STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Parkside	255 Possum Park Road Newark, DE 19711

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 observation, interview, and record review, it was determined that one (R1) of three residents sampled did not receive adequate supervision and assistive devices to prevent elopement, as R1 is a newly admitted resident identified as an elopement risk. This failure resulted in R1 eloping from the facility to a busy road between approximately 5:00 PM and 5:20 PM without supervision or intervention. An Immediate Jeopardy was identified to the facility on 6/25/26 at 10:00 AM and was determined to be past noncompliance as of 6/16/26.Findings include:Review of R1's clinical record revealed:6/12/26- R1 was admitted to the facility for short-term rehab with diagnoses that included, but were not limited to, traumatic subarachnoid hemorrhage (a bump or blow to the head that caused bleeding near the brain). 6/12/26- The admission elopement evaluation documented that R1 was a risk for elopement.6/12/26 10:22 PM- A progress note documented Resident noted independently ambulatory with baseline confusion. Wander risk. Reported to NP (nurse practitioner), via Team Health. Order for Wanderguard (requested).6/12/26 11:23 PM- An order note documented Wanderguard (ordered). Check placement and function q (every) shift. 6/13/26 10:36 AM- A progress note documented that the Wanderguard was placed on the resident's left ankle. 6/15/26 approximately 5:00 PM- Video surveillance revealed that R1 eloped from the healthcare facility through a set of double doors and that the Wanderguard alarm was not activated, and R1 was able to walk out the doors unattended, 6/15/26 5:56 PM- A progress note documented Resident (R1) was found outside the building by the road by (E3 [COTA-L]) without supervision around 1500 (should be 5 PM) on 6/15/26. Resident has baseline confusion, poor safety awareness. BIMS score of 6. Wanderguard had been placed around the Resident's left ankle. Wanderguard failed. Resident brought back into the building.6/15/26- R1, who was assessed as independent but at increased risk for elopement, was observed leaving the facility through the exit double doors without staff knowledge. Despite being seen exiting the building, the wander management system did not activate or alert staff. R1 continued ambulating along a main traffic roadway with a posted speed limit of 45 miles per hour for approximately 0.5 to 1 mile. At approximately 5:20 PM, E3 identified R1 walking along the roadway and returned the resident to the facility. Facility staff was unaware that R1 had exited the building.6/24/26 12:00 PM- During an interview, E3 stated, I was driving home from work when I noticed (R1) walking on the side of the road towards Wendy's. I recognized him as a resident because I worked with him earlier that same day. I pulled over and asked (R1) where he was going, and he said he was going to see his son at college. I was able to get him into my vehicle and brought him back to the facility and back to the unit, where nobody realized he was gone.6/24/26 12:30 PM- During an interview, E1 (ADON) stated, We realized that (R1) eloped from the facility when (E3) brought him back into the building and let the unit manager know. (R1) was fully assessed and no injuries occurred during the elopement. His Wanderguard was immediately replaced, and we moved him to the second floor of the facility.Following the elopement incident, the facility took the following immediate actions:A head-to-toe assessment was completed upon the resident's return, and vital signs were obtained and monitored. The malfunctioning Wanderguard was removed and replaced with a functioning device.The incident was reported to the State in accordance with reporting (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	requirementsThe resident's attending physician and responsible party were notified of the incident.The resident was relocated to the second floor to provide an additional layer of protection, as the Wanderguard system deactivates elevator access when functioning properly.The resident was placed on increased monitoring for elopement risk and related behaviors.The resident was placed in the facility's At Risk for Elopement binder, including a current photograph for staff identification.The resident's elopement assessment was reviewed and updated.The resident's care plan was revised to reflect the elopement incident and include individualized interventions to address elopement risk.An audit was conducted of all residents identified as being at risk for elopement who were wearing wanderguards. Placement and functionality of each device were verified, and any malfunctioning devices were immediately replaced. The wanderguard system, including door alarms and elevator controls, was evaluated to ensure proper operation. Staff education and systemic corrective actions include (completed on 6/16/26):Education was provided to all staff regardingIdentification of residents at risk for elopement;Daily monitoring and verification of Wanderguard placement and functionality;Immediate intervention when a resident identified as being at risk for elopement is observed approaching or exiting a secured area; The requirement for nursing staff to notify the Director of Nursing (DON) or Assistant Director of Nursing (ADON) immediately if Wanderguard placement or functionality cannot be confirmed.Staff competency regarding elopement prevention procedures and Wanderguard monitoring will be validated through observation and follow-up education as needed6/25/26 10:00 AM- An immediate jeopardy was called in the presence of E1 (ADON), and E2 (MDS Coordinator) regarding the 6/12/26 elopement of R1. Based on the immediate actions taken by the facility, no further elopements occurred, and interventions were verified by the surveyor onsite during the survey; this incident was past non-compliance. 6/25/26 - Findings were reviewed during exit conference with E1 and E2.