STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and a review of the policy titled Resident Rights, the facility failed to ensure one of 18 sampled residents (R) (R16) was informed of their rights regarding treatment, financial liability, and resident rights upon admission to the facility. The deficient practice resulted in a resident not having informed consent, not knowing their financial liability, or what their rights were.Findings included:A review of the facility's policy titled Resident Rights dated 2/1/2025, indicated The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Prior to or upon admission, the social service designee, or another designated staff member, will inform the resident and/or the resident's representative of the resident's rights and responsibilities.A review of R16's admission Record in the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including amyotrophic lateral sclerosis, hemiplegia affecting the left nondominant side, dysphagia-oropharyngeal phase, and slurred speech. R16 was discharged home on [DATE].A review of R16's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 11/4/2025 revealed a Brief Interview of Mental Status (BIMS) score of 13 out of 15, which indicated she was cognitively intact. Further review revealed that R16 had unclear speech, was sometimes able to make herself understood, and missed some parts of understanding others. A review of R16's admission Agreement form, provided by the facility, which included consent to treat, revealed it was signed electronically by the resident representative on 11/8/2025. A review of R16's Resident Rights form provided by the facility revealed it was not signed. A review of R16's Financial Expectations Worksheet - Insurance Review form provided by the facility revealed it was completed on 11/6/2025 on the same day as the care conference.A review of R16's Insurance Benefits and Co-Pay Due to Facility During Stay form provided by the facility was blank and electronically signed on 11/8/2025.During an interview with Family Member (FM) FM16 on 12/17/2025 at 11:32 am, FM16 stated, admission paperwork was received electronically via email. I refused to sign it because my name was wrong. [R16] is oriented and takes care of everything herself, so I was not sure why she hadn't signed anything. The form was pre-filled out, and I was not able to make changes. The facility had to keep fixing the documents. admission paperwork was first received on 11/7/2025. [R16] said she never signed anything. They fixed my name and sent it back to me on 11/7/2025. The system stopped me from signing since I could not advance the documents without signing due to incorrect information. I never received a corrected form. The immunization records were wrong, along with other information regarding allergies.During an interview on 12/17/2025 at 10:55 am, the Director of Hospitality/Interim Admissions Staff (DOH/IA) stated, Upon admission, admission paperwork is emailed to the resident/representative for signature. Consent to treat should be signed once the resident comes through the door. The DOH/IA was unable to determine when the email was sent due to it was not sent from her email address.During an interview on 12/17/2025 at 11:03 am, the Administrator stated, Nursing has a consent to treat form that should be signed upon admission in the physical chart.During an interview on 12/17/2025 at 1:01 pm, the [NAME] President of Operations (VPO) stated, The resident's consent for treatment and admission packet was not signed at admission. The packet was created on 11/6/2025. The admissions person, who was responsible, resigned from the position at the time of admission. There is no paper consent to treat form signed. There is no documentation that the resident/representative was informed of the resident's rights or benefits and costs.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, document review, and review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to protect the rights of one of eight residents (R) (R6) reviewed for abuse. Specifically, to be free from exploitation by a staff member. This failure had the potential to cause emotional distress or financial burden for R6.Findings included:A review of the facility's policy titled Abuse, Neglect and Exploitation dated 7/15/2025 revealed, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. 'Exploitation' means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.A review of R6's admission Record located in the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, bipolar disorder, anxiety, depression, and a history of physical and sexual abuse.A review of R6's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/26/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. She exhibited some symptoms of depression but no behavioral symptoms. A review of R6's Care Plan, initiated 10/13/2023, revealed, [R6] has self-reported trauma related to her attention-seeking behaviors. Approaches included, Encourage and empower me to be involved in my own care . Encourage me to express my feelings/concerns/thoughts in a safe space . Keeping me informed about changes to my care, life at the facility, etc.During an interview on 12/15/2025 at 11:40 am, R6 stated that Floor Technician (FT) FT1 had exploited her by asking her for money. She stated the staff member no longer worked at the facility, and she felt comfortable and safe in the facility since FT1 had been gone. R6 stated