STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045380	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth's Place	3010 Middlefield Drive Jonesboro, AR 72401

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, video surveillance review, facility document review, interview, and facility policy review, it was determined that the facility failed to ensure the facility provided an environment that was free from avoidable accidents and hazards for one (Resident #1) of six residents reviewed. Specifically, the facility staff failed to address a sounding alarm on an exit door that directly opened to an unsecured area and allowed Resident #1, who had an altered mental status, to leave the facility premises and travel to an establishment located 0.1 miles behind the facility without the facility's knowledge.It was determined the facility's past non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to the resident. The Immediate Jeopardy (IJ) was related to the Stated Operations Manual, Appendix PP, 483.25 (Quality of Care) for elopement at a scope and severity level of J. The IJ was identified at 04/01/2026 at 4:45 PM.The Director of Operations and the Registered Nurse Consultant (RNC) were notified of immediate jeopardy (IJ) of Past Non-Compliance (PNC) IJ on 04/02/2026 at 2:29 PM. The facility's action plan was reviewed and accepted by the state agency surveyors on 04/02/2026 at 4:30 PM.The findings include:A review of Resident #1's admission Record indicated the facility admitted the resident on 03/25/2026, with diagnoses which included unspecified dementia, difficulty walking, lack of coordination, muscle wasting and atrophy, cachexia [condition that results in loss of skeletal muscle mass], altered mental status, hypoglycemia, and hypothermia.A review of Resident #1's admission Minimum Data Set (MDS), with an Assessment Reference Date of 03/27/2026, revealed a Brief Interview for Mental Status score of 09, which indicated the resident had moderate cognitive impairment. Resident #1's MDS also revealed the resident had an upper body impairment to one side and used a walker and a wheelchair. Resident #1 required partial to moderate assistance for personal and toileting hygiene, showering and bathing, and lower body dressing. Resident #1 required supervision or touch assistance when putting on and taking off footwear. Resident #1 was dependent on staff when walking 50 feet. Resident #1 required partial to moderate assistance for repositioning, and all transfers. Resident #1's MDS further indicated the resident was dependent on staff for walking 10 feet on uneven surfaces such as sloping surfaces or on turf, and to go up and down curbs or one step.A review of Resident #1's Care Plan initiated on 03/25/2026, revealed the resident required assistance from staff for Activities of Daily Living such as assistance with wheelchair mobility. Resident #1's Care Plan also revealed the resident was at risk for elopement. Care Plan interventions included Resident #1 being placed on a secured unit on 03/29/2026, after the resident returned to the facility following the elopement. Care Plan interventions also included to monitor where abouts, redirection, distraction and to attempt to identify patterns and triggers of wandering.A review of a Resident #1's Pre-admission Screen dated 03/20/2026 at 8:38 AM, indicated Resident #1 used a manual wheelchair and walker for ambulation, had nebulizer therapy, oxygen at two liters per minute by nasal cannula/mask, was cognitively impaired, and had dementia. The document also revealed the resident had risk alerts, which included anticoagulation and falls. The resident was receiving therapy services, which included physical therapy, occupational therapy, and speech therapy. Resident #1 required one person assist. Other notes indicated Resident #1 had been admitted to ICU from home (continued on next page)

