STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cabarrus Health and Rehabilitation	**430 Brookwood Avenue NE , Concord, North Carolina, 28025**

(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 from 7/16/2025-718/2025. The following intakes were investigated 2560965 and 868462. Intake 2560965 resulted in immediate jeopardy. 1 of the 2 complaint intakes resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 7/13/2025 and was removed on 7/17/2025. A partial extended survey was conducted. The Statement of Deficiencies was amended on 8/29/2025 at tag F689.	F0000		07/28/2025
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff, resident representative, and physician interviews, the facility failed to effectively supervise a resident with moderate cognitive impairment, repeated falls, and impulsive behaviors. Around 12:00 PM on 7/13/25 Resident #1 left the facility without staff's knowledge and ambulated approximately 0.6 miles from the facility in 90-degree heat with 60% humidity. Resident #1 was	F0689	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F0689 Free of Accident Hazard/Supervision/Devices Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 was admitted to the local hospital for further evaluation and treatment on 07/13/2025. Resident #1 hospital records indicate he was admitted to the hospital with primary diagnosis of hypotension. Resident #1 was re-admitted to the facility on 07/23/2025. Elopement risk assessment was completed on 7/23/2025 for Resident #1 and determined to be at low risk for elopement. Despite the low risk assessment score, Resident #1 was	07/30/2025

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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F0689 SS = SQC-J	Continued from page 1 discovered sitting in a ditch on the side of the road approximately 0.6 miles from the facility. Two passersby stopped to help him and called Emergency Medical Services (EMS). In addition, Housekeeper #1 was on her lunch break and in a car when she happened to see him on the ground on the side of the road. Housekeeper #1 stopped to give Resident #1 assistance and stayed with Resident #1 until EMS arrived. Resident #1 was sent to the hospital for evaluation and treatment for low blood pressure, weakness, urinary tract infection, and pneumonia. There was a high likelihood for serious injury or death considering the resident's cognition, impulsivity and resulting medical conditions. This deficient practice affected 1 of 3 residents reviewed for supervision to prevent accidents. Immediate jeopardy began on Sunday, 7/13/25, when Resident #1 left the facility without staff's knowledge and walked 0.6 miles away from the facility. Immediate jeopardy was removed on 7/17/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and ensure monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 3/31/25 and readmitted 4/18/25 with diagnoses including chronic obstructive lung disease, Parkinson's disease, repeated falls, spinal stenosis (a narrowing of the spinal vertebra causing nerve pain and weakness), extrapyramidal symptoms (side effects from taking antipsychotics; involuntary muscle movements), schizophrenia, and anxiety disorder. Physician medication orders for Resident #1 were as follows: Gabapentin (an anti-seizure medication used for nerve pain) 400 milligrams (mg) three times per day ordered on 4/18/25. Haloperidol (an antipsychotic medication used for control of severe agitation and aggression) 10 mg three times per day ordered on 4/18/25. Clozapine (an atypical antipsychotic used to treat mental illness like schizophrenia) 100 mg 3 tablets twice per day and Clozapine 50 mg twice per day (for a	F0689	Continued from page 1 added to the elopement risk binder, care plan and Kardex updated for extra monitoring following the recent episode of elopement. The weekend supervisor completed a headcount of all residents in the facility; all residents were accounted for as of 07/13/2025. The facility placed a sign on the front door on 7/14/2025 to alert family and visitors not to assist residents outside without checking with the receptionist first and in-serviced Receptionist #1 on 7/14/2025. Identification of other residents having the potential to be affected by the same deficient practice: The Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 completed elopement assessments on all residents in the facility on 7/14/2025 to identify any resident at risk for elopement. All identified residents at risk for elopement were added to the Elopement book at each nurse's station and the front desk for easy identification. On 07/14/2025, the Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 updated care plans to include elopement risk interventions to prevent any successful attempts at elopement for all residents identified to be at risk. The Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 reviewed and updated the Elopement books to include resident demographic information and resident pictures for easy identification. This was completed on 07/13/2025 & 07/14/2025. These binders are located at each nurses' station and at the front desk. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 07/16/2025, all new residents will have an elopement risk assessment completed on admission, readmission, quarterly, and with any changes in exit-seeking behavior, by the licensed nurse on duty. Any resident identified to be at risk for elopement will have appropriate interventions in place and an updated care plan for elopement. The nurse on duty will update residents' information in the elopement binder to include demographic information and pictures. Effective 07/16/2025, the facility clinical team including the Director of Nursing, Assistant Director	

