STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115319	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fifth Avenue Health Care	505 North Fifth Avenue Rome, GA 30165

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews, record review, and review of the facility policy titled Policy and Procedure Abuse, Neglect, and Exploitation, the facility failed to keep one of three sampled residents (R) (R10) free of sexual abuse by another resident, R11. This failure had the potential to cause physical and psychosocial harm to R10. Findings included:A review of the facility policy titled Policy and Procedure Abuse, Neglect, and Exploitation with a revised date of 9/17/2025, revealed that 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. It is noted that sexual abuse is non-consensual sexual contact of any type with a resident. Prevention of Abuse, Neglect, and Exploitation: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. A review of the electronic medical record (EMR) for R10 revealed she was admitted to the facility with diagnoses that included unspecified altered mental status, unspecified depression, generalized anxiety disorder, and dementia with psychotic disturbance. A review of the Quarterly Minimum Data Set (MDS) assessment for R10 dated 3/23/2026 revealed the following:Section B, Hearing, Speech, and Vision: adequate hearing and vision, clear speech, can be understood, and usually understands.Section C, Cognitive Patterns: Brief Interview for Mental Status (BIMS) score was 0, indicating severe cognitive impairment.Section D, Mood: Mood score of 17, indicating moderately severe depression. A review of the Care Plan for R10 revealed the following concerns:Focus: behavior problem (crying, verbal aggression, and agitation) related to (r/t) dementia.Focus: resistance to care (restorative exercises) r/t anxiety.Focus: impaired cognitive function/dementia (staff assessment) or impaired thought processes r/t Alzheimer's dementia.Focus: communication problem r/t cognitive deficits; she is understood and usually understands.Focus: uses antidepressant medication r/t depression.Focus: restorative nursing for impaired cognition, unsteady gait/balance.The focus concerns were complete with appropriate goals and interventions. A review of the Sexual Expression and/or Intimacy-Capacity to Consent Interview, dated 3/7/2025, revealed the following questions and answers:*Who do you wish to initiate sexual contact with? Answer: Yeah, Yes, oh Lord . I have no idea.*Are you currently in a relationship with this person? Answer: Fine*Do you believe that your current partner is your spouse? Answer: Yes*Do you know what it means to have sex? Answer: I don't know. I always have such a good answer.The interview did not express a decision as to R10's ability to consent to a sexual relationship, but her answers were inappropriate. A review of the EMR for R11 revealed he was admitted to the facility with diagnoses that included other stimulant abuse, a history of cerebral infarction without residual effects, transient ischemic attacks (TIAs), and vascular dementia. He was discharged to the local hospital on 4/3/2026. A review of the Quarterly MDS assessment for R11, dated 3/4/2026, revealed (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following:Section C, Cognitive Patterns: BIMS score of 11, indicating moderate cognitive impairment.Section D, Mood: Mood score of zero (0), indicating no depression.Section E, Behaviors: none. A review of the Care Plan for R11 revealed the following focus concerns:Focus: behavior problem-he pulls out his penis in public areas (11/22/2024).Goal: Will have fewer episodes of inappropriate behavior by review date (revised 3/9/2026).Interventions: administer Provera and Depakote as ordered per MD (Medical Doctor) for hypersexual behavior (1/16/2026); anticipate and meet his needs (11/22/2024); consult with facility psychiatrist to eval and treat for hypersexual behaviors (1/16/2026); if reasonable, discuss his behavior-explain/reinforce why behavior is inappropriate and/or unacceptable (11/22/2024); intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; remove from situation and take alternate location as needed.Focus: Expresses public displays of affection with another female resident (holding hands, kissing, hugging, touching, etc.) while sitting in the lobby (6/17/2025).Goal: will have fewer episodes of PDA by review date (revised 3/9/2026).Additional interventions: assist him in developing more appropriate methods of interacting with female residents (6/17/2025); give positive reinforcement for appropriate behaviors (6/17/2025); provide a program of activities that is of interest and encourage him to participate (6/17/2025).Focus: Impaired cognitive function: BIMS score=11 or impaired thought processes r/t history of alcohol abuse (revised 11/10/2025).Goal: will remain oriented to person, place, situation, and time through the review date (revised 3/9/2026).Interventions: administer medications as ordered; monitor/report PRN (as needed) any changes in cognitive function, specifically changes in decision-making ability, memory, recall, and general awareness, difficulty expressing self, difficulty in understanding others, level of consciousness, and mental status (4/20/2023).Focus: Antidepressant medications r/t anxiety (revised 12/18/2025).Goal: will have no adverse reactions through the next review date (revised 3/9/2026).Interventions: administer medications as ordered by the physician; consider psychologist intervention (12/18/2025).Focus: Has conflict with a particular female resident and attempts to get her agitated (3/5/2025).Goal: will not cause other residents to become agitated for 90 days.Interventions: attempt to keep him from the other resident; explain to him why his behavior is unacceptable; intervene as needed to protect others from potential harm. A review of a facility document dated 1/14/2026 revealed an allegation of resident-to-resident sexual abuse in which the Employee Services Manager (ESM) witnessed R11 attempt to get R10 to open her mouth so he could insert his penis in the hall outside of his office. R11 did not expose his genitals, but the HRPM overheard him tell R10 what he wanted her to do. R11 stepped away when the HRPM approached. Staff were immediately educated that R10 and R11 should never be together. The Social Worker (SW) and Administrator spoke with R11 and informed him that he was not to go over to the [NAME] Side, where R10 lives, unless he was unaccompanied. The allegation was reported timely to the State Survey Agency (SSA) and investigated thoroughly, including a timeline containing appropriate notifications (responsible party, Nurse Practitioner, and local law enforcement). Police investigation revealed R10 did not recall the incident. A review of the subsequent investigation, dated 1/22/2026, substantiated the reported allegation. R11 was placed on 1:1 observation for 48 hours, then every fifteen-minute check to monitor his whereabouts. A review of a facility document dated 4/3/2026 revealed an allegation of resident-to-resident sexual abuse, which staff witnessed R11 expose his penis to R10. The staff member immediately intervened and told R11 to put his penis back into his pants. R11 returned to his room, and staff initiated 1:1 supervision. Local law enforcement was notified and informed that the facility that R11 had an outstanding warrant several years ago, and he was given a notice of immediate discharge and taken to the local jail. The subsequent investigation report dated 4/10/2026 revealed a thorough investigation, which included a timeline with a witness account by [NAME] FFF, notifications to responsible parties, Nurse Practitioner, and local law enforcement. The allegation of inappropriate sexual behavior was substantiated, and R11 was already discharged to the local jail. During an interview with Certified Nursing Assistant (CNA) ZZ on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/23/2026 at 12:15 pm, she stated the facility provided in-services on abuse and other topics every pay period, mostly in-person. She named the Abuse Coordinator (AC) as the Administrator who had two hours to report abuse allegations to the SSA, five days to complete the investigation, and a suspension for the accused staff member. She stated that if she encountered an abusive situation, she would make sure the resident(s) was/were safe and then report to the AC. During an interview with CNA OO on 6/23/2026 at 12:48 pm, she stated that the facility provided education on abuse prevention and reporting at least every pay period and as needed. She named the AC as the Administrator who had two hours to report abuse allegations to the SSA, five days to complete the investigation, and a suspension for the accused staff member. She stated that if she encountered an abusive situation, she would make sure the resident(s) was/were safe and then report to the AC. During an interview with the Activities Director on 6/23/2026 at 12:55 pm, she stated that the facility provided education on abuse prevention and reporting at least every pay period and as needed. She named the AC as the Administrator who had two hours to report abuse allegations to the SSA, five days to complete the investigation, and a suspension for the accused staff member. She stated that if she encountered an abusive situation, she would make sure the resident(s) was/were safe and then report to the AC. During an interview with LPN WW on 6/23/2026 at 1:05 pm, she stated that the facility provided education on abuse prevention and reporting at least every pay period and PRN. She stated that the Administrator was the AC who had two hours to report abuse allegations to the SSA, five days to complete the investigation, and, if the alleged perpetrator (AP) was a staff person, he/she would be suspended pending the outcome of the investigation. During an interview with LPN HHH on 6/23/2026 at 2:45 pm, she stated that the facility provided in-service education r/t abuse at least quarterly and PRN. She stated the AC was the Administrator who had two hours to report abuse allegations to the SSA, five days to complete the investigation, with the accused staff person suspended or placed on leave during the investigation period. Regarding R11, she stated he was alert and cognitively intact, but she did not witness any sexual behaviors or verbiage on his part when she took care of him. During an interview with the admission Coordinator on 6/23/2026 at 3:15 pm, she stated that the facility only began checking the Sex Offender Registry last year for potential new admissions. She stated they did not check the Sex Offender Registry for their current resident population. During a joint interview with the Administrator and Director of Nursing (DON) on 6/23/2026 at 3:30 pm, each stated their goal was to do everything possible to keep their residents safe from any form of abuse. They each confirmed that they present staff education with each pay period, which included abuse prevention and reporting. The DON stated that R11 had an outstanding arrest warrant, which they were not aware of, but allowed for an immediate discharge. She stated R11 only targeted R10 because, as he told staff, she reminded him of his ex-wife.