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 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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	related to hypothermia, bradycardia and hypoglycemia.A review of Resident #1's [Nursing] Nsg Admit/Readmit Assessment and Care Plan dated 03/25/2026 at 11:43 AM, indicated Resident #1's Elopement risk score was 9, which indicated the resident was at risk to wander.A review of Resident #1's Nsg Elopement Risk with Care Plan on 03/27/2026 at 9:12 AM, indicated Resident #1's elopement score was 7, which indicated the resident was a low risk for elopement.A review of video surveillance footage was conducted with the Director of Operations on 04/01/2026 at 4:14 PM, for the incident that occurred on 03/28/2026. The following was observed:Outside camera footage- At 11:16:56 PM, Resident #1 was seen leaving the facility.-At 11:18 PM, Resident #1 fell attempting to step up onto the curb. Resident #1 crawled across the grass and sidewalk to the shed.-At 11:26 PM, Resident #1 used a broom and the shed to stand.Dining Room footage- At 11:25:44 PM, Licensed Practical Nurse (LPN) #2 was observed entering the dining room with her cell phone in hand.- At 11:26:18 PM, LPN #2 pulled the door, turned off the alarm, and was observed leaving the dining room on her cell phone.A review of the Police Report on 03/28/2026 indicated at 11:35 PM, a caller advised law enforcement that an elderly [resident] with a possible altered mental status, was at the hotel establishment at which they were employed. At 11:37 PM, the caller said the [resident] arrived there on foot. The Police Report revealed an officer arrived at the hotel establishment at 11:56 PM, and Emergency Medical Services (EMS) was dispatched at 12:08 AM.A review of Resident #1's EMS Records indicated on 03/29/2026 at 12:13 AM, EMS arrived at patient. The EMS Records revealed Resident #1 was alert and oriented x1 [to self only], the resident's skin was cold and dry, and the police officer called for EMS when it was noted that Resident #1 was severely confused. Resident #1 walked with EMS to the ambulance. The EMS Report further indicated that as EMS was leaving the parking lot, [the ambulance was] waved down by staff of [Facility Name]. They told EMS [Resident #1] was a resident at the NH [nursing home] and had been missing for a few hours.A review of Resident #1's Hospital Records dated 03/29/2026, indicated the resident was found in lobby of a hotel near the nursing home, and Resident #1 was orientated to person only. Resident #1's vital signs on 03/29/2026 at 12:33 AM, included a temperature of 96.4 degrees Fahrenheit, a pulse rate of 66 beats per minute, and a blood pressure of 164/94.A review of a statement titled, Establishments Statement by the clerk who was working the front desk of the hotel on 03/28/2026, indicated at around 11:11 PM, Resident #1 walked into the establishment and asked the clerk to help the resident find someone. The clerk called the police department, who arrived at 11:55 PM, then the police called EMS. The report indicated some ladies from next door came in looking for [the resident] at 12:10 AM. A review of an OLTC [Office of Long-Term Care] Witness Statement Form dated 03/30/2026 at 2:30 PM, signed by LPN #2 who was the charge nurse on night shift of 03/28/2026, indicated Resident #1 was last seen while LPN #2 was giving medication to another resident. LPN #2 had given the last medication [on their medication pass] at approximately 11:00 PM and heard the door alarm go off approximately 20 minutes before finishing. LPN #2 thought the alarm was someone taking out the trash, so she did not check the alarm and continued passing medications. LPN #2 indicated the alarm continued sounding and LPN #2 searched the door by laundry first. LPN #2 then indicated she followed the sound to the dining room, entered the code to turn off the alarm, and fully shut the door. LPN #2 indicated I did peak through the door but saw nothing and concluded such. Wrapping up my cart, I grabbed a beverage, went to the bathroom then sat down in the nurses office. About 20-30 minutes later, an [unidentified] CNA indicated they were unable to locate Resident #1. The 300-hall CNA indicated Resident #1, last seen in their wheelchair in dining room, was gone and the wheelchair was still in the dining room.A review of an OLTC Witness Statement Form dated 03/29/2026 at 12:49 AM, signed by CNA #6, indicated Resident #1 was last seen in the dining room at 6:00 PM.A review of an OLTC Witness Statement Form dated 03/30/2026 at 6:42 AM, signed by CNA #4, revealed she was informed that Resident #1 was not in their room, she then exited the back door toward the hotel, behind the building, and saw a police truck and an ambulance. CNA #4 revealed upon approaching the ambulance that she saw Resident #1 in the back, and the ambulance driver had indicated Resident #1 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	would be taken to the hospital.A review of an undated and untimed OLTC Witness Statement Form indicated CNA # 7 returned from break and began helping look for Resident #1 by checking the rooms on the 200 and 300-Hall, the shower rooms, and the utility rooms.A review of an undated and untimed