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F0689 SS = SQC-J	Continued from page 2 total of 350 mg twice per day) ordered on 4/21/25. The most recent Quarterly Minimum Data Set (MDS) assessment dated 4/25/25 assessed Resident #1 to be moderately cognitively impaired. The MDS documented Resident #1 did not wander and had no behaviors. The MDS assessed Resident #1 to require partial assistance to walk 10 feet, and he was dependent on walking 50 feet or more. The MDS documented Resident #1 did not use ambulation devices. The MDS documented Resident #1 was taking antipsychotic medications, antianxiety medications, and medications for seizure disorder. The active care plans in effect on 7/13/25 were as follows: Fall potential due to impulsivity. The interventions included resident education to call for staff assistance, place common items within reach, and remind Resident #1 to use call bell; Behaviors related to the use of psychotropic medications. The goal stated Resident #1's behaviors would not cause him distress, and interventions included to monitor for behaviors, including elopement, delusions, hallucinations, aggression, or refusing care; Cognitive impairment and included the goal that Resident #1 would not have any complications due to cognitive impairment. Interventions for this care plan included observing for changes in cognition and reorient Resident #1 as needed; Antipsychotics use, with interventions to monitor for behaviors, monitor for adverse medication reactions, and provide psychiatric services; and Level II PASRR (Pre-Admission Screening and Resident Review, a screening tool used for residents with a serious mental condition to ensure the resident receives appropriate services). The care plan interventions included psychological/psychiatric interventions or consultation as ordered. A Physician Assistant (PA) note dated 7/3/25 documented an examination after an unwitnessed fall on 7/2/25 where Resident #1 reported he had "gotten up too quickly" and his legs "got weak". The note documented generalized weakness, fatigue, leg weakness, and anxiety. Resident #1 was confused, with impaired insight, and oriented to person. The note documented a recommendation for Resident #1 to use a wheelchair for mobility due to weakness, and to continue fall	F0689	Continued from page 2 of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 revised the process of reviewing all new admits/readmits in a daily clinical meeting. This includes provisions for reviewing elopement assessments to ensure they are completed and documented in electronic medical records, appropriate care plans are in place, and the elopement binders are updated. Any discrepancies identified will be corrected promptly. Findings of this systemic change are documented on the Daily Clinical Meeting Report Form located in the Daily Clinical Meeting Binder. The Regional Clinical Director in-serviced the DON/ADON on 7/13/2025 & 7/14/2025 on how to direct the nursing staff upon any identification of exit-seeking behaviors. These steps will be implemented to include completing the Elopement Assessment, updating the Care Plan, and updating the information in the Elopement Risk Book at each nurse's station and front desk. 100% education of all current staff, including full-time, part-time, and as-needed nursing employees, will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1 and #2). The emphasis of this education includes, but is not limited to, the importance of completing elopement assessments on admission, readmission, quarterly, and upon changes in exit-seeking behaviors. Staff education also focuses on the importance of updating care plans for each resident determined to be at risk for elopement, maintaining updated elopement binders at each nurse station and the front desk, and ensuring residents listed in the elopement binder are not allowed to exit the facility independently. This education will be completed by 07/16/2025. Any staff members who are not educated on or by 07/16/2025 will not be allowed to work until they are educated. This education will be provided annually and will be added to the new hire orientation for all new employees effective 07/16/2025. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 07/28/2025, DON and/or ADON will monitor compliance with elopement risk management by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team validated completion of elopement risk assessment on Admission, readmission quarterly and any changes in exit seeking behaviors. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for two months, or until	