that FT1 texted her requests for money, and she had provided the facility with screenshots of text messages.A review of a Social Services note dated 5/15/2025 revealed, On 5/8 [5/8/2025], resident reported allegations of . misappropriation of funds by a staff member. Allegations were reported to state. SW [Social Worker] interviewed the resident, the resident provided her statement, and the statement was given to Admin [Administrator]. SW informed the resident that an investigation will be done per facility policy. Resident verbalized understanding.A review of the facility's Facility Incident Report Form, the initial report to the State Agency (SA) dated 5/8/2025 in the incident folder revealed, [R6] stated [FT1], a housekeeper, . asked her for money . The staff member was suspended pending investigation. Investigation is ongoing.A review of the facility's Final Report, the follow-up report to the SA, dated 5/15/2025 and provided in the incident folder, revealed the facility's investigation included statements from R6 and her roommate, interviews with other alert and oriented facility residents, and attempted interviews with FT1, with no contact made. The investigation also included screenshots of R6's text messages confirming FT1's requests for money. The allegation of exploitation was substantiated, and FT1 was terminated. A review of FT1's personnel file provided by the Administrator revealed there was no evidence of a criminal background check or reference checks before employment. Cross-reference F606: Not Employ/Engage Staff with Adverse Actions.During an interview on 12/17/2025 at 1:04 pm, the Administrator, who served as the facility's Abuse Prevention Coordinator, stated he had conducted an investigation into R6's allegation and viewed photographic evidence of FT1 requesting money from the resident. The Administrator stated this was exploitation, and the allegation was substantiated as he had proof that it occurred. The Administrator stated FT1 did not respond to calls during the investigation, and he was terminated from facility employment without working again in the building. The Administrator stated resident interviews, and further investigation showed no additional residents had been affected by FT1. The Administrator stated it was against facility policy for staff to request money or gifts from residents, and it was considered exploitation/abuse.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interviews, document review, and review of the policy titled Abuse, Neglect and Exploitation, the facility failed to ensure that one of three staff, Floor Technician (FT) (FT1), completed and documented a criminal background history, including a history of abuse, neglect, or exploitation, before employment. This failure had the potential to contribute to a substantiated allegation of exploitation for a facility resident (R) (R6). Findings included:A review of the facility's Abuse, Neglect and Exploitation policy dated 7/15/2025 revealed, The components of the facility abuse prohibition plan are discussed herein:I. ScreeningA. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, andconsultants.2. Screenings may be conducted by the facility itself, a third-party agency, or an academic institution.3. The facility will maintain documentation of proof that the screening occurred.A review of the Final Report dated 5/15/2025 regarding the investigation of an allegation of exploitation by R6, provided in the incident folder, revealed that R6 alleged that FT1 sent text messages to her asking for money. The investigation also included screenshots of R6's text messages confirming that FT1 requested money. The allegation of exploitation was substantiated, and FT1 was terminated.A review of the personnel file for FT1 provided by the Administrator revealed a hire date of 3/27/2024. There was no evidence of a criminal background check or reference checks before employment. The file indicated that two reference checks were attempted on 3/19/2024; however, not completed.During an interview on 12/17/2025 at 1:04 pm with the Administrator, who served as the facility's Abuse Prevention Coordinator, confirmed that he was unable to locate a background check on FT1, and the only evidence of reference checks was the two that were not completed. Cross-reference F602: Free from Misappropriation/exploitation

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and a review of the policy titled Abuse, Neglect and Exploitation, the facility failed to ensure an allegation of misappropriation of resident property was thoroughly investigated for two of eight residents (R) (R5 and R28) reviewed for abuse. This failure had the potential to contribute to further misappropriation of property in the facility. Findings included:A review of the facility's policy titled Abuse, Neglect and Exploitation dated 7/15/2025 revealed, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . Written procedures for investigations include: 1. Identifying staff responsible for the investigation.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and6. Providing complete and thorough documentation of the investigation. 1. Review of R5's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including but not limited to anxiety and bipolar disorder. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/19/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. She did not exhibit behavioral symptoms. During an interview on 12/18/2025 at 11:45 am, R5 stated she had $173.00 stolen from her while at the facility. She went on to explain her money was stored in her wallet in her lockbox in her room, with the lockbox key tied around her neck. She stated the key went missing from around her neck and was lying in her wheelchair seat upon her return from a shower the next morning. R5 stated she had reported this allegation to the Administrator on 3/3/2025; however, she was told he could not prove it was stolen. A review of R5's Facility Incident Report Form, the initial report to the State Agency (SA), dated 3/20/2025, and provided by the Administrator revealed, Resident stated she was missing $173.00. The resident stated it was in her lockbox, and when she woke up this morning, it was gone. Police were notified, and an investigation was initiated. A review of the facility's Final Report to the SA, dated 3/26/2025 and provided by the Administrator, revealed the police department determined this was not a criminal case as there was no proof that the money had been stolen. Staff did not know about the money. The resident's room and belongings were searched, but the money was not found. The allegation was unsubstantiated. Attached was one statement written by a staff member, whose signature was illegible, which documented that the staff member did not take R5's member. Interviews with five residents documented that they were asked if money had been taken from them while in the facility. There were no resident interviews regarding R5's money, and the interviews did not include R5's roommate. There were no additional staff interviews included. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2025 at 1:05 pm, the Administrator stated he spoke with more staff members as part of the investigation; however, only one of them wrote a statement, and his interviews were not documented. The Administrator stated, Sometimes we just interview verbally; we do not always document staff statements. The Administrator stated he would have expected R5's roommate to be interviewed as part of the investigation and confirmed she was not. 2. A review of R28's admission Record located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including but not limited to epilepsy, traumatic subarachnoid hemorrhage without loss of consciousness, and unspecified fall, sequela. A review of R28's end of Prospective Payment System (PPS) stay MDS with an ARD of 9/17/2025 revealed a BIMS score of five out of 15, indicating severe cognitive impairment. He was recorded to be independent with rolling left/right, sitting to lying, lying to sitting on the side of the bed, and sitting to standing. Since R28's last admission/entry or reentry, he has had one fall with no injury. The MDS indicated R28 was supervision or touch assistance with an ambulance for walking 10 to 150 feet. A review of R28's Situation, Background, Assessment, Recommendation (SBAR), dated 10/6/2025 at 7:05 pm, and located in the EMR under the Progress Notes tab revealed . unwitnessed fall in dining (sic) room at 7:05 pm, injury to back of head, bleeding noted, jerking and foaming at mouth and nose noted. A record review of R28's Post Fall assessment dated [DATE] and located in the EMR under the Assessments tab revealed the facility assessed the resident to have a laceration to the back of the head after the incident, and that the resident was transferred to the hospital. A record review of R28's hospital Discharge summary dated [DATE] and located in the EMR under the Miscellaneous tab revealed the resident had a C3 cervical fracture. A review of R28's Facility Incident Report Form, the initial report to the SA dated 10/9/2025 revealed, Witnessed Fall with Major Injury with No Alleged Abuse.Date and Time of Incident: 10/7/2025 at 7:05 pm.On 10/7/2025, the resident attempted to sit on a chair and missed the handle of the chair, resulting in him falling on the floor. Resident fell in dining (sic) room at 7:05, injury to the back of the head, bleeding noted, pressure applied tothe area, foaming at the mouth and nose.In order to transfer the resident to the hospital.The hospital reached out to the facility on [DATE] and stated the resident obtained a neck fracture. The Facility Incident Report Form dated 10/9/2025 was completed and submitted to the SA after R28's diagnosis of a cervical fracture. This form indicated the resident had a fall on 10/7/2025 that was witnessed. Record review and staff interviewed revealed the resident had an unwitnessed event on 10/06/25 that resulted in a laceration to the back of the head and a discharge to the hospital. The facility failed to ensure the investigation was thorough and corresponded with staff interviews and record review. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2025 at 1:10 pm, Licensed Practical Nurse (LPN) 9 stated that she had heard a thud in the dining room. She said that she and other staff went into the dining room and found R28 on the floor. She stated it was unwitnessed, and the resident was bleeding from the head. LPN9 said the facility called 911 right away, and the resident was picked up by paramedics very quickly. LPN9 stated that she believed R28 was having a seizure, which led to the fall with injury. She said that she completed the SBAR, and then the management team did the reporting and follow-up investigation. During an interview on 12/18/2025 at 4:02 pm, Assistant Director of Nursing (ADON) 2 stated that he was not at the facility but was informed by LPN9 that R28 was found in the day room, foaming at the mouth. ADON2 said that he communicated with LPN9 during the incident. He said the resident was given oxygen, and his neuros were taken. ADON2 said that paramedics came quickly. He said they did a follow-up and found out R28 had a cervical fracture. ADON2 said that he had talked to other residents, but no one could explain what had happened. He said that the facility did not know. ADON2 stated that the Administrator would follow up with any reported events to the SA. During an interview on 12/18/2025 at 4:45 pm, the Director of Nursing (DON) stated that the facility staff called and told her what happened with R28. She stated that the facility reviewed the incident the next day. She said that it was determined that R28 had been in the day room when it happened. She confirmed he was a frequent faller. She said that it looked like R28 might have had seizure activity, but there was no way to know if he had the fall or the seizure first before the injury. During an interview on 12/18/2025 at 5:00 pm, the Administrator stated that when he was notified of a resident going to the hospital, he submitted a Facility Incident Report Form to the SA. The Administrator said that he would use the resident's record and then document what happened in the report. Upon reviewing the resident's record of the incident and the subsequent Facility Incident Report Form submitted to the SA, the Administrator confirmed that they did not correspond. He said he was not sure why he documented the date of the fall as 10/7/2025, and that it was witnessed. He stated that if he had known it was unwitnessed, he would have done an investigation as an injury of unknown origin.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, a review of the policy titled MDS 3.0 Completion, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to accurately code the quarterly Minimum Data Set (MDS) assessment for one of 52 sampled residents (R) (R20) related to a urinary tract infection (UTI) that was not coded when a resident returned from the hospital. This failure had the potential to result in incomplete care planning. Findings included:A review of the facility's policy titled MDS 3.0 Completion, revised/reviewed 03/01/24, revealed Policy: Residents are assessed, using a comprehensive assessment process, to identify care needs and to develop an interdisciplinary care plan . Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State .A review of the Centers for Medicare and Medicaid Services (CMS) LTC RAI 3.0 User's Manual, Version 1.20. 1, dated October 2025, Chapter 3 MDS Items, Section I: Active Diagnoses, indicated . Item I2300 Urinary tract infection (UTI): - The UTI has a look-back period of 30 days for active disease instead of 7 days. - Code only if both of the following are met in the last 30 days: 1. It was determined that the resident had a UTI using evidence-based criteria such as McGreer's, NHSN [National Healthcare Safety Network], or Loeb in the last 30 days, AND 2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, clinical nurse specialist if allowable under state licensure laws) in the last 30 days . If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork .A review of the electronic medical record (EMR), an undated admission Record revealed that R20 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction. A review of R20's SBAR (situation background assessment response) dated 7/23/2025 revealed that the resident's family member called 911 and did not communicate concerns with staff; stated to the EMT [emergency medical technician] that the resident was not responding to her. The EMT transferred the resident via stretcher to the hospital. A review of R20's Hospital Discharge Report dated 8/1/2025 revealed under the Diagnosis and Reason for Visit a diagnosis of UTI and . urine cultures 7/23 (7/23/2025) growing E. coli (group of bacteria that can cause infections in the gut, urinary tract, and other parts of the body) multidrug-resistant sensitive to Meropenem (an antibiotic). Patient treated with 7 days of Meropenem. A review of R20's quarterly MDS assessment, with an Assessment Reference Date (ARD) of 8/2/2025 and located in the EMR under the MDS tab, revealed that under the Infections item I2300 Urinary Tract Infection (UTI) (LAST 30 DAYS) was not marked with an X. During an interview on 12/18/2025 at 12:57 pm, the Resident Assessment Director (RAD), RAD1, confirmed the UTI was not coded on the quarterly MDS assessment for R20 with ARD 8/2/2025. The MDS Director stated R20 was discharged from the hospital on 8/1/2025 and was diagnosed with a UTI based on lab results and treated for it with antibiotics. The MDS Director also stated the MDS Coordinator should have coded the UTI on the MDS since R20 had one in the last 30 days. The MDS Director indicated she did not audit any of the MDS assessments to ensure they were accurately completed by the MDS Coordinators. The MDS Director also indicated that the Regional MDS Coordinator had a couple of calls with her staff monthly related to coding MDS assessments and audited some MDS assessments, but was not aware that any errors in coding UTIs were found at the facility. During an interview on 12/18/2025 at 1:23 pm, RAD2 confirmed he did not code the UTI on the quarterly MDS assessment for R20. The MDS Coordinator stated he was trained to code a UTI if the resident had a UTI while in