STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115272	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joe-Anne Burgin Health and Rehabilitation	321 Randolph Street Cuthbert, GA 39840

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** Based on staff interviews, record review, and review of the facility's policies titled, Elopement and Wandering Patients, the facility failed to ensure adequate supervision to prevent elopement for one of 28 sampled residents (R) (R13) resulting in the resident exiting the facility unsupervised. This deficient practice had the potential for injury and inability to safely navigate outside the facility.Findings include:Review of the facility's policy titled, Elopement dated 12/27/2024 revealed an Intent to promote person-centered care for patients at risk for elopement. Section titled Definition defined elopement as when a patient leaves the premises or a safe area without authorization and/or necessary supervision. Section titled Guideline revealed the center implements mechanisms and procedures for monitoring and managing patients at risk for elopement to minimize the risk of a patient leaving a safe area without authorization and/or appropriate supervision. Under section titled Procedure, subsection Assessment revealed the center will take a proactive approach for new patients and assess new admissions for elopement risk. Further review revealed elopement risk factors related to the patient and appropriate interventions will be identified and implemented into the patient's plan of care.Review of the facility's policy titled, Wandering Patients dated 12/27/2024 revealed an Intent to identify wandering behavior of a patient and to address this behavior appropriately. Section titled Guideline revealed the issue of wandering should be addressed on the interdisciplinary care plan with an appropriate goal and interventions defined.Review of R13's electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE] and pertinent diagnoses included but were not limited to Alzheimer's and dementia.Review of R13's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Section E, Behaviors, revealed rejection of care occurring daily and wandering occurring daily. Section GG, Functional Status, revealed R13 required setup or clean-up assistance with eating, oral hygiene, toileting, shower/bath, and putting on/taking off footwear. Further review revealed R13 required supervision or touching assistance with upper and lower body dressing. Section J, Health Conditions, revealed R13 had a fall prior to admission within the last two to six months.Review of R13's care plan revealed a focus of elopement/risk of elopement evidenced by aimless wandering and/or exit seeking behavior with an onset dated 1/16/2026. The goal of this focus revealed that the patient will have no injuries during any attempts to leave the grounds during the review period. Further review revealed an intervention dated 1/16/2026 for 1:1 supervision while outside and an intervention dated 1/21/2026 to maintain close observation of patient's location.Further review of R13's care plan revealed a focus of attempt to elope evidenced by short-term memory problem with an onset date of 1/16/2026. Goals included patient safety will be maintained through the review period. Further review revealed an intervention dated 1/16/2026 to include analyze key times, places, circumstances, triggers, and what de-escalates behavior, to observe patient's behavior, and to observe the patient's location.Further review on R13's care plan revealed a focus of behaviors evidenced by pacing with an onset date of 1/30/2026, wandering with an onset date of 1/30/2026, and wanders at risk for elopement (exit seeking behavior) with an onset (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date of 1/16/2026. Goals included patient's needs will be met and safety maintained during review period. Further review revealed an intervention dated 1/21/2026 to observe for location frequently and redirect when noted with exit seeking behaviors.Review of the final report for the Facility Incident Report #202600853 dated 1/28/2026 revealed a conclusion that documented, The facility can confirm that the resident exited the building unsupervised. The root cause was the exit door being remotely opened for another resident, and the door was not in line of sight of the staff.An interview on 03/19/2025 at 2:25 PM with the Administrator revealed that regarding the R13's elopement that occurred on 1/21/2026 he was notified by Licensed Practical Nurse (LPN) AA that R13 had exited the building through the side door located near room [ROOM NUMBER]. The administrator stated that R13 was subsequently located across the street near a nearby college.An interview on 03/19/2026 at 3:35 PM with LPN AA, who is the assigned nurse providing care for R13, revealed that R13 exhibited exit-seeking behaviors since her admission to the facility, including going to the door with personal belongings. Interventions implemented to address this behavior included frequent monitoring ensuring R13 remained in the building and to check on R13 every 15 to 30 minutes. LPN AA stated that on the day of the elopement incident, R13 likely exited the building when the doors were unlocked due to a generator outage, reportedly following another resident, and she was located within five minutes by staff across the street near a nearby college.