STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Health & Rehab Center	**610 West Fisher Street , Salisbury, North Carolina, 28145**

(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 An onsite complaint investigation survey was conducted from 5/7/26 through 5/08/26. Additional information was obtained on offsite through 5/13/26 and the exit conference was conducted by phone with the Administrator on 5/13/26. Therefore, the exit date was changed to 5/13/26. Intake NC003005198 resulted in immediate jeopardy. One (1) of 2 complaint allegations resulted in a deficiency. Past noncompliance 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 4/26/26 and the immediate jeopardy removal date and compliance date were 4/28/26. 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 interviews with staff, Contractor for safety systems, and the Medical Director, the facility failed to effectively supervise a resident, who had diagnoses including dementia and altered mental status and a history of falls, from exiting the facility unsupervised and without staff knowledge for 1 of 3 residents reviewed for supervision to prevent accidents	F0689	"Past Noncompliance - no plan of correction required"	04/28/2026

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

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

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F0689 SS = SQC-J	Continued from page 1 (Resident #1). Resident #1 was admitted to the facility on 4/25/26 and according to staff became increasingly confused during the shift which started at 7:00 PM. Resident #1 got out of bed multiple times and self-propelled in his wheelchair up and down the hall and was observed at the exit door looking out the window. Resident #1 was last seen by Nurse #1 in bed at approximately 4:00 AM on 4/26/26 and between 4:00 and 4:30 AM the Nurse Aide (NA) #1 noticed Resident #1 not in bed and immediately began to look for the resident and notified Nurse #1. No staff members recall hearing the 300-hall door alarm that night. NA #2 went out to her car between 4:30 and 4:45 a.m. on 4/26/26 and heard a man yelling for help from the other side of the parking lot. NA #2 could not see because it was dark outside and the area past the parking lot and down the embankment where the man called from was not lit. NA #2 indicated she was afraid to approach because the area felt unsafe, so she dialed 911 as she was walking back into the facility and told NA #3 what she heard and they went outside together. Resident #1 was found sitting on a gravel embankment at the edge of the parking lot, 100 feet from the 300- hall exit door and 200 feet from a four-lane road with a 35-mph speed limit. Resident #1 was wearing only an adult incontinence brief and a gown lay on the ground next to him. He told the staff he had fallen and needed help getting up. The temperature outdoors was 60 degrees Fahrenheit with a light drizzle. Emergency Medical Services (EMS) was called, and the resident was taken to the Emergency Department (ED) hospital for an evaluation. Imaging of the head, spine, and chest were completed without acute findings, and laboratory studies were normal. A contusion (an injury to the tissues that does not break the skin and can cause bruising or discoloration) to the right hand was treated with cleansing and topical antibiotic ointment. He was discharged back to the facility 4/26/26 with diagnoses of fall, contusion to right hand, and dementia. It was determined by staff the 300-hall door alarm power cord was unplugged which disabled both the lock and wander-alarm system. This noncompliance had a high likelihood of causing serious injury or serious bodily harm. Findings included: Review of the hospital discharge summary dated 4/25/26 revealed Resident #1 was admitted on 4/21/26 for recurrent falls and acute on chronic altered mental status. His diagnoses included type 2 diabetes, dementia, chronic kidney disease, generalized weakness, right leg pain and weakness, and encephalopathy. Hospital documentation stated	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 2 he had not seen a physician for approximately one year and had not taken medications for two months. He reported multiple falls during the prior week, including one on 4/20/26 in which he remained on the floor until morning. He lived alone with minimal family support, and his baseline cognitive impairment had worsened. Imaging and blood work showed no acute abnormalities. Therapy evaluations beginning 4/21/26 documented confusion, disorientation, impaired processing time, and the need for contact-guard assistance and full assistance for transfers. Therapy recommended skilled nursing placement. It included recommendations for skilled nursing care, skilled therapy services, and a referral to neurology for his cognitive deficits. Resident #1 was admitted to the facility on 4/25/26 at 12:41 p.m. with diagnoses including dementia, altered mental status, recurrent falls, and right lower extremity weakness and pain. Review of physician orders revealed Resident #1 was not prescribed a blood thinner. Nurse #2's Admission Observation on 4/25/26 at 4:11 p.m. documented Resident #1 required moderate assistance with transfers, bed mobility, and activities of daily living. He had intermittent incontinence, groin redness, and right lower extremity weakness. Resident #1 was alert and oriented but intermittently confused. The elopement risk screening question asking if the resident was identified for risk(s) for elopement was not selected. An additional elopement risk screening question asked if the resident had any elopement risk factors. The risk factors included whether the resident was ambulatory, moved about independently in a wheelchair, had a history of attempted or actual elopement or unsafe wandering, exhibited exit seeking behavior, resident verbalized "wanting to go home", "go on a trip", or "going to meet someone", resident wandered in and out of rooms and rummages in other's belongings, not accepting of present residency situation/location, or had an acute change in cognition. Nurse #2 documented that none of the risk factors listed were exhibited at that time. During a telephone interview on 5/8/26 at 9:33 a.m. with Nurse #2, she reported that she admitted Resident #1 on 4/25/26 around 1:00 p.m. She stated Resident #1 arrived via ambulance stretcher and transferred to the bed with one-person assistance. Nurse #2 described him as pleasant, conversational, mildly confused, and easily redirected, with no exit-seeking behavior. She reported Resident #1	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 3 ambulated short distances with assistance and verbal cues. Nurse #2 indicated she completed his admission assessment and informed Nurse #1 at shift change at 7:00 p.m. that Resident #1 was confused but did not exhibit elopement risks which were listed in the Admission Observation. Nurse #2 explained when Resident #1 arrived on 4/25/26, he was pleasantly confused and family did not accompany him and had previously not provided any historical details for Resident #1. Nurse #2 had reviewed the 4/25/26 hospital discharge summary for his medical history, and it did not indicate he wandered or was exit seeking during his hospitalization. Nurse #2 reported she did not see him wander during her shift on 4/25/26, she reported he was admitted to their rehabilitation unit, 300 Hall, and had not observed him hanging around the door at the end of the 300 Hall. Nurse #2 reported that on 4/25/26 between 1:00 p.m. and the end of her shift at 7:00 p.m. Resident #1 did not interact with the other residents after her assessment was completed. Nurse #2 reported she allowed him time to settle in the room before she oriented him to