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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, staff and resident interviews, record review, and review of the facility policies titled Accidents and Incidents - Investigating and Reporting, Elopement, and Dementia Care, the facility failed to maintain an accident-free environment and provide adequate supervision to prevent accidents for one of three sampled residents (R) (R1). This had the potential to affect at least 10 additional residents identified as being at risk for wandering/elopement. Specifically, the facility failed to implement effective interventions to prevent the elopement of R1, creating an ongoing risk for resident elopement and injury. This deficient practice placed residents at risk for serious harm, injury, and death. On 6/16/2026, 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 6/16/2026 at 2:53 pm, the Administrator and Director of Nursing (DON) were notified that Immediate Jeopardy (IJ) was identified to have existed on 6/7/2026, when R1 eloped from the facility.An Acceptable Removal Plan was received on 6/17/2026. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was confirmed that the corrective plans and the deficient practice were removed on 6/18/2026. The facility remained out of compliance at a lower scope and severity as follows: F689 Scope/Severity: D, 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 assessing, monitoring, and supervising residents at risk for wandering/elopement.Finds included:A review of the facility's initial incident summary revealed that on 6/7/2026 at approximately 8:45 pm, staff were unable to locate R1 after a certified nursing assistant (CNA) reported the resident missing. The facility initiated a search of the building and, when unable to locate R1, expanded the search to the parking lots and surrounding area. Law enforcement was notified at 9:09 pm and arrived at 9:12 pm. R1 was located at 9:47 pm, appeared unharmed, and was transported to the emergency department for evaluation before returning to the facility without new orders. Further review revealed that maintenance staff responded to the facility and inspected all exit doors. The code to the door adjacent to the Minimum Data Set (MDS) office was changed after the door was reportedly found slightly ajar during the search for R1. The investigation further revealed that the facility was unable to determine the exact circumstances under which R1 exited the building.During an observation on 6/15/2026 at 10:24 am, it was revealed that the facility had 11 exit doors. Ten doors were equipped with magnetic locks requiring code access; however, only one exit door had an audible alarm. The observation further revealed that five exit doors had delayed closure, including an approximately nine-second delay on the employee breakroom door. The employee breakroom exterior door remained a primary entrance and exit point and could be easily opened from the interior, as it remained unlocked. The observation revealed that only one surveillance camera in the lobby area was operational, while cameras located near most exit doors were nonfunctional.A review of the facility's investigation of the elopement incident dated 6/7/2026 identified that R1, a resident assessed as being at risk for wandering/elopement, exited the facility without staff knowledge after being redirected multiple times for wandering into resident rooms. The investigation revealed surveillance footage that showed R1 traveling through the facility lobby at approximately 7:53 pm and in an adjacent parking lot by approximately 8:00 pm. The facility concluded that R1 most likely exited through the East Wing exit door adjacent to the employee breakroom; however, the investigation was unable to determine the exact circumstances under which R1 exited the building. A review of the facility's Wandering/Elopement Risk List revealed 11 residents identified as being at risk for wandering/elopement.A review of the electronic medical record (EMR) revealed that R1 was admitted to the facility on [DATE] with diagnoses, including but not limited to late-onset Alzheimer's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	disease, severe dementia with agitation, anxiety disorder, insomnia, Chronic Obstructive Pulmonary Disease (COPD), and a history of breast cancer.A review of R1's annual MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment, and that R1 had no impairments and did not require any assistive devices.A review of the care plan dated 2/25/2026 indicated R1 presented with a problem of cognitive impairment related to dementia and Alzheimer's disease and a history of falling with prior fractures. Goals included, but were not limited to, maintaining safety and preventing injury or complications through the review period. Interventions included, but were not limited to, monitoring the resident for changes in condition, providing appropriate supervision, and implementing safety measures as indicated for the resident's condition and risk factors.A review of R1's Elopement Evaluation dated 4/7/2026 revealed that R1 was assessed as being at risk for wandering/elopement related to severe cognitive impairment and dementia. The evaluation identified interventions, including staff awareness of elopement risk, monitoring whereabouts, frequent observation, redirection, purposeful activities, use of safety devices, and implementation of measures to prevent an unsupervised exit from the facility.A review of the care plan, revised 6/10/2026, revealed that R1 presented with a problem of elopement risk, exit-seeking behaviors, and wandering related to severe cognitive impairment, disorientation, wandering throughout the facility, entering other residents' rooms, and an actual elopement event on 6/7/2026. Goals included, but were not limited to, R1 not leaving the facility unattended through the review period. Interventions included keeping R1 in supervised areas whenever possible, monitoring whereabouts, redirecting as needed, providing structured activities, encouraging