the facility. The MDS Coordinator stated that he used the RAI Manual when coding the assessments and received training on calls monthly held by the Regional MDS Coordinator. During an interview on 12/18/2025 at 2:34 pm, the [NAME] President (VP) of Clinical Reimbursement stated the MDS Coordinators were trained to code a UTI when the resident was diagnosed and treated for a UTI in the hospital within the last 30 days. The VP of Clinical Reimbursement stated she expected the staff to follow the RAI Manual and accurately code the MDS assessments. The VP of Clinical Reimbursement indicated she had regional MDS coordinators over the facilities, and they had not started auditing MDS assessments for accurately coding the UTIs yet. During an interview on 12/18/2025 at 1:29 pm, the Administrator stated he expected staff to code

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and a review of the policy titled Diagnostic Testing Services, the facility failed to ensure a change of condition requiring immediate attention was addressed on time for one of seven residents (R) (R4) reviewed for change of condition. This failure had the potential to lead to increased pain or internal damage related to R4's dislocated left hip arthroplasty.Findings included:A review of the facility's policy titled Diagnostic Testing Services dated 10/1/2025 revealed, Qualified nursing personnel will receive and review the diagnostic test reports and communicate the results to the ordering Physician within 24 hours of receipt unless the report results falls outside of clinical reference ranges and require immediate attention at which time the Physician will be notified upon receipt . Documentation of diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record.A review of R4's admission Record located in the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] following a hospitalization for hip arthroplasty (a surgical procedure to replace or reshape a damaged joint with a prosthetic implant), an infected hip abscess, and hip surgery. She had diagnoses of, but not limited to, left hip septic arthritis, methicillin-resistant Staphylococcus aureus, and femur necrosis.A review of R4's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 8/17/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A review of R4's SBAR - Change of Condition note dated 9/2/2025 at 6:56 pm revealed, Situation: Writer was informed by therapist that the patient's left leg appears to look shorter than the right leg, and the patient is complaining of pain and is unable to participate in the therapy session. Background: Left hip fracture, self-transfers. Assessment: The Writer was informed by the therapist that the patient's left leg appears to look shorter than the right leg, and the patient is complaining of pain and is unable to participate in the therapy session. Patient observed sitting in a wheelchair with no complaints of pain. Call placed to [nurse practitioner]. Response: New orders for X-ray of left hip and knee. A review of R4's Radiology Results Report revealed that on 9/2/2025 at 8:58 pm, R4 had a dislocated left hip arthroplasty. A review of R4's Lab/Radiology Note located under the Progress Notes tab and dated 9/3/2025 at 2:01 pm revealed, Received [X-ray] results . Impression: Dislocated left hip hemiarthroplasty . Call placed to [nurse practitioner]. New orders to transfer to the hospital for further evaluation A review of R4's Transfer/Discharge note located under the Progress Notes tab of the EMR and dated 9/3/2025 at 2:13 pm revealed, Resident transferred [sic] to . hospital for further evaluation.A review of R4's Progress Notes revealed no indication that the X-ray results were reported to the physician or addressed by the nursing staff between 8:58 pm on 9/2/2025 and 2:01 pm on 9/3/2025.During an interview on 12/18/2025 at 8:44 am, the 3rd floor Assistant Director of Nursing (ADON3) stated that on 9/2/2025, the occupational therapist had reported to her that R4 had increased pain in her left hip, and she reported the situation to the physician immediately. The physician ordered an X-ray of the left hip, and the X-ray was performed. ADON3 stated her shift ended at 7:00 pm on 9/2/2025, so she was not working when the X-ray results were faxed in. ADON3 stated she had called in the X-ray results to the physician on 9/3/2025, but did not recall what time. ADON3 stated the X-ray results should have been reported to the physician immediately by the nurse on duty over the night shift when the results were received. During a follow-up interview on 12/18/2025 at 9:35 am, ADON3 stated Licensed Practical Nurse (LPN) 4 was on duty over the night shift beginning 9/2/2025 at 7:00 pm. ADON3 also reported she spoke with the radiologist, who reported they faxed the X-ray results to the facility but did not call the facility with the results. ADON3 confirmed the radiologist faxed the X-ray result at 9:02 pm on 9/2/2025. During a telephone interview on 12/18/2025 at 1:04 pm, LPN4 stated the expectation was that the nurse on the night shift would retrieve faxes from the fax machine, as there was one on each floor, and follow up immediately by calling the physician for any critical results. LPN4 stated that sometimes, however, she was unable to get to the faxes on the night shift because she was so busy taking care of the residents, and in that case, the ADON would look at the faxes when she came in the next day. LPN4 stated she had not worked at the facility in months and did not recall this specific resident or situation. During an interview on 12/19/2025 at 12:05 pm, the Director of Nursing (DON) stated her expectation was that the nurse on duty receive a fax and notify the physician of the results at the time. During a follow-up interview on 12/19/2025 at 12:30 pm, the DON stated she was unable to find any evidence of physician notification of R4's hip arthroplasty dislocation from the time of the fax on 9/2/2025 at 9:02 pm to the time of documented physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	12/19/2025