the set-up of the facility, location of his bathroom, lights, explained the call bell, and told him when and how to call for help. Nurse #2 reported that Resident #1 talked a little with her during the assessment and ate dinner in his room. She reported that he needed verbal cues and his meal tray set up and he ate dinner independently. Nurse #2 reported Resident #1 spoke clearly and communicated his needs, and she provided stand by assist and verbal cues for his proper body mechanics and foot positioning as he stood and used a walker to go into the bathroom at the completion of the lengthy admission assessment. The baseline care plan initiated on 4/25/26 included safety monitoring. The Safety Monitoring portion of the care plan included approaches for fall prevention, toileting assistance, pain management, and therapy services. The fall prevention interventions included assisting Resident #1 with transfers as needed, keeping items within reach, and minimizing potential risk factors related to falls and injury. During a telephone interview on 5/7/26 at 4:56 p.m., Nurse #1 stated she received nurse-to-nurse shift report at 7:00 p.m. on 4/25/26 indicating that Resident #1 was confused. She stated that Nurse Aide (NA) #1 brought Resident #1 to the nurse's station in a wheelchair between approximately 11:00 p.m. and 12:00 a.m. for monitoring by she and the other staff entering notes and tasks completed at the desk. Nurse #1 reported the nurse's station is on	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 4 the corner of the 200 and 300 Halls so if Nurse #1 or NA #1 or NA #3 were responding to a call light down or completing a task, Resident #1 could still be observed and in their direct view. Nurse #1 reported that Resident #1 became increasingly confused during her 7:00 p.m. to 7:00 a.m. shift as the evening progressed into midnight. She reported that Resident #1 got out of bed multiple times and wandered in a wheelchair up and down the 300 Hall hallway and was observed at the exit door looking out the window. She reported that NA #1 and NA #3 redirected Resident #1 and that he remained cooperative and easily redirected. She also reported that she completed walking rounds at the top of the hour, approximately every hour (e.g., 7:00, 8:00, 9:00, etc.). Nurse #1 reported that she observed NA #1 and NA #3 take Resident #1 back to his room around 1:30 a.m. Nurse #1 stated she last saw Resident #1 lying in bed awake at approximately 4:00 a.m. during her hourly round and did not observe him getting out of bed. When NA #1 informed her around 4:30 a.m. that Resident #1 was missing, she initiated Code Green. A Code Green was the facility's emergency protocol announcing that a resident was missing. The facility's Elopement/Missing Person policy stated that once staff determined a resident was missing, they were to conduct a room-by-room search and complete a head count of all residents on all units. If the resident remained missing after these steps, staff were to announce a Code Green which required a message to be broadcasted across the facility that included the resident's name, room number, and location in the building (e.g., 100 Hall, 200 Hall, 300 Hall). Nurse #1 reported that she and NA #1 began searching the 300 Hall, going room by room and taking a head count of all residents as they proceeded. After completing the search of the 300 Hall, she moved to the Dining Room and then to the 200 Hall. She stated that NA #1 informed her that staff outside had called 911 after hearing someone yelling for help. Nurse #1 recalled that NA #2 and NA #3 found Resident #1 outside around 5:00 a.m. She instructed NA #1 to continue checking to account for all residents. Nurse #1 indicated she exited the facility through the 200 Hall door and approached NA #2, NA #3, and Resident #1. She recalled that Resident #1 was seated on the dirt leading up to the edge of the paved parking lot with his back against the curb. She assessed him at the curbside, where he sat wearing only an adult incontinence brief, and she observed an abrasion on his right hand. Resident #1 told her he had fallen but did not know how he got out. Nurse #1 reported EMS arrived while she was exiting the building to assess Resident #1. Nurse #1reported the EMS and she were assessing	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 5 Resident #1's condition at the same time. She stated she instructed EMS to transport him to the hospital due to a possible head injury. Nurse #1 reported she had not unplugged the power cord to the 300 Hall door lock and alarm and did not hear a door alarm. She stated that after ambulance personnel transported Resident #1, staff returned inside and checked the building to determine how Resident #1 had exited, as all doors were closed. She reported the 300 Hall door power cord was observed unplugged from the electrical outlet which disabled the door lock and alarm when unplugged. Nurse #1 reported staff plugged it back in. Nurse #1 stated she did not observe Resident #1 unplug the power cord for the door lock and alarm and that she had not unplugged it that night or at any time in the past. She recalled there was a sign above the outlet stating "do not unplug" and stated she had never seen staff unplug the cord. After observing the 300 Hall power cord unplugged, she reported that staff assumed Resident #1 likely unplugged it and then exited through the 300 Hall door because he had been observed earlier in a wheelchair at the door and window. Nurse #1 recalled seeing an empty wheelchair in the 300 Hall hallway during her last round at 4:00 a.m. but could not recall the exact location. She recalled Resident #1's room was a few doors down from the 300 Hall entry/exit door. She did not recall finding any other items outside near him and stated she was unsure how he ambulated up the sloped parking lot past the dumpsters. During a telephone interview on 5/7/26 at 4:35 p.m. with NA #1, she reported that her shift on 4/25/26 began at 11:00 p.m. and ended on 4/26/26 at 7:30 a.m. NA #1 reported she was assigned to multiple residents on the 300 Hall, which was the rehabilitation unit. She stated the rehabilitation unit had a quick turnover of residents because many stayed only short term for therapy before returning home, so she was not familiar with all the residents on the unit. NA #1 reported she was assigned to provide nurse aide care for Resident #1. NA #1 reported she normally completed hourly rounds opposite the nurse on the unit. NA #1 stated that her Charge Nurse, Nurse #1, informed her that Resident #1 was confused during the evening hours of 4/25/26. NA #1 reported that NA #3 worked with her on the unit and was assigned to the other residents on the 300 Hall and some residents on the 200 Hall. She stated that NA #3 assisted her with caring for residents who required two-person assistance and those who needed close observation or redirection. NA #1 reported that Resident #1 got out of bed and into a wheelchair around 11:00 p.m. and was observed sitting in a wheelchair at the end of the	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 6 300 Hall and watched out the window by the door. NA #1 redirected Resident #1 and put him back to bed. NA #1 stated that NA #3 assisted her with redirecting Resident #1 when he again wandered into the hall from his room shortly after she put him back to bed. NA #1 reported that around 12:00 a.m. Resident #1 got out of bed again, so she assisted Resident #1 into a wheelchair and brought him to the nurse's station for close observation. She stated that she worked with Nurse #1 and NA #3 to monitor Resident #1 closely due to his confusion and repeatedly getting out of bed and wandering. Nurse #1 advised NA #1 that Resident #1 said