participation in activities, and conducting visual safety checks every 15 minutes.A review of nursing documentation dated 4/15/2026 through 6/15/2026 revealed that R1 had a BIMS score of zero, indicating severe cognitive impairment, exhibited chronic confusion, frequent wandering behaviors, entered other residents' rooms, required frequent redirection, and was documented as an elopement risk. Documentation further revealed that R1 eloped from the facility on 6/7/2026 and was subsequently located by law enforcement and transported to the emergency department for evaluation.A review of the emergency department record dated 6/7/2026 through 6/8/2026 revealed that R1 had been missing from the facility for approximately three hours and was found walking along a roadway in the rain before being transported by Emergency Medical Services (EMS) for evaluation.During an interview with R1's family member on 6/15/2026 at 1:13 pm, he was notified on 6/7/2026, after R1 had been located, and was informed that she had left the facility. He stated R1 had resided at the facility for approximately two years, ambulated independently, frequently walked throughout the facility, and was found approximately one block away from the facility. He further stated he did not believe R1 could have independently navigated her way out of the facility and believed someone may have allowed her to exit.During a telephone interview on 6/15/2026 at 3:30 pm, CNA BB revealed that R1 was known to walk throughout the facility, push on exit doors, attempt to open doors, and occasionally attempt to follow others through doorways. CNA BB stated she participated in the search for R1 after staff were unable to locate her on the evening of 6/7/2026.During a telephone interview on 6/15/2026 at 2:50 pm, CNA CC revealed that R1 regularly walked throughout the facility and attempted to exit through the doors. CNA CC stated R1 had been observed wandering on the evening of the incident before being discovered missing.During a telephone interview on 6/15/2026 at 3:43 pm, CNA EE revealed R1 routinely entered other residents' rooms and frequently tested exit doors to determine if they would open. He stated that staff often redirected R1 due to these behaviors. CNA EE stated that staff searched the facility after R1 could not be located.During a telephone interview on 6/15/2026 at 3:11 pm, Registered Nurse (RN) Weekend Unit Supervisor FF revealed that at approximately 8:30 pm on 6/7/2026, staff notified him they were unable to locate R1. He stated that staff conducted a systematic search of resident rooms, bathrooms, closets, and common areas before determining R1 was not in the building. He stated law enforcement was contacted after the facility-wide search was completed. RN FF stated R1 was known to wander throughout the facility (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and enter resident rooms. He further stated that maintenance immediately secured a door identified during the investigation and acknowledged he was unaware of the existence of one of the exit doors before the incident.During an interview on 6/15/2026 at 4:33 pm, the Social Services Director revealed R1 had been a wanderer since admission and routinely required redirection due to entering resident rooms and wandering throughout the facility. Further stated she responded to assist after being notified of the elopement and observed R1 after she was located by emergency responders.During an interview on 6/15/2026 at 4:40 pm, the MDS Coordinator revealed R1 had been identified by the facility as being at risk for wandering/elopement and exit-seeking behaviors. The MDS Coordinator stated interventions included increased monitoring, redirection, and maintaining a wandering resident tracking book at the nurses' stations.During an interview on 6/15/2026 at 4:03 pm, the Maintenance Director revealed that a review of available surveillance footage showed R1 in the facility lobby at approximately 7:53 pm and in an adjacent parking lot by approximately 8:00 pm. Based on the footage and R1's observed path of travel, he believed R1 most likely exited through the breakroom door or the exterior door leading to the parking lot; however, he could not determine the exact door used by R1. The Maintenance Director stated that only one lobby camera was operational and acknowledged he was unable to review footage from other areas because most facility cameras were not functioning. He further stated that residents or visitors may have obtained door access codes from others, that most exit doors were equipped with magnetic locks but lacked audible alarms, and that door closure delays could be adjusted from approximately 10 seconds to 1 second. Further reported that he inspected all exit doors following the incident and changed the code to the exit door adjacent to the MDS office after concerns were raised that the door had not fully closed during the search for R1. He further stated that city surveillance footage showed R1 crossing multiple roadways before being located.During an interview on 6/15/2026 at 4:38 pm, the DON revealed R1 wandered throughout the facility daily and required frequent observation and redirection. Further stated the facility did not know exactly how R1 exited the building, but believed she likely exited through the area adjacent to the employee breakroom. She further stated that family members commonly entered the facility through the breakroom exterior entrance and acknowledged that staff had provided education regarding not sharing door access codes. The DON further stated that she believed, based on fire safety design, the facility exit doors would open if held for approximately 15-30 seconds; however, observation did not confirm this function at the time of survey.During an observation with the DON and Maintenance Director on 6/15/2026 at 5:08 pm, the exit door across from the conference room was tested. The handle was held for multiple minutes to test whether the delayed egress system would release as described by the DON. This test revealed