STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115406	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wrightsville Manor Health and Rehab	337 West Court Street Wrightsville, GA 31096

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 observations, staff and resident interviews, record review, and review of the facility's policies titled Elopement, the facility failed to ensure the facility was free of accident hazards for one of 22 residents (R) (R2) on elopement risk. Specifically, R2 was able to exit the facility without supervision. This deficient practice had the potential to place R2 at increased risk of avoidable injury, unmet care needs, and a diminished quality of life. Findings include:Review of the facility's undated policy titled Elopement revealed the Policy section stated, It is the policy of this facility to take appropriate steps to identify the risk of, prevent, detect, and respond promptly to resident elopement. The Procedure section stated. The facility shall take the following steps to identify, train, prevent, detect, and respond to situations of resident elopement. Review of the electronic medical record (EMR) revealed resident R2 was admitted to the facility on [DATE] and diagnoses included, but were not limited to, schizoaffective disorder, vascular dementia, psychotic disturbances with hallucinations and delusions due to known physiological condition, muscle weakness, and dysphagia.Review of the quarterly Minimum Data Set (MDS) assessment for R2, dated 01/04/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 15, which indicated R2 was cognitively intact. It also revealed that disorganized thinking continuously does not fluctuate. Section GG (Functional Abilities and Goals) documented R2 had no limitation with range of motion and was independent with mobility.Review of the care plan for R2 revealed a focus area, initiated 06/01/2021 and revised 12/18/2025, of the resident was at risk for elopement related to independent ambulation, paranoid schizophrenia, anxiety, hallucinations/delusional thoughts. The goals were for the resident to be provided with a safe living environment, the resident would not leave the facility unsupervised, and that staff would take appropriate steps to identify the risks, prevention, detection, and prompt response for elopement through the next review. Interventions included: Electronic door locks checked routinely. The elopement book should include the resident's photo, face sheet, copy of policy, and other pertinent forms. Elopement drills/staff education. Notify the charge nurse for suspicious activity. Staff to open doors for visitors to enter/exit as needed. Review of the progress notes for R2 revealed an entry dated 12/16/2025 at 05:32 PM of: Behavior - Facility received a call from community stating he recognized one of our pt's walking down street. Activity Assistant went to identify pt and attempt to bring him back to facility. Pt refused to get in car, 3 more staff members went to location and pt continued to cooperate with staff. Pt stated Ya'll trying to kill me 911 was called, pt stated he would only get in car with officers. Pt did get into police car and returned to facility. Paperwork was sent to [local mental health hospital] for possible admission. Possible admission [DATE]. Pt will be 1:1 until transported to [local mental health hospital]. Author: Social Services. {sic} Further review of the progress notes for R2 revealed an entry dated 12/16/2025 at 04:20 PM of: Type: Behavior Note Note Text : Call received from community person stating that (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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(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	he thought one of the facility's residents was walking down the street. Activities personnel responded and arrived at 2:20pm and verified resident identity. Resident unharmed. Resident refused to get in vehicle to return to facility. Resident stated ya'll are trying to kill me. Three other staff members reported on site within minutes and resident refused to get in the vehicle with those three as well. Resident demanding a police officer be called and that he would only get in the car with an officer. 911 notified and reported to scene. Resident willingly got into car with officer and was brought back to the facility. No injuries sustained. Resident ambulated back into facility independently with staff at 2:45pm. Resident requested to speak with daughter. Daughter notified and resident spoke with her. Taken to room after conversation and placed on 1:1 watch. Notified MD (Medical Director). Resident upset due to daughter not being able to visit 2 days ago. Daughter stated she was supposed to come and bring his Christmas gifts but was unable to due to a virus. Resident states that he just wants to go home. [Video/audio virtual] call placed to [Medical Director] to evaluate and speak with resident. During [video/audio virtual] call, resident delusional. Told MD that he had no backbone, neckbone or ribs and that his inside privates had been taken out. Then told him that his backbone had been put back but that he still didn't have a neckbone or ribs. Resident refuses medications often due to paranoia. 10-13 [an emergency commitment to a psychiatric facility] to [local mental health hospital] in progress. Daughter aware of 10-13. Author: DON [Director of Nursing]. {sic}In an interview on 02/04/2026 at 3:45 PM, R2 revealed that on the day he left, he just walked away. He said he went to a lady's house, whom he knew, but she wasn't home. He said he was trying to get to [city name], where he lives.Observation on 02/05/2026 at 10:15 AM revealed R2 walking in the halls.Observation on 02/05/2026 at 12:45 PM revealed R2 finished lunch, left the room, and was observed walking up the hall and outside onto the patio. In an interview on 02/05/2026 at 12:05 PM, Certified Nurse Aide (CNA) AA stated she was working the day R2 left the facility. She stated that she thought that when someone went out the door, R2 went out behind someone. She confirmed that the DON provided education to staff on elopements. She stated the door codes had been changed, and staff were instructed to ensure they locked the doors behind them. She further stated staff was having a Christmas party on the day R2 eloped. In an interview on 02/05/2026 at 12:30 PM, Licensed Practical Nurse (LPN) BB stated that during the staff Christmas party, R2 exited the door on the 200 Hall. LPN BB confirmed staff received education after the elopement. In an interview on 02/05/2026 at 01:00 PM, the DON stated R2 left the facility during the staff Christmas party. She stated that the door the resident exited from previously had a latch/hook that held the door open to get the shower bed in and out, and at the time he went out, the door was not secured after a staff member brought the shower bed in. The DON stated the latch had been removed after the elopement. The DON further stated R2 had always verbalized that he wanted to go home, but had never attempted to leave the facility. In an interview on 02/05/2026 at 02:20 PM, the Administrator stated that she expected staff to follow policies and procedures to prevent elopement. She stated that the side door that the resident exited used to have a latch on it that would hold the door open so that they could bring the shower bed in and out. The Administrator stated that the latch has been removed. The Administrator stated that she expected staff to ensure that all doors were secured when entering or exiting. She confirmed that the incident occurred during a Christmas party when all staff were present. She stated that staff assigned to residents should be accountable to them.