he wanted to go to bed around 1:30 a.m. and NA #3 assisted him back to bed because she was with another resident. NA #1 reported she left the unit only once during the shift, at approximately 3:45 a.m., to use the bathroom, and afterward went into the nourishment room to prepare her cups and supplies for the final round of the shift. She stated that between 4:00 a.m. and 4:30 a.m. she discovered Resident #1 was no longer in bed. NA #1 reported she did not recall hearing a door alarm. She stated she immediately searched the nurse's station, bathroom, and desk area on the 300 Hall, did not find Resident #1, and notified Nurse #1 at approximately 4:30 a.m., which triggered the facility's elopement procedures. NA #1 began to assist Nurse #1 with a complete head count of all residents in the facility, going room by room. NA #1 reported she did not recall seeing Resident #1 attempt to unplug the cord by the door, open the door, or exit the door at the end of the 300 Hall during her shift. She also reported she did not recall observing any staff unplug the door and denied unplugging the door herself to disable the lock and use it for exit or entry. During a telephone interview with NA #3 on 5/7/26 at 11:00 a.m., she reported on the night shift of 4/25/26 (from 11:00 p.m. on 4/25/26 until 7:00 a.m. on 4/26/26) Resident #1 had been monitored closely at the nurses station by her and his assigned NA (NA #1) through the evening and night because he became more confused and was wandering in the 300 Hall in a wheelchair and went to the window by the 300 hall door. NA #3 reported she did not recall observing Resident #1 unplug the 300 Hall door power cord. NA #3 indicated she did not recall seeing Resident #1 ambulate up or down the hallway and observed Resident #1 use a wheelchair for moving around the unit. NA #3 reported she assisted Resident #1 back to bed between 1:30 a.m. and 2:00 a.m. and he was easily redirected; this was the last time she observed Resident #1. NA #3 reported Resident #1 was confused at the beginning of the shift and was more confused as the night went on.	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 7 NA #3 reported she thought he had sundowning (a state of confusion that occurs in the late afternoon and lasts into the night and can cause wandering, ignoring directions, or various behaviors) because he talked normally at the start of her shift but was more confused and wandered more as the night went on. She recalled Code Green was paged overhead around 5:00 a.m. while she was on the 100 Hall charting care she provided to her assigned residents. NA #3 stated NA #2 approached her and asked for the facility's address because she heard someone yelling for help outside in the parking lot and was talking to 911. After the call, NA #3 accompanied NA #2 outside to identify who needed help and wait for EMS. They found Resident #1 between the parking lot and the white building beside the facility. NA #3 stated she initially did not think he was a resident but, upon seeing he was wearing only an adult brief with a hospital gown on the ground beside him, she had NA #2 go back inside the facility and notify Nurse #1. She reported she then called 911 to inform them it was a resident of the facility. NA #3 waited with the resident and police arrived shortly after. NA #3 reported Nurse #1 and the ambulance arrived soon after the police. NA #3 indicated the parking lot was dark and dimly lit along the side towards the white building next door, but light from the police car lit up the area well. NA #3 reported it surprised her that Resident #1 was able to ambulate past the 2 large dumpsters and up the parking lot in the dark. NA #1 stated the event happened so quickly, but she thought the ambulance took Resident #1 away soon after she and NA #2 found him. NA #3 recalled Resident #1 appeared calm when Nurse #1 assessed him and asked him questions. NA #3 reported she went back inside through the staff entrance door by the 200 Hall and began looking around to determine how Resident #1 was able to exit. She recalled staff observed the 300 Hall door's alarm and power cord unplugged from the outlet but does not recall if she, Nurse #1, or NA #2 were first to observe that. NA #3 denied unplugging the power cord for the door lock and alarm. NA #3 reported she always had someone waiting at the 300 Hall door to let her back in when taking out trash to the dumpsters near the 300 Hall door at the edge of the parking lot. During a telephone interview on 5/8/26 at 9:18 a.m. with NA #2, she reported on the night shift on 4/25/26 she worked on the 100 Hall on the opposite side of the facility. She recalled she exited the building at the staff entrance outside the Dining Room and 200 Hall and went to her vehicle in the parking lot around 4:30 to 4:45 a.m. for supplies. NA #2 reported she unlocked her car to get out her	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 8 supplies and heard a man yell for help from the other side of the parking lot. She reported she could not see the man because it was dark outside and the area past the parking lot and down the embankment where the man called out from not lit. NA #2 stated she was afraid to approach because the area felt unsafe because of recurrent criminal activity in that area of the city. NA #2 stated she could not stop thinking about it as she went back to the employee entrance and decided to call 911 to report it. She called 911 around 5:00 a.m. as she returned inside, she told NA #3 what she heard, and both then went outside. NA #3 recognized the individual as a facility resident. NA #2 reported she was not sure how NA #3 knew it was a resident so quickly. NA #2 stated Resident #1 was sitting in gravel near the parking lot curb wearing only an adult incontinence brief and possibly one gripper sock, with his gown on the ground beside him. NA #2 did not observe a wheelchair near the resident. NA #2 reported Resident #1 calmly stated he fell and needed help getting up. She reported that NA #3 sent her inside to retrieve Nurse #1 while NA #3 remained with Resident #1 until EMS arrived. NA #2 did not recall hearing a door alarm. NA #2 indicated she entered and exited through the staff entrance door on the 200 Hall by the dining room when she retrieved Nurse #1 to assess Resident #1. She reported the location they found Resident #1 was on the side of the parking lot that was outside of the 300 Hall door, past the dumpsters at the edge of the parking lot. NA #2 denied that she unplugged the 300 Hall door power cord to exit or enter the facility through there. During a follow-up observational interview with NA #3 on 5/7/26 at 2:45 p.m. she pointed to the curb where she and NA #2 found Resident #1 sitting up with his back against the curb of the parking lot on 4/26/26 around 5:00 a.m. The location was approximately 100 feet from the 300-hall door exit. She reported that shortly after 5:00 a.m., while she was charting at the nurse's station on the 100-Hall, NA #2 approached her asking for the facility's address for a 911 call because she heard someone yelling for help outside and was afraid to check alone. NA #3 stated Resident #1 was new to the facility and staff were not yet familiar with him. NA #3 went over to the side of the parking lot and pointed to the area where she found him sitting. NA #3 described finding Resident #1 sitting upright with his back against the curb in an area covered with several jagged stones and dirt sloping downward from the parking lot. Resident #1's hospital gown was on the ground next to him, and he was wearing only an adult brief. A wheelchair was not observed	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 9 outside or in the vicinity of where Resident #1 was found. She