that the door did not release or alarm. During the same observation, a staff member exited the employee breakroom adjacent to the lobby, and the breakroom door failed to close and latch completely, allowing the surveyor to push the door open. The Maintenance Director confirmed the door delay settings had recently been adjusted from 10 seconds to 1 second. Follow-up interview on 6/15/2026 with the Maintenance Director further clarified that the facility doors do not function in the manner described by the DON, stating the doors would not open if held down for an extended period of time and would only release based on their programmed locking mechanism, not continuous pressure applied to the handle.During a telephone interview on 6/16/2026 at 10:11 am, Licensed Practical Nurse (LPN) KK revealed that she observed R1 wandering on the evening of 6/7/2026, entering resident rooms, and requiring redirection. She stated she last observed R1 shortly after 8:00 pm in a lounge area and later assisted with the facility-wide search when staff were unable to locate her. Further stated staff inspected an exit door near the MDS office during the search after concerns were raised that the door was not closing properly.During an interview on 6/16/2026 at 1:06 pm, LPN GG revealed that staff maintained wandering and elopement books identifying residents at risk and that interventions for residents identified as wanderers included redirection, close monitoring, and 15-minute safety checks following an elopement incident.During an interview on 6/16/2026 at 1:16 pm, CNA HH revealed R1 was well (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	known by staff to wander throughout the facility, enter other residents' rooms, take belongings, push on exit doors, and require frequent redirection. Further, these behaviors had been ongoing and were known to facility staff before the elopement incident.During an observation on 6/16/2026 at 12:42 pm, R1 ambulated independently throughout the East Wing hallway while awaiting departure with her spouse.A review of the policy titled Accidents and Incidents-Investigating and Reporting, revised 2/27/2026, indicated that Assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to reduce the risk of recurrences and improve the management of resident care.A review of the policy titled Elopement, revised October 2023, indicated that This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to reduce the risk of accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Further review of item 1. The facility is equipped with keypad door locks to avoid elopements. Item 2. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.A review of the policy titled Dementia Care dated February 2023 indicated that It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Further review of item 2. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Item 4. If needed, the environment will be modified to accommodate individual resident care needs. Item 5. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary.The facility implemented the following actions to remove the IJ:1. On 6/7/2026, the facility conducted a thorough search of the facility and grounds, and R1 could not be located. At 9:09 pm, 911 was called, and at 9:12 pm, a police officer arrived to obtain information regarding the resident. Per the emergency phone call at 9:27, R1 was seen on one of their cameras, and at 9:47 pm, R1 was located in the parking lot of some apartments, one block from the facility, and was examined by EMS. No injuries were noted, but in an abundance of caution, per the facility's request, she was transported to the emergency room (ER) to be examined. R1 returned to the facility with no new orders. On 6/7/2026, the DON, Administrator, Corporate, the responsible party, and the Medical Director (MD) were notified. On 6/7/2026, a facility-wide audit of all exit doors was completed by the Maintenance Director, and his statement says they were functioning, latching, and locking properly. He changed the west wing door code by the MDS office, and the code was not given to anyone because at that time we suspected that the resident may have exited through that door, as staff reported that the door was not fully latched when they were searching for R1 in the building. 2. On 6/8/2026, an Emergency Quality Assurance (QA) meeting was conducted with the Interdisciplinary Team, and the circumstances surrounding the elopement were reviewed. A root cause analysis was started, and the facility continued to investigate the elopement. The Maintenance Director reviewed the camera footage, and the resident was seen on camera in the lobby at 7:53 pm going from [NAME] Hall to East Hall. The Maintenance Director requested to review the camera footage at a business that is adjacent to the facility. Once the footage was reviewed, R1 was observed at 8:00 pm in their parking lot. On 6/8/2026, exit monitoring to ensure proper door functioning was initiated Monday through Friday to be completed by the Maintenance Director or the Assistant Maintenance Director. On 6/17/2026, the Maintenance Director educated the DON and the Infection Preventionist/Staff Development nurse on how to check the doors to ensure that they are auto-closing, locking when closed with no delay, and that the interim audible alarms are working on the four doors they were added to. The RN Weekend Supervisor will be trained when he comes to work on Saturday (he is not able to come prior) by the (continued on next page)

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	115319	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fifth Avenue Health Care	505 North Fifth Avenue Rome, GA 30165

