STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045290	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dardanelle Nursing and Rehabilitation Center,inc	2199 State Hwy 7 North Dardanelle, AR 72834

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to monitor and supervise a resident with known high-risk elopement assessment and exit seeking behaviors to prevent elopement for 1 (Resident #4) of 6 residents reviewed for elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The Administrator was informed of the IJ on 06/25/2025 at 2:14 pm, and notified it was considered to be Past Non-Compliance (PNC). The findings include: Review of an Internal Investigation dated 03/07/2025 revealed Resident #4, on 03/07/2025 at 5:55 PM, monitored the front door for an opportunity to exit the facility. At 5:55 PM Resident #4 observed a visitor entering the front door of the facility, at that time Resident #4 used their motorized scooter to block the front door from locking and exited the building unsupervised and without staff knowledge. At 6:21 PM off duty Certified Nursing Assistant (CNA) #1 located Resident #4 on a local street (located 1.1 miles from the facility). CNA #1 reported that it was dark outside. (To reach this location, the resident would have traveled on a two-lane highway with no sidewalk on a motorized scooter to a city side street, making it approximately three blocks from a gas station.) CNA #1 discovered Resident #4, and the resident reported they were going to the gas station to get cigarettes. CNA #1 contacted the facility and spoke to the Director of Nursing (DON). She notified the DON of Resident #4's location out of the facility. CNA #1 was able to get Resident #4 into their private vehicle but left the motorized scooter. She then took Resident #4 to get cigarettes. An interview with the resident revealed they did not know the employee, but the employee knew the resident, so they got into the vehicle with CNA #1. A review of an online time and date service revealed that the sun set at 6:10 PM on 03/07/2025. An observation of an electric scooter identical to Resident #4's revealed there were no headlights or reflectors on the scooter. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/2025 at 2:18 PM, CNA #1 revealed she was driving in town when she discovered Resident #4 driving their motorized scooter on a street 1.1 miles from the facility. She revealed it was dark, and she notified the facility. CNA #1 reported she had spoken to the DON and the DON revealed that they did not know Resident #4 had left the building. CNA #1 revealed she was only able to convince Resident #4 to get in her car by telling them she would take them to buy some cigarettes. CNA #1 revealed after she bought cigarettes for Resident #4 she drove Resident #4 back to the facility. During an interview on 06/23/2025 at 12:15 PM, CNA #5 revealed Resident #4 previously made several attempts to elope from the facility, but none were successful except for the incident when CNA #1 found them in town. During an interview on 06/23/2025 at 1:55 PM, CNA #4 revealed Resident #4 previously had several attempts to elope from the facility that were not successful. During an interview on 06/23/2025 at 3:20 PM, Licensed Practical Nurse (LPN) #3 revealed she was new at the time, but since she had been employed Resident #4 had tried to get out of the facility numerous times. During an interview on 06/23/2025 at 3:45 PM, the DON revealed the cameras were reviewed, and footage revealed Resident #4 exited the building through the front door of the facility. She reported Resident #4 exited the building behind a visitor coming into the building. The DON reported that the resident had been making daily comments of wanting to go home, but the resident was not aware they did not have a home anymore. The DON revealed staff were not aware of Resident #4 being gone out of the facility, until she got a phone call from CNA #1 stating she found the resident in town. She revealed once Resident #4 returned to the facility, she assessed them and there were no injuries noted. The physician and family were notified. The DON was unsure if the police were notified. The DON revealed Resident #4 was consistently telling her they wanted to go home and would elope again as soon as staff was not looking, because Resident #4 could not smoke when they wanted to. The DON also revealed a family member would take Resident #4 out on pass about twice a month, but as soon as the family member did not come get the resident their behaviors of wanting to go home and exit seeking would start back. A discharge was arranged at that time for the safety of the resident. A family member was notified of immediate discharge. Staff monitored one on one with the resident until the family member came and picked the resident up. The DON reported an in-service was conducted about a green binder at the nurses' stations which identified residents with pictures who were risks for elopement, because it changed frequently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/2025 at 4:00 PM, the Administrator revealed that he received a phone call from the facility at 6:26 PM requesting he come to the facility because Resident #4 had left the facility unsupervised, was found in town by an off-duty staff member and had just been returned to the facility. The Administrator revealed he arrived at the facility after Resident #4 returned to the facility. He revealed the DON assessed Resident #4 and there were no injuries. The Administrator revealed the resident kept telling him they wanted to go home, and they would elope again. The Administrator reviewed the camera footage, and reported it showed Resident #4 sat in front of the doors for approximately 3-4 minutes before a visitor came in, upon