reported he was calm and spoke clearly. She stated the police arrived first, followed shortly after by Nurse #1, and the ambulance arrived within minutes and transported him to the emergency department. NA #3 reported the events happened quickly and she was doing her best to accurately recall the details. NA #3 recalled she had observed Resident #1 in a wheelchair by the 300 Hall door but had not observed Resident #1 walking around or standing by the door, unplugging the door power cord, or saying he wanted to leave. NA #3 reported Resident #1 was confused all night, was calm and pleasant, and was oriented only to his name. She reported some details were difficult to recall because her attention was focused on Resident #1 being outside in only his brief sitting on the stones and she was concerned he may have been seriously injured because of where they found him on the bank because there was also broken glass and the location was close to a street that was busy during the day time hours. She reported the ambulance arrived as Nurse #1 began assessing Resident #1. NA #3 recalled police asked her how Resident #1 was able to leave the facility and she told him she did not know because all the doors were locked. NA #3 stated on the night of the elopement she observed other staff using the main rear entry door and walking by the window by 300 Hall door where Resident #1 sat and looked outside. The occurred during the first part of the night shift (11:00 p.m. and 2:00 a.m.). NA #3 indicated she used entrance doors by the Dining Room on the 200 Hall to enter and exit during the incident. NA #3 reported once she, NA #2 and Nurse #1 went back inside and began to look for where Resident #1 exited the facility and one of them saw the 300 Hall door and alarm cord unplugged. Nurse #1's nursing note on 4/26/26 at 4:30 a.m. documented Resident #1 was found sitting on ground outside, Emergency Medical Services (EMS) was notified and took resident to emergency room as she was unsure if he had an injury or how resident got out of the building. Nurse #1 documented she attempted to notify family and no one answered. The Director of Nursing (DON) was notified of event. Review of the 911 Communications Log for 4/26/26 indicated the first call from NA #2 was received at 5:03 a.m. with reports of an unknown person in the back parking lot of the facility calling out for help and was reported to be in immediate danger, and 911 caller (NA #2) did not know where the unknown person came from. The 911 log further indicated the	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 10 report was coded as a “suspicious person” and the police department were dispatched at that time, 5:03 a.m. The 911 communications log revealed a second call from NA #3 came in at 5:05 a.m. and NA #3 stated the person calling out for help was a resident of the facility. The 911 call log indicated the police arrived at the facility’s back parking lot at 5:05 a.m. The log was updated at 5:11 a.m. to state an officer requested emergency medical services for an elderly male who they located out back of the facility in the wet grass, who was naked wearing only an adult incontinence brief, hospital gripper socks, and a medical bracelet from the facility. The 911 log indicated EMS were dispatched at 5:12 a.m. The 911 log further stated the callers who were employees of the facility came out and provided information on the resident, stated Resident #1 eloped from the facility and may have fallen outside. The callers reported they did not initially know the man calling out for help was theirs. The report also indicated employees stated they did not know how Resident #1 exited the building because all doors were locked. The Emergency Medical Services (EMS) dispatch report for 4/26/26 showed EMS were dispatched at 5:12 a.m. and arrived at the facility at 5:23 a.m. EMS documented no head, neck, chest, back, pelvic, or extremity abnormalities, and noted minor scratches. His vital signs and neurological assessment were normal. Resident #1 denied any injury or pain. He was alert but disoriented to time and place and believed he was in another city. He was oriented to person and what was happening and able to answer questions about himself and reported that he had fallen. He could not provide further details of his fall. Resident #1 reported no pain or injuries. EMS documented a primary impression of dementia, with no physical abnormalities. The resident was transported non emergently at 5:36 a.m.to the local hospital. No lights and sirens were used during transport. Upon arrival at the hospital, the final vital signs were all within normal ranges. Resident #1 had a pain level was 0 out of 10 (zero meaning no pain), blood pressure of 110/60 (normal is between 100/60 and 140/90), hear rate of 84 beats per minute (normal is between 60 and 100 beats per minute), he was alert, his condition remained unchanged. The Emergency Department (ED) records revealed on 4/26/26 EMS reported that Resident #1 had a fall and needed evaluation. Resident #1 was alert and oriented to self only and unable to provide details of the fall reported by EMS. Vital signs were within normal ranges with a blood pressure of 119/60, heart rate of 88 beats per minute, 16 breaths per	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 11 minute (normal is between 12 and 20 breaths per minute), and no pain. Imaging of the head, spine, and chest were completed without acute findings. Laboratory studies were normal. A contusion (an injury to the tissues that does not break the skin and can cause bruising or discoloration) to the right hand was treated with cleansing and topical antibiotic ointment. He was discharged back to the facility 4/26/26 with diagnoses of fall, contusion to right hand, and dementia. There were no new medication or treatment orders. Resident #1 was to follow up with primary care in 3 days, around 4/29/26. During an observational interview on 5/7/26 at 11:45 a.m. with the facility's Regional Clinical Nurse Consultant, it was determined that the facility had a rolling measuring tape that was available to measure how far from the 300 Hall door exit that Resident #1 was found on 4/26/26. When communicating that a review of information from the telephone interview with NA #3 and report from the DON about location where Resident #1 was found, the Regional Clinical Nurse Consultant advised she requested the DON call NA #3 and ask NA #3 to report to the facility and physically demonstrate where she found the resident and provide further details from when she and NA #2 identified that he was one of the facility residents. On 5/7/26 at 6:00 a.m. an observation of the facility's rear parking lot revealed a sloped dark and dimly lit black-top paved parking lot that had an approximately 12-inch blacktop paved curb around the perimeter. There were large trees with heavy amounts of green foliage which made visibility difficult in the pre-dawn hour darkness of 5/7/26. The parking lot faced a 4-lane street which had two-way traffic with a posted speed limit of 35 miles per hour. The was a light on at the end of the facility building outside the 300 Hall door and at the other door designated as staff entrance. There was outdoor lighting that illuminated the sidewalk that went around the perimeter of the building and led to two large metal dumpsters located approximately 25 feet from the exit door at the bottom corner of the parking lot and the grassy lawn located adjacent to the 300 Hall. During a follow up observational interview with DON on 5/7/26 at 2:43 p.m. she stated her investigation and interviews led her to believe Resident #1 was found outside the door at the end of the sloped parking lot between the 300 hall exit and where the 2 