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F0689 SS = SQC-J	Continued from page 3 precautions and neurological checks. A phone interview was conducted with Resident #1's Representative on 7/17/25 at 10:42 AM. The Representative reported Resident #1 had paranoia and had delusions with auditory hallucinations episodes in the past and on Saturday 7/12/25 Resident #1 called the Representative and told them that a resident at the facility wanted to "fight him". The Representative reported Resident #1 did not seem to be upset or mention wanting to leave the facility. The Representative reported Resident #1 said he did not want to fight this other resident. The Representative reported he had not reported to the facility that Resident #1 had called him regarding the other resident wanting to fight him because Resident #1 did not seem to be upset or concerned. An interview was conducted with Nursing Assistant (NA) #1 on 7/16/25 at 4:04 PM. NA #1 reported she was assigned to Resident #1 on Sunday, 7/13/25, and he had appeared to be his normal self. NA #1 explained that Resident #1 was mostly independent with washing up, dressing, and toileting and rarely called for help. NA #1 reported she had seen Resident #1 sometime between breakfast and lunch, but did not recall the exact time, and reported he had not said anything to her about being "fed up" and did not seem to be upset at all. NA #1 reported that Resident #1 had a routine of sitting in the front lobby from just after breakfast until after lunch, when he would return to his room to rest before dinner. NA #1 reported Resident #1 had never showed any signs of exit-seeking. Nurse #2 was interviewed by phone on 7/17/25 at 9:06 AM. Nurse #2 reported she was assigned to Resident #1 on 7/13/25 and had administered his morning medications to him. Nurse #2 reported Resident #1 was "just fine, no distress, no discomfort" and he had approached her after breakfast for his morning medications. Nurse #2 reported Resident #1 did not act abnormally or mention that he was "fed up". Nurse #2 explained that Resident #1 had a routine, and he would sit in the front lobby most of the day until after lunch and then return to his room to rest in the afternoon. Nurse #2 reported Resident #1 had not been exit-seeking or expressed any desire to leave. An interview was conducted by phone with Receptionist #1 on 7/16/25 at 1:41 PM. Receptionist #1 reported he worked weekends and some evenings, and he was familiar	F0689	Continued from page 3 the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a "Elopement assessment" monitoring tool located in the facility compliance binder. Effective 07/28/2025, DON and/or ADON will monitor compliance with elopement risk management by reviewing the three randomly selected elopement risk residents to ensure proper intervention to prevent elopement are in place, care plan and Kardex is up to date, and elopement risk binder is updated with pertinent information. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for two months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a "Exit seeking" monitoring tool located in the facility compliance binder. Effective 07/28/2025, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 07/29/2025.	

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F0689 SS = SQC-J	Continued from page 4 with Resident #1. Receptionist #1 reported on Sunday, 7/13/25 sometime “before noon”, Resident #1 had approached Receptionist #1 and asked him to open the front door so Resident #1 could sit outside on the front porch. Receptionist #1 explained he checked the elopement book (a book kept at the front entrance and at the nursing stations with pictures and demographics of residents at risk for elopement) and because Resident #1 was not in the elopement book, he unlocked the front door and allowed Resident #1 to exit the building and sit on the front porch. Receptionist #1 reported he did not notify a nurse that Resident #1 was outside, and he recalled several other times Resident #1 had requested to sit outside. Receptionist #1 explained that sometime after 12:00 PM, Housekeeper #1 came into the facility through the front door and notified him that Resident #1 was found on the side of the road. Receptionist #1 reported that Resident #1 did not act upset or agitated, and Receptionist #1 did not think anything was wrong with allowing Resident #1 to sit outside on the porch. An interview was conducted with Housekeeper #1 on 7/16/25 at 12:09 PM. Housekeeper #1 explained she clocked out for lunch at 12:00 PM on 7/13/25. Housekeeper #1 turned right out of the facility and right again onto the road that ran behind the facility. Housekeeper #1 reported that about one half a mile from the facility, she saw a man sitting in the ditch on the side of the road and recognized him as Resident #1. Housekeeper #1 described Resident #1 as wearing long pants, shoes, a short sleeve T-shirt, and he was sitting on the ground, sweating, and appeared to be shaking. Housekeeper #1 reported two bystanders were with Resident #1 and they reported they had called EMS. Housekeeper #1 reported Resident #1 had said he was “fed up” and left the facility but did not say anything more than that. Housekeeper #1 reported she stayed with Resident #1 until EMS arrived and then she returned to the facility, where she notified Receptionist #1 and the Nursing Supervisor (Nurse #1). A nursing note written by Nurse #1 dated 7/13/25 documented Resident #1 went to Receptionist #1 and requested to be let out to sit on the front porch. The Receptionist opened the door and Resident #1 went to the chairs on the front porch and seated himself. Receptionist #1 went back to his desk to attend to his job. Housekeeper #1 was coming back from lunch and stated she saw this resident sitting by the ditch in the grass. Housekeeper #1 reported she stayed with Resident #1 until EMS arrived, which was called	F0689		

