STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106079	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Regional Rehab Center	2144 Welbilt Blvd Trinity, FL 34655

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to protect the residents' right to be free from neglect by failing to respond to an exit door alarm and provide supervision to prevent an elopement for one (Resident #1) out of three residents sampled. On 1/11/26, approximately 2:15 p.m., Staff F, Certified Nursing Assistant (CNA), discovered Resident #1 was not in his room. At 2:15 p.m., a Dr. Walker (code announced overhead to indicate a potential missing resident) was called in the facility. Resident #1 exited the facility without staff knowledge from the second-floor hallway next to the Maintenance Directors office into the stairwell leading to the first floor. Resident #1 proceeded down the stairs to the first floor through an unlocked door with no alarm. Resident #1 walked to another door, next to the business office, and proceeded to exit this alarmed door to the parking lot. Resident #1 continued walking North through the parking lot to a road with a 30 mile per hour (mph) speed limit and headed to another street with a 55-mph speed limit. The resident walked approximately 0.6 miles from the facility. Resident #1 was missing from the facility for 10 minutes without staff knowledge. This failure created a situation that resulted in the likelihood for serious injury and/or death to Resident #1 and resulted in the determination of Immediate Jeopardy on 1/11/26. The findings of Immediate Jeopardy were determined to be removed on 2/12/26 and the scope and severity was reduced to a D after verification of removal of immediacy of harm. Cross reference to F689 Findings included: Review of Resident #1's progress notes revealed:1/11/26 2:50 p.m. Nursing Note The approximate time of 1415 [2:15 p.m.] patient was not reported to be in his room. Last seen by the nurse at 1400 [2:00 p.m.]. Facility search started at approximately 1435 [2:35 p.m.] patient observed on [street name] south of the facility. Patient returned to the facility by staff certified nursing assistant. Patient stated, I was going for a walk and was just about to turn around patient smiling in good spirits. Patient denies pain or discomfort, skin assessment completed without any abnormal findings. Elopement assessment completed. Patient placed on 1:1 monitoring will continue. Review of admission records showed Resident #1 was admitted to the facility on [DATE] with diagnoses to include unspecified sequelae of cerebral infarction, alcohol abuse with alcohol-induced anxiety disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, and syncope and collapse. Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], Cognitive Patterns, showed a Brief interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Functional Abilities showed he could walk 150 feet with supervision or touching assistance. Restraints and Alarms showed a wander/elopement alarm was used less than daily. Review of Resident #1's Physician orders showed:-Device: Wander management bracelet-check placement every shift. Started: 11/14/25 Ended: 11/20/25. Review of Resident #1's care plan showed a focus area of [Resident #1] at risk for elopement as evidenced by Exhibit exit-seeking behavior-ambulating without assist in (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hallways, etc. Initiated on 11/10/25. Interventions included: Use diversional activities when exit-seeking behavior is occurring . initiated 11/10/25; - continue frequent visual checks as indicated initiated 1/7/26; and Use audible monitoring system to alert staff of exit seeking behaviors {electronic monitoring device} initiated 11/10/25 resolved on 12/11/25. Review of Resident #1's Elopement Risk Evaluations identified he was an elopement risk on 9/17/25, 11/3/25, and 12/23/25. Review of Resident #1's Progress notes showed:-9/24/25 Palliative care Note: . spoke with [resident representative] who states that patientlives [sic] in an apartment just down the road from her. She does admit that she works during the day. She states that patient's dementia has progressively slowly gone [sic] worse. She also states that she is concerned with patient's wandering during the day and hisoverall [sic] safety . -11/10/25 Nursing Note: Patient exhibited escalating behavioral concerns. Patient refused to sit down and refused redirection or instruction from nurse and cna. Patient repeatedly attempted to leave the unit through exit door. -12/10/25 Psychology Provider Note: The patient is an [AGE] year-old-male with recent episodes of agitation and combativeness secondary to confusion. He has presented with agitation, not following safety instructions, and exit seeking. He continues to present with cognitive decline. The patient was unbale [sic] to provide information about his diagnosis and treatment. Symptoms are reported to