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Maintenance Director. If the RN Supervisor is not available to check the doors on the weekend, the DON or the Infection Preventionist/Staff development nurse will do exit monitoring. 3. On 6/15/2026, a CNA was observed exiting the breakroom with several snacks in her arms/hands, and the door did not fully shut. This was observed by the DON. The breakroom does have a keypad door lock to enter and exit the breakroom from the hallway of the facility, as well as an automatic closer. There is also an external door to exit the building into the parking lot from the breakroom that does not have a keypad lock on it.On 6/15/2026, signage with a red stop was placed on every exit door stating Please Do Not Let Residents Leave the Building. Please check that the door is securely locked before your departure. This sign was placed on all 11 facility exits and the inside of the breakroom door to remind staff to ensure the door locks.On 6/15/2026, the facility completed a comprehensive security and physical plant assessment. It was determined that one of the 11 doors had an audible door alarm. On 6/15/2026, Interim Audible Alarms were placed on the breakroom door, the door exiting the breakroom into the parking lot, the main entrance into the East Wing, and the Main Entrance by the Administration Hall. The door leading to the Courtyard has a functioning alarm.4. On 6/16/2026, the Maintenance Director replaced the automatic door closer to the breakroom, and it now shuts even if both hands are occupied. It was tested after closing, and it could not be pushed open. On 6/16/2026, the Maintenance Director changed the door codes to the main door on the East Wing and the door that leads from the hall to the breakroom. The staff will only have the codes for the following doors: The main entrance by the administration hall, the door to the courtyard, the main entrance door on the east wing, and the door that leads into the breakroom. All the doors listed have the interim audible alarm now, except for the courtyard, which has a functioning alarm. On 6/16/2026, the door codes for the six remaining doors were changed and will not be shared with staff. On 6/16/2026, the Maintenance Director changed the time for the doors to lock (dwell time) to one second on all 10 of the 10 exit doors with keypads5. On 6/16/2026, for each of the nine residents identified at risk for wandering/elopement, their care plan wandering and/or elopement care plan and interventions were reviewed by the Regional Nurse Consultant to ensure appropriate safeguards were in place.On 6/16/2026, the Regional Nurse Consultant completed a 100% review of all residents to identify those residents identified as being at risk for wandering or elopement. No new residents were identified, and two residents that were on the list were removed (their assessment no longer identified them at risk); a total of nine residents were identified at risk; however, they are not exit-seeking, they wander within the facility. The wandering list at the desk was updated. 6. As of 6/17/2026, education was started for CNAs, LPNs, and RN's only. As of 6/17/2026, the following education has been completed: 25 out of 27 nurses (19 LPNs and six RNs for a total of 93%); 37 out of 43 CNAs were educated for a total of 86%. Education included the Accidents and Incidents Investigating and reporting policy, and an education sheet titled Elopement Response and Notification Education All Staff (however, it was only used for nursing at this time). The remaining two LPNs are PRN (as needed), and the remaining three CNAs, two are full-time, and four are PRN and could not be reached will be educated by the DON or the Infection Preventionist/Staff Development nurse before their next shift.As of 6/17/2026, education was done for all departments other than nursing on Elopement Response and Notification Education for All Staff: nine out of nine Dietary for a total of 100%; two out of two Maintenance staff for a total of 100%; 13 out of 14 Housekeeping and Laundry staff for a total of 93%; Activities staff two out of two for a total of 100%; Administrative staff six out of six were educated for a total of 100%, 10 out of 10 Therapy staff for a total of 100%. The remaining one housekeeping and laundry staff member has no phone, so will be educated by the DON or the Infection Preventionist/Staff Development before the next scheduled shift. As of 6/17/2026 20 out of 22 nurses (16 LPNs six RNs for a total of 91%), 33 out of 38 for a total of 87%, nine out of nine Dietary staff for a total of 100%; two out of two Maintenance staff for a total of 100%; 13 out of 14 Housekeeping and Laundry for a total of 93%; Activities staff two out of two for a total of 100%; Adminstartive staff six out of six were educated for a total of 100%, Therapy staff 10 out of 10 for a total of 100% were educated on the Interim Audible (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Alarms that were placed, the new signage reminding people not to let residents out of the building, and new signage to be sure that doors latch when you enter and exit placed on the breakroom door. The remaining one housekeeping and laundry staff member has no phone, so will be educated by the DON or the Infection Preventionist/Staff Development before the next scheduled shift. 7. All corrective actions will be completed on 6/17/2026, and the facility alleges that the IJ will be removed on 6/18/2026. State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows:1. A review of the Resident Census Checklist dated 6/7/2026 demonstrated that all residents were accounted for between 9:10 pm and 9:15 pm except R1. Written statements from CNAs, nursing staff, and the Maintenance Director described the facility search efforts and were consistent with surveyor interviews conducted on 6/15/2026. A review of the Police Report documented a missing adult report initiated on 6/7/2026 at 9:09 pm and indicated R1 was located at 9:50 pm by the Fire Department on the North 5th Avenue walking trail. The report documented an EMS evaluation with no apparent injury and transport to the emergency department at the facility's request. A review of the Emergency Department After Visit Summary confirmed R1 arrived on 6/7/2026 at 10:24 pm, was discharged on 6/8/2026 at 3:08 am in stable condition, had no medication changes, and returned to the facility.A review of the EMR revealed