dumpsters were located. The DON pointed to where she believed Resident #1 was found after the	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 12 investigation was complete. The location was approximately 25 feet from the 300 Hall exit. The parking lot's perimeter had a black-top curb with jagged drainage stones on the unpaved side that were 2 to 4 inches in size. The stones sat atop dirt from the edge of the curb and down an approximately 8-foot sloped embankment. The first 50 feet of the embankment edge of the parking lot after the two dumpsters on the bottom corner led to a grassy lawn. The next 50 feet of the curb and embankment led to a paved parking lot behind a multiple unit residential building next door. The location where Resident #1 was found was measured by the state surveyor and the Regional Clinical Nurse Consultant and measured approximately 200 feet from the main street which had 4 lanes for traffic with a posted speed limit of 35 miles per hour. Review of the Weather Underground website recorded weather conditions for the facility's location on 4/26/26 between 4:00 a.m. and 5:35 a.m. indicated the temperature was 60 degrees Fahrenheit, and a light drizzle or rain, with wind gusts at 5 miles per hour. Review of Resident #1's record included a telephone order from Nurse Practitioner #1 dated 4/26/26 at 3:30 p.m. signed by the Director of Nursing for 1:1 observation and to initiate/apply wander guard. Review of Nurse #2's progress note dated 4/26/26 at 3:44 p.m. indicated Resident #1 returned to the facility and his family was present. Nurse #2 completed a full skin assessment, confirmed the right-hand contusion, applied a wander-guard device, and initiated 1:1 observation. It further stated she moved him to a room closer to the nurse's station for enhanced supervision. In the interview with Nurse #2 on 5/8/26 at 9:18 a.m., Nurse #2 reported when Resident #1 returned to the facility on 4/26/26 from the ED she moved him to a room on the 200 Hall which was closer to the nurse's station. She reported there was an order for 1:1 observation by staff and initiation of wander guard alarm. Nurse #2 reported that a wander alarm bracelet was applied to his ankle and staff were assigned for close 1:1 observation of Resident #1. She stated they sat in a chair in his room close to him. Nurse #2 reported 1:1 observation of Resident #1 continued for the remainder of her shift when she reported off to Nurse #1 when her shift ended at 7:00 p.m. on 4/26/26. In an interview on 5/7/26 at 9:45 a.m. with the	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 13 Maintenance Director, the Maintenance Director reported approximately 10 months prior he reported to the previous Administrator that the 300 Hall door, located at the rear of the building, posed security concerns. He reported that the timed lock setting allowed extended periods of time each day/night when the door was unlocked. He reported the door was used by staff to take out trash, and anyone could enter/exit to the rear of the building when it was unlocked. A timed lock setting allowed a locked door to automatically unlock and remain unlocked during programmed periods of time during the 24-hour day. The Maintenance Director stated that the 300 Hall door was programmed by the prior Maintenance Director to automatically unlock one hour before and after each shift change for the day. Facility shifts were 7:00 a.m. to 7:00 p.m., 7:00 p.m. to 7:00 a.m., 7: 00 a.m. to 3:30 p.m., 3:30 p.m. to 12:00 a.m., and 12:00 a.m. 8:00 a.m. The Maintenance Director discontinued staff use of the 300 Hall door as a means of entry/exit after determining it was unsafe. The Maintenance Director could not recall the date staff were instructed to use the 200 hall Staff entrance door by the dining room to take out the trash and were told they could not go in and out of the 300 Hall door unless it was used for emergency exit. The Maintenance Director reported that he removed the programmed feature for a timed unlock several months prior to the 4/26/26 elopement incident in February 2026. He could not recall the date that he posted signs above the electrical outlet on the wall instructing staff not to unplug the alarm power cord. The Maintenance Director could not recall the date he installed the signage and staff were instructed not to use the 300 Hall door for enter/exit. The Maintenance Director explained that unplugging the door alarm power cord disabled both the lock and wander-alarm system and would allow any person to come and go through the door without triggering an audible alarm. The Maintenance Director explained there were six entry/exit doors and only two, the dining room and 300 Hall doors, required an outlet for power cord to power and operate the door lock and alarm. He had ordered outlet covers two months earlier. He reported around 2 weeks prior to the 4/26/26 incident he applied one cover to the dining hall door that had the same power cord plugin-to-outlet set-up, but the 300 Hall door outlet cover required a custom modification due to the door frame design. The door frame was located within an inch of the electrical outlet, so the cover needed to be modified to fit into the space. The Maintenance Director reported he had not applied the cover to the outlet for power cord on the 300 Hall before the elopement incident because he had other operational	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 14 maintenance needs that required his urgent attention and he had not previously observed the power cord unplugged on the 300 Hall. The Maintenance Director stated he had the safety systems contractor come on 2/16/26 to obtain the security code to the 300 Hall door lock and alarm because the prior Maintenance Director had changed the security code and could not recall what it was. He explained the security code was an access code that allowed a person to enter the code and temporarily turn off the door lock and alarm. The Maintenance Director reported that after the contractor completed their work, the Maintenance Director changed the 300 Hall door so that it was always locked and alarmed and it could not be bypassed by entering a code. The Maintenance Director stated he was approved around the beginning of March 2026 by regional office to obtain a cost estimate for replacing the door lock and alarm system with one that was directly wired inside the wall behind where it would be mounted and would have no exposed power cord or plugin. The Maintenance Director reported the contractor offered their first available appointment for a facility wide entry/exit door replacement workload and cost estimate. The contractor came to the facility on 4/20/26 to complete an inspection of the current set-up and identify what was needed to make the 300 Hall and Dining Room doors direct-wired like the 4 other entry/exit doors and provided him with an email copy of the work required and cost estimate. He reported the Administrator notified him 4/26/26 between 9:00 and 10:00 a.m. about the elopement. The Maintenance Director stated he resided close to the facility and reported to work immediately after the phone call. The Maintenance Director reported that the Administrator told him Resident #1 exited through the 300 Hall door, but the staff did not witness it. The Maintenance Director reported that the power cord for the 300 Hall door lock and alarm was plugged into the wall outlet when he arrived around 11:00 a.m. The Maintenance Director reported the security cameras were not operational for recording data and are only able to show live feed images and the Administrator was working on resolving that issue. When he was asked about door security and safety audits for the 300 Hall door to make sure they were functioning