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F0689 SS = SQC-J	Continued from page 5 bystanders. The note documented Resident #1's representative was notified Resident #1 was taken to the hospital for evaluation. Nurse #1 was interviewed on 7/16/25 at 3:11 PM. Nurse #1 reported she was the weekend supervisor, and she usually worked from 11:00 AM to 11:00 PM on Saturday and Sunday. Nurse #1 explained she had forgotten something in her car, and she saw Resident #1 outside on the front porch when she went out to her car. Nurse #1 reported Resident #1 did not appear upset. Nurse #1 was not certain what time she had gone to her car but recalled at 12:20 PM on 7/13/25 Receptionist #1 had reported to her that Resident #1 was discovered sitting in a ditch on the side of the road and EMS had been called. Nurse #1 reported she called the hospital to get a report on Resident #1, and called the police, the resident representative, the Administrator, the Director of Nursing (DON), and the on-call physician. The EMS report dated 7/13/25 at 12:02 PM documented a clinical impression of generalized weakness with behavioral/psychiatric episode. Vital signs for Resident #1 were as follows: Blood pressure 102/58 at 12:16 PM, 93/52 at 12:18 PM, and 93/54 at 12:19 PM (normal 120/80), pulse 77 at 12:16 PM, 133 at 12:18 PM, and 132 at 12:19 PM (normal 60-100). Temperature at 12:16 PM was 98.3 (normal 98.6). The report documented Resident #1 had left the facility after an altercation with another resident. Resident #1 reported weakness, and he was assisted to stand and transfer to the stretcher where he was transferred to the hospital emergency department for evaluation. Emergency Department records dated 7/13/25 at 12:49 PM documented Resident #1 was walking for 45 minutes when a bystander called for EMS. Resident #1 reported he left the facility because he thought another resident was going to beat him up. Resident #1 reported weakness and buttocks pain from walking and sitting on the ground. Resident #1 was assessed to be alert and oriented with a blood pressure of 81/64. The note documented that Resident #1 was “fed up” with the facility and wanted to take a long walk. Resident #1 reported feeling disoriented, but he was assessed to be alert and oriented to person, place, time, and situation. At 1:05 PM his temperature was 100.3 degrees, heart rate 114, respiration rate 30 (normal 12-20), and blood pressure 94/61. Blood work revealed his blood glucose was elevated at 170 (normal 70-120) and lactic acid (a by-product produced by the body after exercise; elevated levels can be attributed to infection and poor oxygenation) was elevated to 3.6	F0689		

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F0689 SS = SQC-J	Continued from page 6 (normal 0.5-2.2). A chest x-ray showed possible pneumonia. The note concluded that Resident #1 had no signs of trauma, no neurological signs indicating a stroke and he was admitted to the hospital with altered mental status, elevated lactic acid level, acute kidney injury, pneumonia, and lightheadedness. Hospital records were reviewed and urinalysis with culture and sensitivity was collected on 7/13/25 and the results on 7/14/25 showed greater than 100,000 e. faecalis (a bacteria that causes a urinary tract infection). A nursing note dated 7/13/25 documented Resident #1 was admitted to the hospital on 7/13/25 and remained hospitalized on 7/18/25. An observation of the route from the facility to the place where Resident #1 was discovered in a ditch on the side of the road was conducted by car with Housekeeper #1 and the Administrator on 7/16/25 at 12:25 PM. Turning right from the parking lot, the road was two lanes with a 35 miles per hour speed limit. The road did not have a sidewalk, and there was an incline from the facility to the stop sign at the intersection of the road. Turning right at the stop sign, this road was also 2-lane with a speed limit of 35 miles per hour with several curves and a slight incline. There was no sidewalk on this road and houses were located back from the road. The distance from the facility to where Resident #1 was located was approximately 0.6 miles. While the observation of the route was taking place, the Maintenance Director measured the distance from the front sitting area on the porch to the road as 223 feet. The weather on Sunday, 7/13/25, was mostly clear with partial clouds, the temperature was 90 degrees Fahrenheit and humidity was 60% and no wind according to historic weather on timeanddate.com. According to the national weather service, a heat index of 90 degrees and 60% humidity would be equivalent to 100 degrees Fahrenheit. The Physician was interviewed on 7/17/25 at 10:05 AM by phone. The Physician reported Resident #1 had not mentioned wanting to leave the facility and had not had a history of attempting to leave the facility. The Physician reported that Resident #1 spent most of his time sitting in the lobby and he had seen him sitting on the front porch a few times. The Physician reported he did not believe Resident #1 was cognitively able to	F0689		