have been present for more than two weeks. The patient's current health issues present a barrier to symptom improvement. -12/15/25 Nursing Note: noted periods of agitation and exit seeking, after multiple redirection attempts NSG [nursing] staff was able to comfortably transfer him back to his room without incident, Psych notified, awaiting for further instructions. -1/6/25 Nursing Note: PT [patient] is resting on bed, alert with confusion, up and moving around the hall way [sic] period for a few minutes then back to bed, . -1/10/25 Nursing Note: Pt is up and walking around the hall way [sic] for a short time, then back to bed, meds [medications] take [sic] with supervision, fluid encourage, continue to monitor. The weather on 1/11/26 was 66 degrees Fahrenheit cloudy with brief precipitation and 84% humidity. (https://world-weather.info/forecast/usa/trinity_west/11-january/). During an interview on 2/10/26 at 9:30 a.m. with Staff A, Receptionist, he stated he received elopement training about a week ago and has not had any residents leave on his shift. He stated he updates the elopement book daily with direction from Human Resources (HR) and the Nursing Home Administrator (NHA) when they get a new admit. He stated he confirms the residents who are in the book and checks to see the electronic monitoring devices are working daily. During an interview on 2/10/26 at 10:15 a.m., with Staff C, Licensed Practical Nurse (LPN), she stated she has had elopement training. She stated they did have an elopement recently. She stated Resident #1 asked her to leave multiple times throughout her shift. She stated she redirected him and she let the nurse know. She stated he was found after going missing for about an hour. During an interview on 2/10/26 at 1:10 p.m. with Staff D, Certified Nursing Assistant (CNA), she stated she is unsure how to identify who is an elopement risk or who is supposed to be wearing an electronic monitoring device. She stated she is not sure of the process or know if there are any residents at risk for elopement in the facility. During an interview on 2/10/26 at 1:17 p.m. with Staff E, LPN, she stated they have orders in the Medication Administration Record (MAR) for the electronic monitoring devices. She stated they do a daily huddle [meeting] to notify staff if they have a new resident with exit seeking behaviors and check it daily, and every shift they document they have seen and checked the electronic monitoring device. She stated someone else comes in with a device to check that the electronic monitoring device is working every day. During an interview on 2/10/26 at 1:52 p.m. with Resident #1's primary care physician he stated, Resident #1 was a sneaky guy and had cognitive decline. He stated his mental state varied. He stated if the facility decided to take off the electronic monitoring (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	device, they should have communicated this with him. He stated they were trying to cover the fact that his mentation would vary, and that Resident #1 could not understand the time of day sometimes. He stated he does not have any awareness of Resident #1 having exit seeking behaviors and that was not communicated to him from the facility. He stated he was notified of Resident #1's elopement by the NHA and understands he was found miles away. During an interview on 2/10/26 at 2:38 p.m. with the Nursing Home Administrator (NHA), Regional Nurse and the Regional Director of Operations, the NHA stated, Resident #1 went out the exit door on the second floor and down the stairs. She stated he went by the maintenance office on the second floor, saw the stairs, held the door handle for 30 seconds which opened the door, went down the stairs and when he got downstairs, he opened the exit door and went outside of the facility. She stated the door leading to the outside did not have an alarm at time of the incident. She stated the door locks from the outside, but you can open it from the inside. The NHA stated Resident #1 did not exhibit wandering and exiting behaviors prior to the incident. The NHA stated when interviewing staff nobody noticed the resident trying to leave and nobody heard any door alarms. The NHA stated Resident #1 had an elopement assessment upon admission and was identified as being at risk. The NHA stated Resident #1 left somewhere between 2:00 p.m. and 2:15 p.m. The NHA stated the temperature outside was 70 degrees and was not raining at that time. The NHA stated at one point [in previous months] Resident #1 had an electronic monitoring device but did not have one on at the time of him leaving. The Regional Nurse stated that the electronic monitoring device only works for the front door on the first floor, so it wouldn't have mattered in this situation anyway because it does not alert at any of the other doors. The NHA stated the exit door on the second floor with the delayed press, an alarm normally stays on once