documentation dated 6/7/2026 showing notification of the DON by the RN Unit Supervisor at 8:45 pm, notification of the responsible party by the DON at 10:15 pm, and notification of the attending physician at 10:30 pm. The Administrator's written statement documented notification by the DON on 6/7/2026. Surveyor interviews conducted on 6/15/2026 corroborated the documented notifications.A review of maintenance documentation dated 6/7/2026 demonstrated that all facility exit doors were inspected and found to be functioning, latching, and locking appropriately. Documentation and an interview with the Maintenance Director on 6/15/2026 confirmed that the code to the west wing exit door near the MDS office was changed following identification of the door as a possible exit point. A review of the facility map dated 6/7/2026 identified all facility exit doors inspected during the assessment.2. A review of Emergency Quality Assurance Process Improvement (QAPI) meeting records dated 6/8/2026 demonstrated attendance by the Administrator, DON, Business Office Manager (BOM), Infection Preventionist (IP), Treatment Nurse, MDS Coordinator, Activities Director, Social Services Director, Medical Records staff, Maintenance Director, and Human Resources. Meeting documentation reflected review of the elopement event, initiation of a root cause analysis, implementation of interim corrective actions, addition of the event to the QAPI program, installation of door signage and alarms, staff education, and initiation of plans to upgrade door locking systems. A review of camera footage images dated 6/7/2026 showed R1 inside the facility at 7:53 pm and outside the facility in an adjacent parking lot at approximately 8:01 pm.A review of door-monitoring records demonstrated daily exit-door audits completed and signed by the Maintenance Director on 6/8/2026, 6/9/2026, 6/10/2026, 6/11/2026, 6/12/2026, 6/15/2026, 6/16/2026, 6/17/2026, and 6/18/2026. Audit documentation identified each exit door inspected and verified door closure, latching, locking, and alarm functionality. Education records dated 6/17/2026 documented training provided by the Maintenance Director to the DON and IP/Staff Development Nurse regarding door-monitoring procedures. Interviews conducted on 6/18/2026 confirmed understanding of the monitoring process and education.3. Direct observation by the surveyor, DON, and Maintenance Director on 6/15/2026 confirmed a CNA exited the breakroom carrying multiple items, and the door failed to fully latch. Observation further confirmed that the breakroom exterior exit door did not contain a keypad lock.Direct observation on 6/18/2026 confirmed laminated stop signs were posted on all 11 facility exit doors and on the interior breakroom door. The signage instructed staff not to permit residents to leave the building and to verify doors were securely locked upon exit.A review of the facility security assessment dated [DATE] identified only one exit door equipped with an audible alarm. Observation by the surveyor on 6/15/2026 confirmed the presence of a single functioning audible alarm in the lobby area.Direct observation on 6/18/2026 confirmed installation and functionality of interim audible alarms on the breakroom hallway door, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breakroom exterior exit door, east wing main entrance, and administration hallway main entrance. Observation also confirmed the courtyard door alarm remained operational. Maintenance records and an interview with the Maintenance Director on 6/18/2026 corroborated the installation of the alarms.4. A review of maintenance records dated 6/16/2026 documented the replacement of the breakroom automatic door closer. Direct observation on 6/18/2026 confirmed the door closed and latched automatically when released and remained secured after closure.Direct observation and staff interviews conducted on 6/18/2026 confirmed implementation of new access codes for the east wing entrance and breakroom hallway door. Staff consistently identified only authorized employee access points. Maintenance records dated 6/16/2026 documented the code changes.Staff interviews conducted on 6/18/2026 with nursing, dietary, housekeeping, administrative, and maintenance personnel confirmed employees did not have access to the codes for the six restricted exit doors. Maintenance documentation dated 6/16/2026 verified the code changes.Direct observation conducted with the Maintenance Director on 6/18/2026 confirmed all ten keypad-controlled exit doors were programmed to relock within one second following closure. Maintenance records dated 6/16/2026 documented completion of the programming changes.5. A review of the EMR on 6/16/2026 confirmed that wandering and elopement care plans for all nine residents identified as at risk for wandering or elopement were reviewed by the Regional Nurse Consultant and contained individualized interventions. A review of facility elopement risk assessments and the Elopement/Wanderer Binder on 6/16/2026 confirmed completion of a 100% resident review. Documentation demonstrated that nine residents were identified as being at risk for wandering/elopement and included current photographs. Assessment review verified that no additional residents were required for inclusion, and two residents were appropriately removed based on reassessment findings.6. A review of education records and sign-in sheets dated 6/7/2026 through 6/17/2026 demonstrated completion of education regarding Elopement Response and Notification and the Accident/Incident Investigation and Reporting Policy for 98 of 103 active staff members. Training records identified attendees, dates of completion, educational content, and instructors. Staff interviews conducted between 6/15/2026 and 6/18/2026 confirmed receipt and understanding of the education.A review of education records dated 6/7/2026 through 6/17/2026 demonstrated completion of Elopement Response and Notification education for dietary, maintenance, housekeeping/laundry, activities, administration, and therapy