderguard door function properly. · The Director of Nursing/Designee will verify 3 wanderguards are functioning properly weekly for 12 weeks. · The Director of Nursing/Maintenance Director were notified by the Regional Clinical Director on 7/17/2025 of their responsibility to conduct elopement drills. These drills will be conducted as follows: 1 drill on	F0689		

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F0689 SS = SQC-J	Continued from page 13 each shift for 1 month for a total of 3 drills, then 2 drills a month for 3 additional months to ensure proper staff response. These drills will be conducted unannounced, on random days of the week/shifts/times. · The Director of Nursing/Designee will review all new admissions elopement assessments weekly for 12 weeks to ensure proper interventions are implemented. This will include physician notification to obtain orders for interventions, residents responsible party notification, care plan, Nursing Aides (NA's) kardex's, elopement books updates as indicated. · The Director of Nursing/Designee will review progress/behavior notes 5 times a week for 12 weeks during clinical morning meeting using the 24 hour report to ensure wandering behaviors have been addressed with proper interventions implemented as indicated. · The Director of Nursing/designee and the Maintenance Director will be responsible for reporting the results of these audits to the facility s monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. Immediate Jeopardy Removal date: 7/19/2025 On 09/04/25, the corrective action plan was validated by onsite verification through facility staff interviews. The interviews revealed all staff were educated on ensuring that once outside of the facility door, staff should make sure the door was closed and locked from outside and that resident have not followed them outside as well as to check their surroundings. All staff were educated on ensuring the residents whereabouts and notifying nursing staff if residents exhibited new wandering behaviors. Nurses received education on completing the elopement risk assessment, change of condition documentation and who to notify if an incident occurred. Nurses stated they were to verify wanderguard placement daily and functionality of the device. Nurse Aides verified they had received education on reviewing the Kardex for each assigned resident. All staff including dietary staff, maintenance, housekeeping staff and nursing staff were interviewed and confirmed they had received education on the process/policy on how to respond to elopement or	F0689		

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F0689 SS = SQC-J	Continued from page 14 a missing resident. The facilities in-service log, monitoring results and training material was reviewed along with audit tools. An observation was conducted of “stop” signs on the exit doors. The validation verified immediate jeopardy was removed on 07/19/25 and the deficiency was corrected on 07/19/25.	F0689		