

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Christian City Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 Lester Road Union City, GA 30291	
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 - 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 interviews, record review, and review of the facility's policy titled Elopement Prevention, the facility failed to implement adequate supervision and elopement prevention measures to safeguard one of three sampled residents (R) (R1). This failure allowed the resident to leave the facility without staff knowledge, resulting in an elopement. On July 23, 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. The facility's Administrator, Director of Health Services (DHS), and Corporate Nurse Consultant were informed of the Immediate Jeopardy (IJ) on July 23, 2026, at 6:05 PM. The noncompliance related to the IJ was identified to have existed on July 16, 2026. Additionally, Substandard Quality of Care was identified with the requirements at 42 CFR 483.25- Quality of Care (F689 (S/S): J). An Acceptable IJ Removal Plan was received on July 27, 2026. Based on observation, record reviews, 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 July 27, 2026. The facility remained out of compliance while the facility continues to develop and implement a Plan of Correction (POC). This oversight process includes analyzing the facility's staff's conformance with the facility's policies and procedures related to ensuring resident safety, including care plan review and interventions, risk assessments, resident checks, and maintaining functional locking doors. The Immediate Jeopardy was related to the facility's noncompliance with the program requirements as follows: F689: S/S: J, F835: S/S: J. The Immediate Jeopardy was validated as removed on July 27, 2026, and the following Scope and Severity were downgraded: F689: S/S: D, F835: S/S: D. Findings include: Review of the policy titled Elopement Prevention, Last Revised May 6, 2025, documented Policy: The center has the responsibility for the care and safety of its residents. At the same time, the residents have the right to free access to their private residential area, all center common areas including outdoor spaces, and (excluding the Memory Support Unit) has the right to leave the assisted living campus at will. The center's care partner team members shall be vigilant in its care and supervision of all residents, especially those deemed as vulnerable, such as those who are confused or require assistance with tasks due to a physical or medical condition. Residents of the center with cognitive deficits which place them at risk for elopement or engaging in unsafe wandering, will be referred for residency in the Memory Support Unit, where applicable, or for transfer/discharge to an environment secure enough to accommodate their needs. Review of the Electronic Medical Record (EMR) revealed that R1 was admitted on [DATE] with diagnoses of, but not limited to, Alzheimer's disease, dementia in other diseases classified elsewhere, psychotic disturbance, mood disturbance, and anxiety. Review of the admission Minimum Data Set (MDS) for R1 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 115573	Facility ID: 115573 If continuation sheet Page 1 of 5