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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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and a review of the policy titled Elopements and Wandering Residents, the facility failed to provide adequate supervision and assistance devices to prevent accidents for one of 52 sampled residents (R) (R49) related to ensuring that R49's unit was secure to prevent elopement. On 12/18/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents.On 12/18/2025 at 3:15 pm, the Administrator, Director of Nursing, [NAME] President of Operations, and Chief Compliance Officer were notified that IJ was identified to have existed on 7/1/2025, when Resident (R) (R49) eloped from the facility by exiting the second-floor secured unit. It was determined that the alarms and the delayed egress paddle door were not functioning properly.An Acceptable Removal Plan was received on 12/19/2025. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 12/19/2025. The facility remained out of compliance while the facility continued management-level staff oversight, as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes monitoring the physical building for functioning egress doors and assessing and monitoring residents with elopement risk.Findings included:A review of the facility's policy titled Elopements and Wandering Residents, dated 3/1/2022 and revised 7/1/2025, revealed that if the resident is not found indoors or in the vicinity of the building, the Administrator will call the police to act as a liaison to locate the missing resident. A review of the electronic medical record (EMR) revealed that R49 was admitted to the facility on [DATE] with diagnoses of orthopedic aftercare following surgical amputation, cellulitis of the left toe, idiopathic aseptic necrosis of the left toes, vascular dementia, psychotic disturbance, mood disturbance, anxiety, and cognitive communication deficit.A review of R49's physician's orders revealed an order for a wander guard to the right ankle, to check placement each shift on 4/17/2025. A review of R49's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/26/2025 revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident was severely cognitively impaired. The MDS indicated no upper or lower extremity impairment, and sit-to-stand requires maximum assistance. A review of R49's Elopement Risk Evaluation dated 7/1/2025, revealed the resident scored a 14, which indicated high risk.A review of R49's care plan, dated 4/17/2025, revised on 6/29/2025, revealed R49 was an elopement risk and wanderer, and his safety would be maintained. The Care plan indicated interventions of checking the sensor placement on the leg and function, and to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. A review of R49's progress notes revealed that on 6/21/2025 at 5:13 pm, R49 was observed ambulating on the unit with an unsteady gait requiring redirection to his wheelchair for safety. R49 was non-compliant with redirection for safety measures due to fall risk multiple times throughout the shift. At times, failed to utilize the wheelchair during the shift, having limited safety awareness. Further review of the progress notes revealed on 7/1/2025 at 2:50 pm, the alarm from the wander guard system went off, and a search within the facility was initiated to see if all residents are present. The resident was nowhere to be found in the unit and in other units after checks. Code Yellow was immediately initiated, and all staff went out to search for the resident. The resident was found at approximately 3:40 pm in the parking garage across the street and was brought back to the facility. R49 was assessed and was not injured. Resident will be on 30-minute checks and room change initiated, will continue plan of care.A review of the Facility Reported Incident (FRI) dated 7/1/2025 provided by the facility revealed that at 2:55 pm, the alarm on the second floor went off. The report concluded that R49 eloped through the exit doors on the second floor. The elopement code was called and performed well; staff performed inside and outside searches, and R49 was found less than an hour after the call. R49 was placed on one-on-one 24 hours after the incident. The report further indicated that a code yellow was implemented after the alarm for the wander guard was sounding and R49 was not in sight. There is no reference to the outside exit discharge door alarm, only the stairway exit door wander guard alarm. Further review of the FRI indicated on 7/1/2025 at 3:15 pm or 20 minutes later, a code yellow was announced over the intercom, alerting all staff that a resident had eloped. Police were notified that a resident was missing from our facility. After the police were contacted, the FRI indicated, management staff and floor employees searched outside the premises An interview with