prior to 4/26/26, he recalled they were completed during the annual facility assessment. During a telephone interview on 5/8/26 at 9:00 a.m. with the Contractor who specialized in safety systems which included door alarms, door locks, all wander guard alarm systems, and handicap buttons for automated door open/closure. He explained that the 300 Hall door used an electrical cord and	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 15 transponder (plug part of an electrical cord) plugged in to an electrical outlet on the wall to power its alarm and lock mechanisms. He stated unplugging it disabled both systems. He reported his company was contacted by the facility to obtain an override code for the door lock and alarm system so the facility could reprogram the door and limit access to enter/exit it at preprogrammed times. He reported they scheduled the visit for 2/26/26 and provided the report on the same day 2/26/26 to the Maintenance Director. The Contractor could not confirm the date he was contacted by the facility but reported the average wait time for service call appointments was 3 to 5 weeks. In an interview on 5/7/26 with the Director of Nursing (DON), she reported Resident #1 was admitted on 4/25/26 and discovered missing around 4:30 a.m. on 4/26/26. The DON stated she was notified at 5:00 a.m. during Code Green. She stated nursing's standard practice was that interventions began with frequent rounding unless the resident had a previous elopement, which there was no report of in his discharge summary reviewed for admission to the facility. She reported Resident #1 displayed high-risk behaviors overnight, including repeatedly approaching the 300 Hall exit door. The DON stated the nurse should have contacted her to report the wandering risks so the staff or she could apply a wander guard device. The DON reported the wander guards were secured in her locked office, but she has an extra key that she would instruct the charge nurse to use in her absence to access the wander guards. The DON reported staff can also ask the Charge Nurse for a wander guard and the Charge Nurse can assess the need and obtain the wander guard order and apply it to the resident. She stated she learned EMS transported the resident to the hospital due to concerns for head injury. The DON reported she was very concerned about the harm that could have come to Resident #1 being outside unattended in the dark of night. The DON reported she was aware the 300 Hall door lock and alarm cord was plugged into the wall outlet for the past several years. The DON reported staff were allowed access to the 300 Hall door during specific times of the day and night until changes were made by the new Maintenance Director several months prior. The DON reported there were no prior reported issues with staff or residents unplugging the cord that powered the 300 Hall door lock and alarm. The DON reported she worked with the Administrator to complete an investigation. She reported she took staff's statements and typed them up and had the witnesses review the statements for accuracy before signing them. The DON reviewed the staff's	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 16 statements in the binder and indicated there were no observations of Resident #1 touching the power cord for the 300 Hall door lock and alarm. The DON reported they were unable to determine who had unplugged the cord. The DON reported the facility cameras could not record so there was no video evidence. The DON reported none of the staff working 4/25/26 and 4/26/26 acknowledged that they unplugged the 300 Hall door cord. During a telephone interview on 5/8/26 at 9:10 a.m. with the Medical Director, he reported that he was informed by Administrator that Resident #1 was able to unplug the door lock and alarm power cord, and that surprised him. The Medical Director reported that a nurse notified him of the incident on 4/26/26 around 6:00 a.m. and he was updated later in the day on 4/26/26 by the Administrator with what observations were made by staff, location where resident was found, and details of interviews and investigation efforts. He described the incident as rare and reported that he believed the facility corrected the issue. When asked if he felt Resident #1 knew that unplugging the cord would allow him to exit through the door, the Medical Director replied that he had not met Resident #1 and could not speak to his cognitive level. He declined to offer an opinion on what kind of injuries could happen when a resident exits the facility unsupervised and stated residents should be supervised when outside the facility. In an interview on 5/7/26 at 9:00 a.m. with the Administrator, she reported that she was notified of Resident #1's elopement incident around 6:00 a.m. on 4/26/26 and immediately came in to begin the investigation. She confirmed the 300 Hall door lock and alarm power cord was plugged into an outlet that was not secure and allowed easy access and called the Maintenance Director around 9:30 a.m. to come in and secure the outlet. When the Maintenance Director arrived around 11:00 a.m. she directed him to replace the cover with the screw-secured version he had purchased. The Administrator reported she started at the facility in October 2025 and became aware sometime between November 2025 and end of December 2025 that the 300 Hall door was not secure and allowed entry/exit access during set periods of time throughout the day and night. The Administrator reported that she approved the Maintenance Director to coordinate with the Contractor to obtain the code. She reported that the Contractor came on 2/16/26 to obtain the code to the keypad at that door to restrict access. The Administrator reported that the regional office approved in March 2026 the facility's request to	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 17 obtain a cost estimate from the same contractor to replace the lock and alarm system on the two doors that required an outlet so the lock and alarm power cord could be plugged in. She reported the Contractor came out and provided the quote to the Maintenance Director. The Administrator reported that she authorized the Maintenance Director to order the tamper-proof outlet covers in February 2026. The Administrator was unaware Resident #1 had repeatedly gone to the door overnight. She stated his dementia and new-environment curiosity may have contributed to his elopement. She stated the unsecured plug was the primary factor in Resident #1's elopement. In a follow-up interview with the Administrator on 5/7/26 at 5:17 p.m., she stated closer supervision at the nurse's station and securing the plug earlier may have prevented the incident. The Administrator was asked if she was aware that the Maintenance Director reported he had not applied the covers before the elopement incident because he had other operational maintenance needs that required his urgent attention and he had not previously observed the power cord unplugged. The Administrator acknowledged she was aware and that the facility had several power surges and outages and needed his urgent attention. She reported there was some major electrical work needed which required the replacement of the facility's emergency power generator. The Administrator reported the power outages and electrical issues caused the camera surveillance system to go down and that destroyed the hard drive. The Administrator was notified of immediate jeopardy on 5/8/26 at 1:34 p.m. The facility provided the following corrective action plan for immediate jeopardy removal. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was admitted to the facility on 4/25/26 at 12:41 PM from a local hospital for recurrent falls and acute altered mental status. Resident #1, who was able to ambulate but used a wheelchair for locomotion due to unsteady gait, presented with periods of confusion but no exit seeking behaviors based on observation upon admission. Family was not available upon admission to provide additional information. The Admitting Nurse completed the admission observation which is a comprehensive assessment that includes items such as: fall risk,	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 18 Braden scale, self-administration of medication, continence, and elopement risk assessment. The elopement risk assessment is an ongoing assessment over a period of time with the initial portion of the assessment consisting of a series of questions related to the resident such as: Is the resident ambulatory or independent in wheelchair locomotion; Does the resident verbalize wanting to go home; Does resident wander without sense of purpose; Does resident wander in and out of other residents rooms; Does resident make statements questioning the need to be here; Does resident exhibit exit-seeking behaviors? The only question triggering for Resident #1 in the original elopement risk assessment was current acute change/confusion. This initial portion of his admission observation was completed within the first hour of his stay. The Admitting Nurse implemented frequent rounding by the Nursing assistant (NA) assigned to Resident #1 at a minimum of every one hour due to resident confusion. Resident #1 was observed by NA #1 to be going up and down the hallway via wheelchair during care rounds, but Resident #1 was not displaying exit seeking behaviors. No additional staff reported exit seeking behaviors for Resident #1. Resident #1 was last observed in his bed around 4:00 AM by NA #1. When NA #1 started her care rounds around 4:30 AM, NA #1 went by Resident #1's room and noticed he was not in his bed. NA #1 immediately checked the nurses' station because that is the central area of the unit giving full visibility of the entire unit and identified that Resident #1 was not there. NA #1 reported resident missing to Nurse #1 at approximately 4:30 AM. Nurse #1 followed facility elopement/missing person policy, and staff began conducting a head count at approximately 4:30 AM. Nurse #1 called a code "green," simultaneously as the staff were searching the two units. Code green is the code for an elopement/missing person and involves physical checks of all areas unsecured and secured. If the resident is not located indoors, the search continues outdoors. Around 4:50 AM, NA #2 heard someone yelling out while coming inside from her break in the back parking lot. NA #2 was not aware that a code green was in process due to being on break in her car at the time the code green was called. NA #2 could not see who was yelling in the parking lot due to it being dark and her apprehension to investigate alone. NA #2 then elected to call 911. NA #2 went into the building while on the phone with 911 to get	F0689		04/28/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Health & Rehab Center	**610 West Fisher Street , Salisbury, North Carolina, 28145**

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F0689 SS = SQC-J	Continued from page 19 the facility's address, as requested by dispatch, and she did not have it committed to memory. When NA #2 entered the building, she was informed by NA #3 that a code green was in process. Both NA #2 and NA #3 went outside to discover Resident #1 sitting on the curb of the pavement in the back parking lot approximately 100 feet from the exit door. NA #2 stayed with Resident #1 and NA #3 went to notify Nurse #2. Nurse #2 completed an assessment of Resident #1 was found to only have an abrasion to right hand. Resident #1 did not indicate why he went outside. Emergency medical services arrived around 5:15 AM and transported Resident #1 to the hospital for treatment and evaluation. Upon returning inside after Resident #1 had been sent to the hospital, Nurse #1 conducted a walkthrough of the hall to determine the root cause of how Resident #1 was able to exit the building without staff being aware. While doing her walkthrough, Nurse #1 observed the door security system on the exit door of 300 hall had been disconnected from the power source, therefore disabling it. Nurse #1 immediately enabled door security system by reconnecting the system to the power source, and appropriate interventions were put into place. The interventions included: Nurse #1 repowering the door alarm security system, the exit door being continuously monitored by Nurse #1 until the Director of Nursing arrived at the building, and the Maintenance Director installing a secure tamper-proof device to prevent the alarm system from being disabled. The Administrator and Director of Nursing were then contacted by phone and made aware of the incident. When the Director of Nursing arrived, she relieved Nurse #1 from monitoring the door on the 300 hall and she monitored the exit door until the Maintenance Director arrived and put into place a safeguard on the door. The Maintenance Director placed the tamper-proof secure device to prevent the door alarm system and magnetic lock from being disabled. On 4/26/26, Nurse #1 and the Director of Nursing both made attempts via telephone to contact Resident #1's responsible party but were unsuccessful at 6:01AM and 8:14 AM. The Director of Nursing was able to successfully contact the resident's responsible party via telephone at 11:14 AM. The Resident's Primary Care Physician and the Medical Director were made aware of the incident at 6:01AM. Resident #1 returned to facility from the hospital,	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 20 which determined there were no additional injuries beyond the abrasion to the right hand, on 4/26/26 at 3:26 PM via Emergency Medical Services. Resident #1 was reassessed for elopement upon return by the Admitting Nurse, 1:1 was initiated and wander guard transmitter was placed on Resident #1 right ankle. A room change was conducted for Resident #1 to be closer to the nurse's station for increased observation. These interventions remained in place for the duration of his stay. Resident #1 did not have any additional wandering incidents for the remainder of his stay. Resident #1's care plan was reviewed the Admitting Nurse and updated to include new elopement interventions. Resident #1 was added to the elopement binder located at each nurse's station and reception desk. There is no video footage of the incident. Resident #1 was transferred to the hospital on 4/27/2026 for an unrelated condition and did not return to the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The head count did not identify any other residents missing. On 4/26/26 the Assistant Director of Nursing reviewed elopement risk assessments for all residents to ensure accuracy and confirm appropriate interventions were in place. Five total residents, excluding Resident #1, were previously indicated as elopement risks. No additional residents were identified. Previously identified residents had wander guard transmitters in place. New elopement risk assessments were conducted for all residents. On 4/26/26 the Director of Nursing reviewed and checked the placement, function, and expiration date of all residents with wander guard transmitters. No issues were identified. In addition, resident elopement books, which are binders indicating residents that are High Risk for Elopement located at the reception desk and nurses' stations, were verified to have been in place and updated appropriately. During educational sessions, staff were also asked to identify any additional residents that they believe could be an elopement risk, and if they would identify any additional residents in the future. These educational sessions were conducted on all three shifts by the Administrator and Director of Nursing.	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 21 Any staff member unable to attend the sessions were required to receive education prior to the start of their next shift. Elopement risk assessments and progress notes for new admissions within the last 30 days were reviewed by the Director of Nursing on 4/26/26. No issues were identified. Nurses are to complete elopement risk assessments upon admission, quarterly, with any significant change in condition, and as needed. For any change in condition that may occur on off hours, the nurse will assess and notify the physician and Director of Nursing and follow up with any necessary interventions. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nurse #1 immediately enabled door security system on 4/26/26 by reconnecting the power system and safeguards were put into place by installing the tamper-proof device. All staff and alert and oriented residents were interviewed and educated by the Administrator and Director of Nursing about the security system on the door. The Administrator and Director of Nursing conducted an immediate review of the incident on 4/26/26 including interviewing staff present during incident. The Administrator and Director of Nursing determined that the root cause of the incident was that the side door security mechanism was disabled by Resident #1, which allowed Resident #1 to exit the facility without staff awareness. On 4/26/25 at approximately 11:00AM the Maintenance Director permanently installed a tamper-proof device over the electrical source to the door’s security system to prevent it from being disabled. On 4/26/26 at 11:00 AM the Maintenance Director evaluated all exit doors in the facility to ensure proper function and added any additional security features necessary. The Maintenance Director permanently installed a tamper-proof device over the electrical source for each door’s security system to prevent it from being disabled. When disabled, all electronic security features of the door are not functional. From 5:00AM to 11:00AM the Director of Nursing monitored the 300 hall door until the tamper-proof device was installed. This was the only door that was affected. All other doors were	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 22 assessed by the Administrator, and all doors were functioning properly. On 4/26/26 the Director of Nursing initiated education that was completed on 4/27/26 to all staff to include the facility elopement policy to include how to conduct an elopement code “green” and how to identify residents at risk for elopement. Staff were instructed to immediately report new or increased behaviors, including verbalizations of wanting to leave the facility or changes in mental status, to nurse management. Education was also provided to all staff to not tamper with any door-related security systems and if any observations were made, to immediately ensure door was continuously monitored and report the findings to administration. On 4/26/26 the Director of Nursing initiated education to licensed nurses on elopement assessments. Upon admission, the licensed nurse will complete an elopement assessment, which is the same assessment that Resident #1 received upon admission, and implement interventions as needed based on the score from the elopement risk assessment. Residents identified as being at risk for elopement are listed in the facility’s High Risk for Elopement binders, located at the reception desk and nurses’ stations, to promote staff awareness. This education was completed on 4/27/2026. The ADON/designee is responsible for ensuring the elopement binders are updated and accurate daily and as needed. New hires, any staff who were unable to receive the training due to paid time off or family medical leave, and agency staff will receive education regarding the elopement policy, identifying residents at risk for elopement, and door security prior to working an assignment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator and the Director of Nursing conducted an immediate review of the incident on 4/26/26. The Administrator and the Director of Nursing determined the root cause of the incident was that the side door security mechanism was disabled which allowed Resident #1 to exit the facility without staff awareness. Elopement drills were conducted by the Maintenance Director (or designee) to reinforce staff response procedures: first shift – 4/26/2026, second shift- 4/26/2026, and third shift- 4/27/2026. Beginning	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 23 4/26/2026: weekly drills for four weeks followed by monthly drills for two additional months. The Maintenance Director or assigned manager on duty to include the Social Services Director, Life Enrichment Director, Business Office Manager, MDS Coordinator, or Charge Nurse will conduct daily door checks to ensure all doors are secured appropriately on an ongoing and permanent basis. Securement would include properly functioning keypads, magnetic locks, and audible sounders. The Director of Nursing or Assistant Director of Nursing will review elopement risk observations and new admission assessments during clinical morning meeting Monday through Friday as a part of the facility activity report (24-hour report) weekly for four weeks and monthly for two additional months. Any concerns identified are addressed at that time. Beginning 4/27/26, wander guard transmitter functionality checks were implemented daily by nursing leadership to include the Director of Nursing, Assistant Director of Nursing, or charge nurse. Audits of elopement drills, wander guard transmitter functionality checks, and elopement risk observation review for new admissions will be reviewed weekly during the clinical meeting and monthly during the QAPI meeting. On 4/27/26, the interdisciplinary team including the Administrator, Director of Nursing, Social Services Director, Admissions Director, Life Enrichment Director, Maintenance Director, MDS Coordinator, and Medical Director, reviewed the incident and implemented monitoring through the facility's Quality Assurance and Performance Improvement (QAPI) program for 12 weeks to ensure sustained compliance. Interventions for the deficient practice were implemented immediately on 4/27/2026. At the conclusion of the 12-week monitoring period, the QAPI committee including the Administrator, Director of Nursing, Social Services Director, Admissions Director, Life Enrichment Director, Maintenance Director, MDS Coordinator, and Medical Director will evaluate the results and determine whether additional monitoring is necessary to ensure sustained compliance. Above responsibilities were discussed during Ad-hoc QAPI completed on 4/27/26. Alleged date of immediate jeopardy removal and	F0689		04/28/2026

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F0689 SS = SQC-J	Continued from page 24 compliance date was: 4/28/26 Onsite validation of the credible allegation of immediate jeopardy removal was conducted on 5/8/26 by interviewing nursing assistants, nurses, administration, housekeepers, and dietary staff 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. Audits for elopement drills, wandering assessments, wander guard transmitter device functionality checks, and door security conducted on 4/26/26 to 4/27/26 across various shifts with all disciplines were reviewed. The ad hoc QAPI Committee meeting was held on 4/27/26. Additional audits were reviewed and daily door security checks were completed, and additional elopement drills were conducted. The immediate jeopardy removal and compliance date of 4/28/26 was validated.	F0689		04/28/2026