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F0689 SS = SQC-J	Continued from page 7 leave the facility alone and reported Resident #1 had a significant chance of being injured by walking in 90-degree heat and without supervision. The DON was interviewed on 7/17/25 at 1:50 PM and she reported that new admission residents were assessed for elopement risk, and then quarterly and as needed after. The DON explained that Resident #1 had been assessed as a low risk for elopement and had no exit seeking behaviors, and for him to walk away from the facility was out of his normal behavior. The DON reported she was not aware Resident #1 had told his family that another resident wanted to fight him. The DON reported a binder was kept at the front desk and at each of the nursing stations with a picture of each resident who was at risk of eloping, and staff were expected to check the binder before allowing any residents to exit the building unsupervised. The Administrator was interviewed on 7/17/25 at 10:55 AM and he reported he started as the facility administrator on 7/14/25 and the former administrator was notified by phone on 7/13/25 when Resident #1 was found on the road one-half mile from the facility. The Administrator was notified of immediate jeopardy on 7/17/25 at 12:25 PM. The facility implemented a credible allegation of immediate jeopardy removal on 7/18/25. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #1 diagnoses included (in part); Spinal stenosis in lumber region, pulmonary fibrosis, Chronic Obstructive Pulmonary Disease (COPD), Parkinson's Disease, and anxiety disorder. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of 04/25/2025 indicated that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 10 (which indicated moderate cognitive impairment). Resident #1 was also assessed to be always understood and able to understand others. Further review of Resident #1's MDS assessment indicated Resident #1 had no short-term or	F0689		