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated 7/13/2026 revealed a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. Section E: Has the resident wandered? Behavior of this type occurred 1 to 3 days. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)? Yes. Section GG: Walk 150 feet: once standing, the ability to walk at least 150 feet in a corridor or similar space, supervision or touching assistance. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel, not attempted due to medical condition or safety concerns. Review of the admission Elopement Risk Assessment for R1, dated 7/13/2206, revealed that R1 was assessed to be at high risk for elopement. Review of the facility incident report documented that on 7/16/2026, R1 was seen at 3:30 AM in his room by a Certified Nursing Assistant (CNA). The receptionist last saw the resident at 4:30 AM sitting in the front lobby. At 5:45 AM, staff were unable to locate R1. The elopement protocol was initiated at 6:10 AM. R1 was located at approximately 7:10 AM by Licensed Practical Nurse (LPN) AA three miles away from the facility. Review of a facility-provided document, dated 7/16/2026, revealed that the Unit Manager (UM) was instructed to place a wander guard on the resident and prepare to move him to the Memory Unit. Further review revealed that the Administrator's instructions had not been followed and the UM was terminated from employment. Review of a facility-provided document, dated 7/20/2026, from Front Desk Receptionist 1T documented that on 07/16/2026 a man came downstairs and sat in the lobby at approximately 4:00 AM. At approximately 4:30 AM, Front Desk Receptionist 1T stepped outside through the front door for a break and was unaware that the resident had gone out the door after her. Further review revealed Front Desk Receptionist 1T was unaware he was an elopement risk. Interview on 7/22/2026 at 5:00 PM, the Administrator stated there was no picture of R1 in the elopement book at the receptionist's desk until after his elopement. Review of the Police Report dated 7/16/2026 at 7:31 AM documented that the Police Department arrived at the facility, was met by CNA 1R, and spoke with LPN 1S regarding the missing resident. While on the scene, the officer was advised that a facility staff member had located the resident on the {highway name}. Interview on 7/22/2026 at 11:42 AM, the Director of Nursing (DON) revealed that the Memory Unit was always locked. He stated that a few residents tended to wander toward the doorway and that they also had Wander Guard devices on. He revealed that an elopement assessment was performed on admission and that a dementia diagnosis helped determine if the resident was suitable for the Memory Unit. Interview on 7/22/2026 at 2:32 PM, the Administrator revealed that when the resident was admitted on [DATE], it was reported to her that he had wandering tendencies. The Unit Manager was instructed to place a Wander Guard device on the resident and move him to the Memory Unit. The Administrator further stated the instructions were not followed, resulting in the UM's termination. Observation on 07/23/2026 at 8:45 AM revealed two sets of automatic doors at the facility's main entrance. Both sets of doors opened automatically, and visitors were not required to sign in. Interview on 7/23/2026 at 9:31 AM, the Administrator revealed that R1 was found by a staff member on {road name} near {highway name}. Interview on 07/23/2026, the Corporate Nurse Consultant revealed that visitation was 24/7 and staff had no way to identify visitors from residents. She stated that visitors could come and go as they pleased. Observation on 7/23/2026 between 11:15 AM and 11:28 AM, a drive on {road name} revealed that after leaving the facility campus, there was no sidewalk. The route revealed a two-lane highway with traffic in both directions, with woods, creeks, and ponds along the path. The route led to {highway name}, which was an extremely busy area where electrical surges were present. Additional observation of the surrounding area after exiting the facility property revealed there was no lighting, walking paths, or sidewalks, and the neighboring area was approximately three miles (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	away.Observation on 7/23/2026 at 11:35 AM, upon returning to the facility, both of the facility's main entry doors opened automatically. Residents were observed ambulating in the common area near the facility's entrance and exit doors.Interview on 7/23/2026 at 11:42 AM, Receptionist 1Q revealed she had been with the facility for 11 months as a receptionist. She stated that the entrance doors were open 24/7.Interview and observation on 7/23/2026 at 4:38 PM, the Maintenance Assistant LLLL stated that there was no delay mechanism on the facility's main entry door. He reported that he conducted daily rounds on the doors each morning. He confirmed that the main entry door remained open and that a Wander Guard system was not connected to the door to provide an alarm if a resident attempted to exit. The Maintenance Director approached the doors with an active Wander Guard device, and the door did not alarm. The Maintenance Director stated that the facility was in the process of implementing a system to address the issue.		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and reviews of the Administrator and Director of Nursing (DON) Job Descriptions, the facility administration failed to manage the facility in a manner that protects residents and safeguards them from elopement. Specifically, the administration was aware that the front entry door did not have an operational Wander Guard system to ensure residents at risk for elopement were protected. Despite this known hazard, corrective measures were not implemented. Resident (R) (R1) was placed in imminent danger due to the facility's failure to implement interventions for R1 upon admission. As a result, R1 was able to exit the facility unsupervised, exposing the resident to serious injury, harm, or death. On July 23, 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. The facility's Administrator, Director of Health Services (DHS), and Corporate Nurse Consultant were informed of the Immediate Jeopardy (IJ) on July 23, 2026, at 6:05 PM. The noncompliance related to the IJ was identified to have existed on July 16, 2026. Additionally, Substandard Quality of Care was identified with the requirements at 42 CFR 483.25- Quality of Care (F689 (S/S): J). An Acceptable IJ Removal Plan was received on July 27, 2026. Based on observations, staff interviews, record reviews, and review of facility policies as outlined in the Removal Plan, it was validated that the corrective plans and the immediacy of the deficient practice were removed on July 27, 2026. The facility remained out of compliance while the facility continues to develop and implement a Plan of Correction (POC). This oversight process includes analyzing the facility's staff's conformance with the facility's policies and procedures related to ensuring resident safety, including care plan review and interventions, risk assessments, resident checks, and maintaining functional locking doors. The Immediate Jeopardy was related to the facility's noncompliance with the program requirements as follows: F689: S/S: J, F835: S/S: J. The Immediate Jeopardy was validated as removed on July 27, 2026, and the following Scope and Severity were downgraded: F689: S/S: D, F835: S/S: D. Findings included: Review of the Administrator Job Description, modified 12/16, revealed that the Administrator directs day-to-day functions of the nursing center in accordance with current federal, state, and local regulations that govern long-term care centers, and as may be directed by the Area [NAME] President, to provide appropriate care for our patients/residents. Review of the Director of Nursing Job Description, modified 12/16, documented that the DON plans, organizes, develops, and directs the overall operation of our Nursing Services Department in accordance with current federal, state, and local regulations governing our nursing center, and as directed by the Administrator and the Medical Director, to provide appropriate care. The facility failed to implement adequate supervision and elopement prevention measures to safeguard one of three sampled residents (R) (R1). Cross Reference: F689 Review of the facility incident report documented that on 7/16/2026, R1 was seen at 3:30 AM in his room by a Certified Nursing Assistant (CNA). The receptionist last saw the resident at 4:30 AM sitting in the front lobby. At 5:45 AM, staff were unable to locate R1. The elopement protocol was initiated at 6:10 AM. R1 was located at approximately 7:10 AM by Licensed Practical Nurse (LPN) AA three miles away from the facility. Review of a statement dated 7/20/2026 by the Front Desk Receptionist 1T documented that she was a new employee and stated the resident had been seated in the lobby and walked out after she left for her break around 4:30 AM. She stated she did not recognize him as a resident. Interview on 7/22/2026 at 5:00 PM, the Administrator stated that the facility did not have a picture of R1 in the elopement book at the receptionist's desk until after his (continued on next page)		

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