which the resident approached the door and used their electric scooter to block the door from locking and exited the building. The resident exited the building at 5:55 PM and returned to the building at 6:21 PM. The Administrator revealed Resident #4 reported they came up with the plan about 15 minutes before they exited the building. The Administrator reported when he asked the resident what would have happened if they had gotten hurt, Resident #4 reported I don't care, let me die and to call their family member to come get them because they wanted to go home. During an interview on 06/24/25 at 4:08 PM, the Assistant Administrator revealed she had returned to the facility with the Administrator at 6:26 PM. She stayed with Resident #4 and took them out to smoke. She reported the resident continued to say they wanted to go home, and the resident kept saying they would do it again as soon as someone turned their head. Resident #4 also reported they could not live there anymore because they didn't get enough cigarettes. The Assistant Administrator revealed Resident #4 had no cognitive impairment and knew what they were doing. She reported Resident #4 kept saying they were going to get cigarettes and would come back to the facility. During an interview on 06/23/2025 at 4:29 PM with CNA #2 she revealed she was assigned to Resident #4. She revealed she had picked up Resident #4's supper tray. She reported she did not see him again until after the resident returned to the facility. She revealed she assisted with packing up the resident's belongings to discharge. On 06/24/2025 at 9:14 AM a request to view camera footage was made to the Administrator but footage was only saved from 05/28/2025. During a phone interview on 06/24/2025 at 4:08 PM, Resident #4 revealed the electric scooter did not have lights on it and did not think it had reflectors on it either. Resident #4 revealed they went out the door when a visitor came in. The resident revealed they were tired of being inside of the facility, so they wanted to go out and had no plans. The resident reported they did not know the staff member who found them, but the staff member knew them, so they got in the car with the staff member. During an interview on 06/25/2025 at 8:25 AM, the Administrator revealed Resident #4 did not have a bracelet which alerted staff when the resident was trying to exit the facility. The Administrator revealed a new alarm system was ordered on 03/31/2025 and an invoice was reviewed. The new system was installed on 04/17/2025. The alarm would sound at the nurses' station when the front door opened. The alarm system could only be deactivated at the front door by the nursing staff. The nursing staff would come to the front door, look out the door, and then deactivate it. He revealed the door alarm they currently had on the front door could not be heard at the nurses' station and especially if a staff member was in a room they would not be able to hear it. He reported that due to many visitors in the evening a sign was placed at the front door asking visitors to enter and exit through the side door. He revealed the front door was locked at 6:00 PM by the charge nurse on duty. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Progress note dated 02/20/2025 at 11:19 AM revealed Resident #4 was discovered attempting to open the front doors to exit the facility but was intercepted by staff. A review of Care Plan with initiation date of 05/19/2023 indicated Resident #4 was high risk to elope/wander related to active exit seeking and diagnosis of psychosis. Interventions included to distract the resident from wandering with activities, food, conversation, television and books. Resident #4 preferred to watch television and smoke. Staff were to identify patterns of wandering behaviors and de-escalate with re-direction or administer an as needed sedative. A review of quarterly Minimum Data Set with an Assessment Reference Date of 12/17/2024 revealed that Resident #4 had a Brief Interview of Mental Status score of 14, which indicates no cognitive impairment. It revealed that Resident #4 felt depressed, hopeless, and feeling down nearly every day during look back period. The MDS also revealed that the Resident felt bad about themselves or that they had let their family down nearly every day during lookback period. A review of Resident #4 ' s Medical Diagnoses revealed diagnoses of psychosis, cerebral infarction, history of suicidal behavior, history of falling, and anxiety disorder. A review of a Release of Responsibility for Leave of Absence sheet revealed that Resident #4 did not sign out prior to leaving the facility on 03/07/2025 at 5:55 PM. A review of a policy titled, Elopement and Wandering, revised 11/22/2016, revealed the facility will identify and respond promptly to elopement and wandering. Interventions will be put in place for resident's specific needs. Residents would be informed of the proper procedure to sign out of facility. Following the elopement and prior to the survey team entering the building, the facility implemented a door monitoring program, installed a secondary alarm system, in-serviced staff on elopement prevention and response, and Resident #4 was discharged from the facility. A review of door monitoring forms was conducted. The front doors were monitored on 2 shifts, 5 days a week for 4 months with no issues noted upon observation. The installation of a secondary alarm system was placed at the front door with a keypad for staff to deactivate, verified to be functional. A staff in-service was performed including a green binder, identifying residents at risk for elopement. Resident #4 was discharged from the facility on 03/07/2025, the day of elopement incident, due to resident wanting to go home and stating they would do it again.