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F0689 SS = SQC-J	Continued from page 8 long-term memory problems. Review of Section GG (functional status) of the MDS assessment indicated Resident #1 is independent with ambulation, functional cognition, and was coded with no use of functional devices (such as wheelchair, cane, and/or walker). Review of Resident #1's elopement risk assessment dated 04/18/2025 indicated a low risk for elopement. On 07/13/2025, between 11:30 am – 12:00 pm, Resident #1 walked to the front receptionist desk and requested to sit on the front porch. Resident #1 was not an elopement risk per initial assessment; therefore, was not in the Elopement Book (Elopement Book is a binder that contains residents who are at risk for elopement). The receptionist opened the front door and allowed Resident #1 out to sit on the front porch. Resident #1 walked out of the facility without the use of a wheelchair to sit on the front porch. Historically, Resident #1 routinely sat on the front porch. The facility front porch is not enclosed. At the time of exit on 7/13/2025, Resident #1 had on sweatpants, a T-shirt, and enclosed shoes. The clothing was appropriate for the weather conditions at the time he exited the facility. A facility housekeeper, Housekeeper #1, observed Resident #1 sitting on the grass, about half a mile from the facility during her lunch break. Housekeeper #1 further reported there were a couple of bystanders with Resident #1 who had already called 911/Emergency Medical Services (EMS) at the time she arrived at the scene. Housekeeper #1 remained with Resident #1 until Emergency Medical Services (EMS) arrived to transport Resident #1 to the local hospital for further evaluation and treatment. Housekeeper #1 then drove back to the facility and informed the facility Registered Nurse (RN) Supervisor she observed Resident #1 sitting on the grass about half a mile away from the facility beside the road and that Resident #1 was transported to the local hospital for further evaluations. Resident #1 was admitted to the local hospital for further evaluation and treatment on 07/13/2025. Resident #1 hospital records indicate he was admitted to the hospital with primary diagnosis of hypotension. Resident #1 remained in Hospital as of 7/16/2025. Upon return Resident #1 will be reassessed as a re-admission to the center following the revised process outlined below.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 9 The weekend supervisor completed a headcount of all residents in the facility; all residents were accounted for as of 07/13/2025. The facility placed a sign on the front door on 7/14/2025 to alert family and visitors not to assist residents outside without checking with the receptionist first and in-serviced Receptionist #1 on 7/14/2025. The Governing body led by the Regional Clinical Director, facility Administrator and Director of Nursing in collaboration with the selected members of the facility Quality Assurance and Performance Improvement (QAPI) committee conducted the root cause analysis on 07/14/2025, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences. The root cause analysis (RCA) identified that the alleged noncompliance resulted from the failure to reassess Resident #1 when noted to have change in his exit seeking behaviors on 7/13/2025. The RCA concluded that Resident #1's elopement resulted from not being assessed as an elopement risk. The Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 completed elopement assessments on all residents in the facility on 7/14/2025 to identify any resident at risk for elopement. All identified residents at risk for elopement were added to the Elopement book at each nurse's station and the front desk for easy identification. On 07/14/2025, the Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 updated care plans to include elopement risk interventions to prevent any successful attempts at elopement for all residents identified to be at risk. The Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 reviewed and updated the Elopement books to include resident demographic information and resident pictures for easy identification. This was completed on 07/13/2025 & 07/14/2025. These binders are located at each nurses' station and at the front desk.	F0689		

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F0689 SS = SQC-J	Continued from page 10 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. Effective 07/16/2025, all new residents will have an elopement risk assessment completed on admission, readmission, quarterly, and with any changes in exit-seeking behavior, by the licensed nurse on duty. Any resident identified to be at risk for elopement will have appropriate interventions in place and an updated care plan for elopement. The nurse on duty will update residents' information in the elopement binder to include demographic information and pictures. Effective 07/16/2025, the facility clinical team including the Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1, and/or Unit Coordinator #2 revised the process of reviewing all new admits/readmits in a daily clinical meeting. This includes provisions for reviewing elopement assessments to ensure they are completed and documented in electronic medical records, appropriate care plans are in place, and the elopement binders are updated. Any discrepancies identified will be corrected promptly. Findings of this systemic change are documented on the Daily Clinical Meeting Report Form located in the Daily Clinical Meeting Binder. The Regional Clinical Director in-serviced the DON/ADON on 7/13/2025 & and 7/14/2025 on how to direct the nursing staff upon any identification of exit-seeking behaviors. These steps will be implemented to include completing the Elopement Assessment, updating the Care Plan, and updating the information in the Elopement Risk Book at each nurse's station and front desk. 100% education of all current staff, including full-time, part-time, and as-needed nursing employees, will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1 and #2). The emphasis of this education includes, but is not limited to, the importance of completing elopement assessments on admission, readmission, quarterly, and upon changes in exit-seeking behaviors. Staff education also focuses on the importance of updating care plans for each resident determined to be at risk for elopement, maintaining updated elopement binders at each nurse station and the front desk, and ensuring	F0689		

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F0689 SS = SQC-J	Continued from page 11 residents listed in the elopement binder are not allowed to exit the facility independently. This education will be completed by 07/16/2025. Any staff members not educated on or by 07/16/2025 will not be allowed to work until they are educated. This education will be provided annually and will be added to the new hire orientation for all new employees effective 07/16/2025. Immediate Jeopardy Removal date: 07/17/2025 The validation of the credible allegation of immediate jeopardy removal was conducted on 7/18/25 by interviewing nursing assistants, nurses, administration, housekeepers, receptionists regarding elopement prevention, elopement assessments, monitoring residents for exit-seeking behaviors, updating the elopement binders, and care plans. Sampled residents' medical records were reviewed for updated elopement assessments and elopement care plans. Education was reviewed. The immediate jeopardy was removed on 7/17/25.	F0689		