OLTC Witness Statement Form filled out by Registered Nurse (RN) #5 indicated the other nurse [LPN #2] and their CNA approached myself, [RN #5] and the 300 hall CNA asking if we'd seen a resident who wasn't in their room. Information was communicated to all staff, and a facility wide search was initiated. RN #5 went to the hotel and observed the ambulance preparing to leave with Resident #1 in the back. Emergency Medical personnel stated Resident #1 was being taken to the hospital due to being very cold. RN #5 spoke with the hotel desk clerk who advised Resident #1 had entered the lobby at approximately 11:00 PM.During an interview on 04/01/2026 at 9:12 AM, CNA #1 indicated the last time she saw Resident #1 was on 03/28/2026 at 10:50 PM, prior to the end of her shift at 11:00 PM. She revealed she worked from 7:00 PM to 11:00 PM, on 03/28/2026. CNA #1 indicated she had reported to LPN #2 that Resident #1 was observed wandering and coming out of Resident #1's room multiple times. She stated she was told during shift change at 7:00 PM, to keep an eye on Resident #1 because the resident was moving fast and getting up often.During an interview on 03/31/2026 at 7:53 PM, CNA #8 revealed they worked on 03/28/2026 from 3:00 PM to 7:00 PM, on the same hall that Resident #1 resided on. CNA #8 indicated Resident #1 would not stay in their bed, and that the resident kept getting up. CNA #8 reported, At one point, [the resident] was really roaming bad and looking for [the resident's spouse]. CNA #8 reported that at certain times, Resident #1, who resided on 600-hall, was going in and out of other resident's rooms and the empty rooms on the 500-Hall. CNA #8 reported she told the oncoming nurse[about the behaviors].During an interview on 04/01/2026 at 11:42 AM, LPN #2 revealed she worked from 7:00 PM on 03/28/2026 until 7:00 AM on 03/29/2026. LPN #2 reported she was covering the 300, 400, and 600 Hall, and that around 11:20 PM, an unidentified aid that was covering the 400-600 Halls came to her and told her she could not find Resident #1. LPN #2 stated the last time she saw Resident #1 was around 9:20 PM. Other staff in the building were notified and a search for Resident #1 began inside and outside of the building. LPN #2 reported that RN #5 and an unidentified CNA had found Resident #1 at the hotel behind the facility. LPN #2 stated she did hear the alarm sounding on the dining room door but was unsure of the time. LPN #2 revealed she did look out the door and had turned the alarm off but did not exit the building. LPN #2 revealed she was trained on the egress-door alarm system in December of 2025, and that she was trained to assess why the alarm was sounding and to exit the facility and see if any residents had gotten out. LPN #2 confirmed they were the nurse responsible for Resident #1, and that Resident #1 resided on the 600-Hall.During an interview on 04/01/2026 at 2:13 PM, CNA #3 revealed she worked on 03/28/2026 from 11:00 PM to 7:00 AM on the 400-600 Halls. CNA #3 confirmed she was responsible for the 600-Hall, which was where Resident #1 resided. CNA #3 reported she made rounds around 11:10-11:12 PM and noticed Resident #1 was not in their room. CNA #3 stated they continued to look for Resident #1 and reported to LPN #2 a few minutes later that she was unable to locate the resident. CNA #3 indicated she searched inside and outside of the building and denied hearing the door alarm. CNA #3 reported by the time she made it to the hotel, Resident #1 was on a stretcher in the back of an ambulance and RN #5 told the ambulance driver Resident #1 was a resident of the facility. During an interview on 04/01/2026 at 8:56 AM, CNA #4 reported that RN #5 told her Resident #1 was missing and she began to search for the resident. CNA #4 indicated she walked out of the dining room door and into the field towards the hotel and ditch behind the facility. CNA #4 revealed she looked in through the closed doors of the ambulance inside the back of the ambulance and Resident #1 was being connected to the equipment in the ambulance by the EMS person. CNA #4 revealed that RN #5 arrived and informed the ambulance driver that Resident #1 was a resident to the facility located behind the hotel.During an interview on 04/01/2026 at 10:39 AM, the Maintenance Director indicated the doors to the facility had two alarm systems. The first was the egress alarm system, which controlled getting in and out of the facility. The Maintenance Director then stated, It is not a fire (continued on next page)

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