STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115120	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savannah Post Acute LLC	815 East 63 Street Savannah, GA 31405

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on staff interviews, record review, and review of the facility policy titled, Person Centered Care Plans, the facility failed to develop a care plan for one of four sampled residents (R) (R1) with a history of wandering and exit-seeking behaviors. This failure increased the potential for R1 to not receive treatment and/or care according to their needs. Findings include: A review of the facility policy titled Person Centered Care Plans, dated 2/1/2024, revealed the Policy Statement was A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Procedure section included . 8. The comprehensive, person-centered care plan will: . b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. g. Incorporate identified problem areas. H. Incorporate risk factors associated with identified problems. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. A review of R1's clinical record revealed diagnoses including, but not limited to, dementia, psychotic disturbance, mood disturbance, anxiety, depression, lack of coordination, and unsteadiness on feet. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section E (Behaviors) documented wandering behavior occurred one to three days, section GG (Functional Abilities and Goals) documented R1 was independent with mobility, and section P (Restraints) documented a wander/elopement alarm was not used. A review of R1's care plan revealed no focus area, goals, or interventions for wandering or elopement prior to 9/15/2024. A review of the clinical record revealed on 8/18/2024 at 11:29 pm, Licensed Practical Nurse (LPN) GGG documented R1 continued to ambulate, entering residents' rooms and occasionally getting out of the wheelchair and attempting to hit the writer. Continued to exit seek and will not cooperate with staff. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed on 9/15/2024 at 6:20 pm, LPN NN documented that a visitor approached her and reported he had to push R1 back into the facility when he saw R1 near the school located near the facility. R1 stated she went outside to make a call to her mother. A review of the clinical record revealed on 9/15/2024 at 6:35 pm, Registered Nurse (RN) FF documented R1 was found outside of the facility with no injuries. During an interview with the DON on 9/18/2024 at 2:20 pm, the DON verified there were no care plan interventions for wandering or elopement on R1's care plan before 9/15/2024. The DON further confirmed there was a delay in assessing R1 for elopement. During an interview on 9/18/2024 at 2:30 pm, the Administrator stated behaviors of wandering and exit-seeking should be care planned. During an interview on 9/23/2024 at 10:44 am, LPN PP stated that staff used the care plan as guidance for interventions to properly address residents' concerns. During an interview on 9/23/2024 at 11:36 am, the MDS Coordinator stated all residents should be assessed for elopement upon admission and quarterly thereafter. The MDS Coordinator stated R1 was cognitively impaired and had insisted on leaving the facility on numerous occasions. The MDS Coordinator further stated if a resident exhibited exit-seeking behaviors, the behaviors should be included in their care plan. During further interview, the MDS Coordinator verified that R1's care plan did not include a focus area or interventions for elopement until after the resident had eloped on 9/15/2024. Cross-Reference F689

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 49470 Based on staff interviews, record review, and review of the facility policy titled, Elopement Risk and Prevention Program, the facility failed to provide protective oversight and supervision to prevent elopement when one of four sampled residents (R) (R1) exited the facility and was unaccounted for by staff for over one hour. Findings include: A review of the facility policy titled, Elopement Risk and Prevention Program, dated 2/1/2024, revealed the Policy Statement of To identify those residents that have the potential to wander or are at risk for elopement. The Procedure section included 1. An elopement risk assessment will be completed by the admitting nurse/designee upon admission and readmission to the facility. The Elopement Prevention Program section included A. Residents identified at risk of elopement will have interventions placed. A review of R1's clinical record revealed diagnoses including, but not limited to, dementia, psychotic disturbance, mood disturbance, anxiety, depression, lack of coordination, and unsteadiness on feet. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score was 99 (indicating R1 was unable to complete the interview), Section E (Behaviors) documented wandering behavior occurred one to three days, Section GG (Functional Abilities and Goals) documented R1 was independent with mobility, and Section P (Restraints) documented a wander/elopement alarm was not used. A review of the clinical record revealed no assessment for elopement was completed before R1 eloped from the facility on 9/15/2024. A review of the clinical record revealed on 8/18/2024 at 11:29 pm, Licensed Practical Nurse (LPN) GGG documented R1 continued to ambulate, entering residents' rooms and occasionally getting out of the wheelchair and attempting to hit the writer. Continued to exit seek and will not cooperate with staff. A review of the clinical record revealed on 8/23/2024 at 11:06 pm, LPN JJ documented R1 was noted to have increased confusion in comparison to baseline. R1 questioned LPN JJ when her family was coming to get her and take her out of the hospital. LPN JJ advised R1 she was in a nursing home. R1 then stated she wanted to call her family to have them pick her up so she could return home. A review of the clinical record revealed on 9/15/2024 at 10:33 am, LPN OO documented that R1 became increasingly agitated and insisted on leaving the facility. R1 stated she was in jail, and LPN OO explained to R1 that she was not in jail. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed on 9/15/2024 at 6:20 pm, LPN NN documented a visitor approached her and reported he had to push R1 back into the facility when he saw R1 near the school located near the facility. R1 stated she went outside to make a call to her mother. A review of the clinical record revealed on 9/15/2024, Receptionist MM documented that R1 went out of the front door while she was in the copy room printing off orientation packets. A review of the clinical record revealed on 9/15/2024 at 6:35 pm, Registered Nurse (RN) FF documented that R1 was found outside of the facility with no injuries. R1 was taken back to the facility. RN FF documented she informed the Director of Nursing (DON) regarding the elopement. During an interview on 9/18/2024 at 9:05 am, Certified Nursing Assistant (CNA) FFF revealed she worked on 9/15/2024 from 7:00 am to 3:00 pm and from 3:00 pm to 11:00 pm on the hall where R1 resided. CNA FFF stated that on 9/15/2024, R1 was agitated, stated she wanted to go home and repeatedly asked to visit her relatives. CNA FFF further stated she last saw R1 looking outside the door at approximately 4:30 pm on 9/15/2024. During an interview on 9/18/2024 at 9:10 am, LPN KK revealed she worked 9/15/2024 from 7:00 am to 1:00 pm. LPN KK stated that R1 was confused and was able to ambulate without assistance. LPN KK stated that R1 had been asking if she could go home multiple times in the last five months. During an interview on 9/18/2024 at 9:20 am, CNA EEE stated she had not completed elopement training. CNA EEE stated that when a resident requested to leave the facility, she would redirect the resident. During an interview on 9/18/2024 at 10:38 am, Receptionist LL revealed she was the receptionist during the day, and she explained that she always had to make sure she was at the reception area to assist visitors. She stated that in the event she had to take a break, another staff member would assume her position. Receptionist LL revealed the front exit door had a delay before the door lever latched on to close the door. During observation and interview with Assistant Maintenance Director HH on 9/18/2024 at 9:15 am, the front exit door was observed to not latch closed. Assistant Maintenance Director HH revealed staff had not brought the issue to his attention. During an interview on 9/18/2024 at 9:30 am, Maintenance Director II revealed that a switch on the front exit door was turned off. Maintenance Director II activated the switch, and the door latched and functioned as required. During an interview on 9/18/2024 at 2:20 pm, the Director of Nursing (DON) confirmed there was a delay in assessing R1 for elopement. The DON further stated that on 9/15/2024, Receptionist MM did not lock the front exit door when she stepped out, and R1 exited the building unnoticed. She stated RN FF was the last staff member to observe R1 on 9/15/2023 at 5:20 pm and R1 was unaccounted for at least for one hour. During an interview on 9/18/2024 at 2:30 pm, the Administrator revealed a staff member was required to be present at the front door during the day. The Administrator stated R1 exited the facility without being noticed and was brought back by a family member who was visiting the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/2024 at 10:44 am, LPN PP revealed she was on duty 9/15/2024 from 1:00 pm to 9:00 pm. LPN PP stated R1 was very confused and had always expressed she wanted to go home. She further stated on 9/15/2024 at approximately 6:30 pm, a family member observed R1 near a school that was located near the facility and notified her that R1 was outside. LPN PP stated she reported the incident to RN FF. LPN PP stated staff were to guard the front door and lock the door when they were not present at the front door. During an interview on 9/23/2024 at 11:07 am, the Social Service Director (SSD) revealed that R1 was cognitively impaired and had always wanted to leave the facility. The SSD stated a staff member should always be at the front exit door during the day, or the door should be locked. The SSD further stated that R1 was able to exit the building on 9/15/2024 unnoticed. During an interview on 9/23/2024 at 11:50 am, Nurse Practitioner (NP) CC stated she wrote an order for R1's departure alert system on 9/15/2024.