it is opened, but this one time it did not work. The NHA stated they tested the door and it was working. During an interview on 2/10/26 at 3:17 p.m. with Staff G, CNA, she stated we had a code Dr. [NAME] (missing resident) called, and everyone went downstairs and got assigned an area to search for the missing resident. She stated she had just gotten back from break and went to the assigned area. Earlier she heard someone, (she thinks it was a visitor) say they had seen someone with a matching description on the road. She stated a couple of staff members left the facility to go look for him. She stated she got in her car and left the facility; she made a left and then a right and saw his clothing description and found the Resident #1. Resident #1 was on the road in front of the plaza with a coffee shop and other stores. She stated she told Resident #1 to get in her car and brought him back to the facility. She stated she asked Resident #1 if he was ok and he stated he did it on purpose and that no one saw him leave. She stated Resident #1 did not remember where he was going. She stated it was raining and the resident was damp from the rain. She stated she did not hear any door alarms. During an interview on 2/10/26 at 3:31 p.m. Staff B, Registered Nurse (RN) stated Resident #1 was assigned to her on the day of the elopement. Staff B, RN stated Resident #1 did not have any exit seeking behaviors. She stated he would walk back and forth from nursing station and his room. She stated she was doing her med pass around 2:00 p.m., saw the resident walking to and from the nursing station and his room. She stated she went to another residents' room to give medication. The CNA came back from break and notified her of not seeing Resident #1 in his room. They both initiated the code Dr. [NAME] (missing resident) and started the search. She stated the search started around 2:15 p.m. She stated she does not know how the resident was found. She stated she saw a team member bring Resident #1 back and assessed resident. She does not remember if it was raining and stated the residents' clothes were a little damp. She stated Resident #1 did not say a word to her when he was back, was just smiling. She stated she does not remember hearing any door alarms. During an interview on 2/10/26 at 3:39 p.m. with Staff F, CNA (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated being assigned to Resident #1 on the day of the elopement. Staff F, CNA stated that day she had left the resident at nurse's station around 1:45 p.m. so she could go on her lunch break. When she came back around 2:15 p.m., she went to check on the resident, and he was not in his room. She stated she looked around the building and could not find him. She told the nurse she could not find him and that's when the code Dr. [NAME] was called. She stated the resident was found down towards a plaza about a half mile away. She stated Resident #1 would walk around the facility all the time. She stated she did not hear any alarms. During an interview on 2/11/26 at 9:20 a.m., with the Maintenance and Housekeeping Director. She stated the electronic monitoring devices are checked every day. She stated the main lobby door is the only door that is protected by electronic monitoring devices. She stated the other doors do not use electronic monitoring devices. She stated she checked them every day, to ensure they beeped and locked and the lock is working properly and if it opened it would beep and alarm. She stated they have never had problems with the doors and have never had to have the manufacturers come out and check the doors due to any issues. During an interview on 2/12/26 at 9:28 a.m. Staff H, CNA stated a Dr. [NAME] code (missing resident) was initiated on 1/11/26 around 2:17 p.m. Staff H stated Resident #1 arrived back to the facility around 2:25 p.m. and was a little damp from the rain. Staff H stated Resident #1 has shown behaviors of exit-seeking in November and December. Staff H stated if the staff knew more maybe we could have been more aware of continuing to look out for Resident #1.A review of the facility policy titled Missing Resident/Elopement, with no revision date, revealed the following: POLICYIt is the policy of the facility to provide a safe and secure environment for all residents. In the event of a resident elopement it is the policy of [NAME] to implement its police/procedures immediately to locate the resident in a timely manner. If an at risk of elopement resident is seen attempting to leave the premises the situation will be immediately reported to the DON/designee, documented, and reviewed as part of the facility QA&A.For a Resident attempting to leave the facility:Redirect the resident in a courteous manner.Get help from other staff in the immediate vicinity if necessaryInstruct staff member to inform the Charge Nurse or Director of Nursing Services/designee and review the need for the need to the individual plan of care.Discovery of a Missing Resident:If the resident was not authorized to leave, immediately notify the facility Administrator or highest ranking official/designee. Notify 911/law enforcement (as determined per state guidelines) the Director of Nurses/designee, the resident's legal representative, Regional Manager(s), The attending physician/Medical Director. The facility's immediate actions to remove the Immediate Jeopardy included:-1/11/26 1:1 enhanced monitoring implemented upon Resident #1 return to the facility until discharge 1/12/26- care plan updated-Post Traumatic Stress Disorder (PTSD) evaluation completed 1/11/26 with no concerns.-1/11/26 Review of identified Resident #1 for elopement risk. An updated Elopement evaluation was completed and plan of care update as indicated-1/11/26 Resident #1 was interviewed upon return to the facility and was able to describe to NHA/DON the path that he had taken and what occurred. The Identified door that was used to exit the unit was evaluated at that time for proper function and alarm and no issues were identified-All facility internal exit doors were then evaluated for proper function 1/11/26 and no issues identified. Education on doors and alarms completed on 100% of staff on 1/12/26.-1/11/26 Temporary auditory sensor alarms were placed at identified secondary doors that exit the facility 1/11/26-Ad Hoc [unplanned] Committee meeting 1/11/26 5:45 p.m. with review of the concern and potential corrective interventions and approval of PIP [Performance Improvement Plan]. -Mock elopement drills initiated 1/11/26 at 4:06 p.m. and completed q shift [every shift] x 1 week then q day [every day] x 1 week then every other day ongoing per QAPI [Quality Assurance Performance Improvement] recommendations.-1/11/26 initiated education regarding (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Missing Resident/Elopement Policy/Procedure, including elopement books, Abuse/Neglect/Exploitation. As of 1/12/26 - 114 of 114 facility staff members and 26 of 26 contract therapy staff have been educated.-1/11/26 - record of previous daily exit door checks were reviewed for past 90 days to validate completion and no concerns identified. Door checks are to continue daily at the direction of the QAPI committee-1/11/26 Elopement books reviewed to ensure proper information is in place and books are easily accessible.-1/11/26 Verification of functioning of current [electronic monitoring device] device check machine-1/11/26 Current residents were evaluated for elopement risk and new Elopement Evaluations were completed with plan of care reviews and updates as indicated-1/11/26 Review of current residents with [electronic monitoring devices] - verified evaluation for accuracy and appropriateness. Verified proper order and documentation for placement. Update evaluation, order, and plan of care as indicated. [Electronic monitoring device] system checked at front door and found to be functioning.-Follow up Ad Hoc Committee meeting 1/11/26 at 10:30 p.m. with members in attendance to review the days' actions, interventions and outcomes. Follow up review and approval of PIP items. The Medical Director participated in the QAPI meeting in facility. -1/12/26 25 of 25 direct care Licensed Nursing staff educated on completion of Elopement Evaluations-1/12/26 Verification of proper functioning of exit doors and alarms by the regional maintenance consultant-1/12/26 Locked exit doors were converted to remove the delayed egress. Exit doors function using key fob/keypad for exiting the facility with Education to staff. 114 of 114 staff members. 26 of 26 contract therapy staff have completed.-1/12/26 Education for 25 of 25 direct care Licensed nursing staff on interventions and notification for residents who refuse/remove wander guard device. -1/12/26 Verification of resident Photos and resident room name door tags completed for identification/verification. Updated as indicated-Ad Hoc Committee meeting 1/12/26 at 2:00 p.m. with members in attendance to review the steps taken above. Follow up review and approval of PIP item completion.-1/15/26 - Ad Hoc committee meeting held. Elopement drill tracking form and process reviewed and updated to promote better organization of the search. Location form updated to ensure all areas of the facility are assigned.-On 1/11/26 Initiated ongoing competency testing in support of continued education related to Resident Elopement Awareness and Prevention with an emphasis on signs and symptoms of exit seeking behavior and including related potential interventions and including notification. Currently 129 of 131 staff have completed. 26 or 26 contract therapy staff members have completed. 2 staff members have not been scheduled to work.2/12/26- Education to licensed staff on Identifying Elopement Risk and locating [electronic monitoring device] status. Verification of the facility's removal plan was conducted by the survey team on 2/12/26.Reviewed the updated care plan for Resident #1. Reviewed sign in sheets for education to staff completed 1/11/26 on doors and alarms with 100% completion. Observed permanent alarms on secondary exit doors. Reviewed sign-in sheet for 1/11/26 Ad Hoc QAPI meeting. Reviewed audits for mock elopement drills. Reviewed sign-in sheets for education to staff on 1/12/26 on abuse and neglect with 100% completion. Reviewed the door checks provided by the Maintenance Director. Reviewed elopement books were updated with the correct information as it pertains to the policy. Observed the Maintenance Director verifying the electronic monitoring device check machine to ensure it is functioning. Reviewed current residents who were identified as elopement risks with updated elopement evaluations and care plans updated. Reviewed education sign-in sheets completed 1/12/26 on elopement evaluations with 100% completion to direct care Licensed Nursing staff. Observed and verified exit doors functioning with a keypad or key fob to exit. Reviewed education sign-in sheets to staff completed 1/12/26 related to the exit doors and use of keypad or key fob to exit with 100% completion. Reviewed Ad Hoc meeting sign-in sheets for 1/12/26 and 1/15/26. Reviewed competency testing related to elopement (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	awareness and exit seeking behavior for all staff. On 2/12/26 interviews were conducted over two shifts, regarding elopement reeducation with 26 staff, 17 Certified Nursing Assistants, 4 Licensed Practical Nurses, 4 Registered Nurses and 1 Physical Therapy staff. The staff members were able to state that they had been trained related to identifying residents at risk for elopement and were knowledgeable about the new policies. On 2/12/26 at 4:10 p.m., the facility was asked to conduct an elopement (Dr. Walker) drill. Staff on both the first and second floors responded promptly after a code was announced via portable radio. Staff were observed saying Dr. [NAME] to their peers. Clinical, non-clinical, and administrative staff that responded checked on residents, and searched inside the facility. A debriefing was conducted, following the drill, to discuss opportunities for improvement. Based on verification of the facility's immediate jeopardy removal plan the immediate jeopardy was determined to be removed on 2/12/26 and the non-compliance was reduced to a scope and severity of D.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide adequate supervision to one resident (Resident #1) who was cognitively impaired and identified as an elopement risk, from exiting the facility out of three residents sampled. On 1/11/26, approximately 2:15 p.m., Staff F, Certified Nursing Assistant (CNA), discovered Resident #1 was not in his room. At 2:15 p.m., a Dr. Walker (code announced overhead to indicate a potential missing resident) was called in the facility. Resident #1 exited the facility without staff knowledge from the second-floor hallway next to the Maintenance Directors office into the stairwell leading to the first floor. Resident #1 proceeded down the stairs to the first floor through an unlocked door with no alarm. Resident #1 walked to another door, next to the business office, and proceeded to exit this alarmed door to the parking lot. Resident #1 continued walking North through the parking lot to a road with a 30 mile per hour (mph) speed limit and headed to another street with a 55-mph speed limit. The resident walked approximately 0.6 miles from the facility. Resident #1 was missing from the facility for 10 minutes without staff knowledge. This failure created a situation that resulted in the likelihood for serious injury and/or death to Resident #1 and resulted in the determination of Immediate Jeopardy on 1/11/26. The findings of Immediate Jeopardy were determined to be removed on 2/12/26 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Cross reference to F600Findings included: Review of Resident #1's progress notes revealed:1/11/26 2:50 p.m. Nursing Note The approximate time of 1415 [2:15 p.m.] patient was not reported to be in his room. Last seen by the nurse at 1400 [2:00 p.m.]. Facility search started at approximately 1435 [2:35 p.m.] patient observed on [street name] south of the facility. Patient returned to the facility by staff certified nursing assistant. Patient stated, I was going for a walk and was just about to turn around patient smiling in good spirits. Patient denies pain or discomfort, skin assessment completed without any abnormal findings. Elopement assessment completed. Patient placed on 1:1 monitoring will continue. Review of admission records showed Resident #1 was admitted to the facility on [DATE] with diagnoses to include unspecified sequelae of cerebral infarction, alcohol abuse with alcohol-induced anxiety disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, and syncope and collapse. Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], Cognitive Patterns, showed a Brief interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Functional Abilities showed he could walk 150 feet with supervision or touching assistance. Restraints and Alarms showed a wander/elopement alarm was used less than daily. Review of Resident #1's Physician orders showed:-Device: Wander management bracelet-check placement every shift. Started: 11/14/25 Ended: 11/20/25. Review of Resident #1's care plan showed a focus area of [Resident #1] at risk for elopement as evidenced by Exhibit exit-seeking behavior-ambulating without assist in hallways, etc. Initiated on 11/10/25. Interventions included: Use diversional activities when exit-seeking behavior is occurring . initiated 11/10/25; - continue frequent visual checks as indicated initiated 1/7/26; and Use audible monitoring system to alert staff of exit seeking behaviors {electronic monitoring device} initiated 11/10/25 resolved on 12/11/25. Review of Resident #1's Elopement Risk Evaluations identified he was an elopement risk on 9/17/25, 11/3/25, and 12/23/25. Review of Resident #1's Progress notes showed:-9/24/25 Palliative care Note: . spoke with [resident representative] who states that patient lives in an apartment just down the road from her. She does admit that she works during the day. She states that patient's dementia has progressively slowly gone worse. She also states that she is concerned with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	patient's wandering during the day and his overall safety . -11/10/25 Nursing Note: Patient exhibited escalating behavioral concerns. Patient refused to sit down and refused redirection or instruction from nurse and cna. Patient repeatedly attempted to leave the unit through exit door. -12/10/25 Psychology Provider Note: The patient is an [AGE] year-old-male with recent episodes of agitation and combativeness secondary to confusion. He has presented with agitation, not following safety instructions, and exit seeking. He continues to present with cognitive decline. The patient was unbale to provide information about his diagnosis and treatment. Symptoms are reported to have been present for more than two weeks. The patient's current health issues present a barrier to symptom improvement. -12/15/25 Nursing Note: noted periods of agitation and exit seeking, after multiple redirection attempts NSG [nursing] staff was able to comfortably transfer him back to his room without incident, Psych notified, awaiting for further instructions. -1/6/25 Nursing Note: PT [patient] is resting on bed, alert with confusion, up and moving around the hall way [sic] period for a few minutes then back to bed, . -1/10/25 Nursing Note: Pt is up and walking around the hall way [sic] for a short time, then back to bed, meds [medications] take [sic] with supervision, fluid encourage, continue to monitor. The weather on 1/11/26 was 66 degrees Fahrenheit cloudy with brief precipitation and 84% humidity. (https://world-weather.info/forecast/usa/trinity_west/11-january/). During an interview on 2/10/26 at 9:30 a.m. with Staff A, Receptionist, he stated he received elopement training about a week ago and has not had any residents leave on his shift. He stated he updates the elopement book daily with direction from Human Resources (HR) and the Nursing Home Administrator (NHA) when they get a new admit. He stated he confirms the residents who are in the book and checks to see the electronic monitoring devices are working daily. During an interview on 2/10/26 at 10:15 a.m., with Staff C, Licensed Practical Nurse (LPN), she stated she has had elopement training. She stated they did have an elopement recently. She stated Resident #1 asked her to leave multiple times throughout her shift. She stated she redirected him and she let the nurse know. She stated he was found after going missing for about an hour. During an interview on 2/10/26 at 1:10 p.m. with Staff D, Certified Nursing Assistant (CNA), she stated she is unsure how to identify who is an elopement risk or who is supposed to be wearing an electronic monitoring device. She stated she is not sure of the process or know if there are any residents at risk for elopement in the facility. During an interview on 2/10/26 at 1:17 p.m. with Staff E, LPN, she stated they have orders in the Medication Administration Record (MAR) for the electronic monitoring devices. She stated they do a daily huddle [meeting] to notify staff if they have a new resident with exit seeking behaviors and check it daily, and every shift they document they have seen and checked the electronic monitoring device. She stated someone else comes in with a device to check that the electronic monitoring device is working every day. During an interview on 2/10/26 at 1:52 p.m. with Resident #1's primary care physician he stated, Resident #1 was a sneaky guy and had cognitive decline. He stated his mental state varied. He stated if the facility decided to take off the electronic monitoring device, they should have communicated this with him. He stated they were trying to cover the fact that his mentation would vary, and that Resident #1 could not understand the time of day sometimes. He stated he does not have any awareness of Resident #1 having exit seeking behaviors and that was not communicated to him from the facility. He stated he was notified of Resident #1's elopement by the NHA and understands he was found miles away. During an interview on 2/10/26 at 2:38 p.m. with the Nursing Home Administrator (NHA), Regional Nurse and the Regional Director of Operations, the NHA stated, Resident #1 went out the exit door on the second floor and down the stairs. She stated he went by the maintenance office on the second floor, saw the stairs, held the door handle for 30 seconds which opened the door, went down the stairs and when he got (continued on next page)

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	106079	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Regional Rehab Center	2144 Welbilt Blvd Trinity, FL 34655

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	downstairs, he opened the exit door and went outside of the facility. She stated the door leading to the outside did not have an alarm at time of the incident. She stated the door locks from the outside, but you can open it from the inside. The NHA stated Resident #1 did not exhibit wandering and exiting behaviors prior to the incident. The NHA stated when interviewing staff nobody noticed the resident trying to leave and nobody heard any door alarms. The NHA stated Resident #1 had an elopement assessment upon admission and was identified as being at risk. The NHA stated Resident #1 left somewhere between 2:00 p.m. and 2:15 p.m. The NHA stated the temperature outside was 70 degrees and was not raining at that time. The NHA stated at one point [in previous months] Resident #1 had an electronic monitoring device but did not have one on at the time of him leaving. The Regional Nurse stated that the electronic monitoring device only works for the front door on the first floor, so it wouldn't have mattered in this situation anyway because it does not alert at any of the other doors. The NHA stated the exit door on the second floor with the delayed press, an alarm normally stays on once it is opened, but this one time it did not work. The NHA stated they tested the door and it was working. During an interview on 2/10/26 at 3:17 p.m. with Staff G, CNA, she stated we had a code Dr. [NAME] (missing resident) called, and everyone went downstairs and got assigned an area to search for the missing resident. She stated she had just gotten back from break and went to the assigned area. Earlier she heard someone, (she thinks it was a visitor) say they had seen someone with a matching description on the road. She stated a couple of staff members left the facility to go look for him. She stated she got in her car and left the facility; she made a left and then a right and saw his clothing description and found the Resident #1. Resident #1 was on the road in front of the plaza with a coffee shop and other stores. She stated she told Resident #1 to get in her car and brought him back to the facility. She stated she asked Resident #1 if he was ok and he stated he did it on purpose and that no one saw him leave. She stated Resident #1 did not remember where he was going. She stated it was raining and the resident was damp from the rain. She stated she did not hear any door alarms. During an interview on 2/10/26 at 3:31 p.m. Staff B, Registered Nurse (RN) stated Resident #1 was assigned to her on the day of the elopement. Staff B, RN stated Resident #1 did not have any exit seeking behaviors. She stated he would walk back and forth from nursing station and his room. She stated she was doing her med pass around 2:00 p.m., saw the resident walking to and from the nursing station and his room. She stated she went to another residents' room to give medication. The CNA came back from break and notified her of not seeing Resident #1 in his room. They both initiated the code Dr. [NAME] (missing resident) and started the search. She stated the search started around 2:15 p.m. She stated she does not know how the resident was found. She stated she saw a team member bring Resident #1 back and assessed resident. She does not remember if it was raining and stated the residents' clothes were a little damp. She stated Resident #1 did not say a word to her when he was back, was just smiling. She stated she does not remember hearing any door alarms. During an interview on 2/10/26 at 3:39 p.m. with Staff F, CNA stated being assigned to Resident #1 on the day of the elopement. Staff F, CNA stated that day she had left the resident at nurse's station around 1:45 p.m. so she could go on her lunch break. When she came back around 2:15 p.m., she went to check on the resident, and he was not in his room. She stated she looked around the building and could not find him. She told the nurse she could not find him and that's when the code Dr. [NAME] was called. She stated the resident was found down towards a plaza about a half mile away. She stated Resident #1 would walk around the facility all the time. She stated she did not hear any alarms. During an interview on 2/11/26 at 9:20 a.m., with the Maintenance and Housekeeping Director. She stated the electronic monitoring devices are checked every day. She stated the main lobby door is the only door that is (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	members in attendance to review the days' actions, interventions and outcomes. Follow up review and approval of PIP items. The Medical Director participated in the QAPI meeting in facility. -1/12/26 25 of 25 direct care Licensed Nursing staff educated on completion of Elopement Evaluations-1/12/26 Verification of proper functioning of exit doors and alarms by the regional maintenance consultant-1/12/26 Locked exit doors were converted to remove the delayed egress. Exit doors function using key fob/keypad for exiting the facility with Education to staff. 114 of 114 staff members. 26 of 26 contract therapy staff have completed.-1/12/26 Education for 25 of 25 direct care Licensed nursing staff on interventions and notification for residents who refuse/remove wander guard device. -1/12/26 Verification of resident Photos and resident room name door tags completed for identification/verification. Updated as indicated-Ad Hoc Committee meeting 1/12/26 at 2:00 p.m. with members in attendance to review the steps taken above. Follow up review and approval of PIP item completion.-1/15/26 - Ad Hoc committee meeting held. Elopement drill tracking form and process reviewed and updated to promote better organization of the search. Location form updated to ensure all areas of the facility are assigned.-On 1/11/26 Initiated ongoing competency testing in support of continued education related to Resident Elopement Awareness and Prevention with an emphasis on signs and symptoms of exit seeking behavior and including related potential interventions and including notification. Currently 129 of 131 staff have completed. 26 or 26 contract therapy staff members have completed. 2 staff members have not been scheduled to work.2/12/26- Education to licensed staff on Identifying Elopement Risk and locating [electronic monitoring device] status. Verification of the facility's removal plan was conducted by the survey team on 2/12/26.Reviewed the updated care plan for Resident #1. Reviewed sign in sheets for education to staff completed 1/11/26 on doors and alarms with 100% completion. Observed permanent alarms on secondary exit doors. Reviewed sign-in sheet for 1/11/26 Ad Hoc QAPI meeting. Reviewed audits for mock elopement drills. Reviewed sign-in sheets for education to staff on 1/12/26 on abuse and neglect with 100% completion. Reviewed the door checks provided by the Maintenance Director. Reviewed elopement books were updated with the correct information as it pertains to the policy. Observed the Maintenance Director verifying the electronic monitoring device check machine to ensure it is functioning. Reviewed current residents who were identified as elopement risks with updated elopement evaluations and care plans updated. Reviewed education sign-in sheets completed 1/12/26 on elopement evaluations with 100% completion to direct care Licensed Nursing staff. Observed and verified exit doors functioning with a keypad or key fob to exit. Reviewed education sign-in sheets to staff completed 1/12/26 related to the exit doors and use of keypad or key fob to exit with 100% completion. Reviewed Ad Hoc meeting sign-in sheets for 1/12/26 and 1/15/26. Reviewed competency testing related to elopement awareness and exit seeking behavior for all staff. On 2/12/26 interviews were conducted over two shifts, regarding elopement reeducation with 26 staff, 17 Certified Nursing Assistants, 4 Licensed Practical Nurses, 4 Registered Nurses and 1 Physical Therapy staff. The staff members were able to state that they had been trained related to identifying residents at risk for elopement and were knowledgeable about the new policies.On 2/12/26 at 4:10 p.m., the facility was asked to conduct an elopement (Dr. Walker) drill. Staff on both the first and second floors responded promptly after a code was announced via portable radio. Staff were observed saying Dr. [NAME] to their peers. Clinical, non-clinical, and administrative staff that responded checked on residents, and searched inside the facility. A debriefing was conducted, following the drill, to discuss opportunities for improvement.Based on verification of the facility's immediate jeopardy removal plan the immediate jeopardy was determined to be removed on 2/12/26 and the non-compliance was reduced to a scope and severity of D.