staff. Training records documented attendance, dates completed, and educational content. Interviews conducted by the surveyor confirmed staff understanding of their responsibilities related to resident elopement prevention and response.A review of education records and sign-in sheets dated 6/15/2026 through 6/17/2026 demonstrated completion of education for 93 of 103 active staff members regarding interim audible alarms, exit-door signage, and door-latching expectations. Educational records identified attendees by name, department, date, and trainer. Interviews with staff from nursing, dietary, housekeeping, activities, maintenance, and administration, conducted between 6/15/2026, 6/18/2026, and 6/23/2026, confirmed understanding of the new procedures and security measures.7. The IJ was identified by the survey team on 6/16/2026, and both the DON (in person) and the Administrator (via phone) were notified on 6/16/2026 at 2:53 pm. The facility immediately initiated corrective actions to protect all residents from the identified risk. The IJ Removal Plan was submitted on 6/17/2026. The facility alleged IJ removal effective 6/18/2026 following implementation of interim audible alarms, restriction of staff access to exit-door codes, replacement of the breakroom door closer, completion of resident elopement-risk reviews, implementation of daily exit-door monitoring, and education of staff rega

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, staff interviews, and review of the facility policy titled Medication Administration-General Guidelines, the facility failed to ensure accurate administration of medications for three of 32 medication opportunities observed, resulting in a medication error rate of 9.37%. This deficient practice had the potential to negatively impact residents (R), leading to complications of their current health status. Findings included:During an observation on 6/22/2026 at 8:40 am, Licensed Practical Nurse (LPN) WW revealed medication administration discrepancies for R14 and R13.* LPN WW administered One Daily Multivitamin with Minerals, which did not match the ordered medication. A review of the electronic medical record (EMR) revealed that R14 had a physician order for Multiple Vitamin tablet, give 1 tablet by mouth one time daily for weight loss.* LPN WW administered an Aspirin 81 milligrams (mg) chewable tablet, which was not the ordered dosage form. A review of the EMR revealed that R13 had a physician order for Aspirin EC (enteric-coated) 81 mg delayed-release tablet, give 1 tablet by mouth one time daily for essential (primary) hypertension.* LPN WW administered a Memantine 5 mg tablet, which did not match the ordered strength of 10 mg. A review of the EMR revealed that R13 also had a physician order for Namenda (Memantine HCl) 10 mg tablet, give 1 tablet by mouth twice daily for vascular dementia.During an interview on 6/22/2026 at 1:08 pm, LPN WW confirmed that regarding medication discrepancies made during medication administration observations. LPN WW reviewed the medications and acknowledged that the multivitamin available for administration did not match the physician's order. She stated that the medication available was a multivitamin with minerals, while the physician's order specified a multivitamin. She confirmed that the medication available was not the same as the medication ordered. LPN WW also acknowledged a discrepancy involving Aspirin. She stated that the physician's order specified enteric-coated Aspirin; however, the medication available for administration was chewable Aspirin. Regarding Namenda, LPN WW stated that the physician's order and Medication Administration Record (MAR) reflected Namenda 10 mg; however, the medication supplied by the pharmacy and linked to the MAR was Namenda 5 mg. Observation of the blister pack revealed that 18 doses had been removed from the card. LPN WW stated she was unsure why the discrepancy existed and acknowledged that she had not identified the incorrect medication strength before the survey observation.During an interview on 6/22/2026 at 4:56 pm, the Director of Nursing (DON) revealed that medications administered should match the physician's orders. Regarding the Namenda discrepancy, the DON stated that the MAR reflected an order for Namenda 10 mg; however, a 5 mg tablet had been linked to the order in the MAR. The DON stated it appeared that when the medication was received and entered into the system, the 10 mg order may have been incorrectly associated with the 5 mg medication supplied by the pharmacy. The DON stated the facility had already initiated staff education regarding medication administration and the identification of medication discrepancies. She reported that nurses are expected to compare physician orders, the MAR, and the medication available for administration and to resolve any discrepancies before administering medications. The DON stated that when a discrepancy is identified, nursing staff are expected to take immediate corrective action, including contacting the pharmacy, physician, or other appropriate healthcare providers for clarification. The DON further stated that recent education included reinforcement of the Five Rights of Medication Administration. She reported that the facility's expectation is a zero-percent medication error rate.A review of the facility's policy titled Medication Administration-General Guidelines, dated 4/1/2025, indicated that medications are administered as prescribed in accordance with good nursing principles and practices. Review of item 4. FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication is put away. a. Check #1: Select the Medication - label, container, and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. Further review of item 5. The medication administration record (MAR) is always employed during medication administration. Before administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged, indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed, and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions.