STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115596	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tucker Operating Company LLC	2165 Idlewood Road Tucker, GA 30084

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled, Elopements and Wandering Residents, the facility failed to report elopement within two hours to law enforcement and the State Agency for one of four sampled residents (R) (R1). Findings include:Review of the undated facility policy titled Elopements and Wandering Residents documented under Policy: This facility ensures that Residents who exhibit and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with the Resident Centered Care Plan addressing the unique factors contributing to wandering or elopement risk. Under Policy Explanation and Compliance Guidelines: 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.4. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.d. Adequate supervision will be provided to help prevent accidents or elopements. 5. c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between facility and the police department. g. Appropriate reporting requirements to the State Survey agency should be conducted.Review of R1's face sheet showed R1 was admitted with diagnoses of but not limited to cerebral infarction, end stage renal disease, cognitive communication deficit, unspecified dementia, and psychotic mood disturbance.Review of R1s admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated R1 had severe cognitive impairment.Review of R1's Comprehensive Care Plan (CCP) Initiated on 10/1/2025 documented R1 was at risk for wandering looking for his home. R1 was disoriented to place, had impaired safety awareness and wandered aimlessly. Care plan directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books.During an interview on 10/8/2025 at 11:59 am with the Administrator revealed on 10/1/2025 at approximately 8:20 pm, staff reported R1 was missing. She told staff to look everywhere inside and outside the building. The Administrator explained that facility staff were under the impression R1 was unable to walk and concentrated on searching the inside of the facility. The Administrator explained at approximately 10:15 pm that the facility owner located R1. The Administrator stated she attempted to call law enforcement and was on hold for 40 minutes and eventually hung up without making a police report.During an interview on 10/9/2025 at 12:29 pm, the Administrator revealed she did not notify the State Agency since R1 was not harmed.

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	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, resident representative and staff interviews, record review, and review of the facility policies titled, Incident and Accidents and Elopements and Wandering Residents, the facility failed to prevent the elopement of one of four sampled residents (R) (R1). The deficient practice had the potential to place R1 and other cognitively impaired residents at risk of compromised health and safety.Findings include:Review of the facility policy titled Incidents and Accidents revised 9/23/2025 documented under Policy: It is the policy of the facility for staff to report, investigate and review any accidents or incidents that occur, on facility property and may involve or allegedly involve a Resident. Under Definitions: An incident is defined as an occurrence or situation that is not consistent with the routine care of a Resident or with the operation of the organization. Under Compliance Guidelines: .5. The following incidents/accidents require an incident/accident report but are not limited to: Alleged abuse, Choking, Combative behavior, Drug diversion, Elopement, Entrapment and Falls. Review of the undated facility policy titled Elopements and Wandering Residents documented under Policy: This facility ensures that Residents who exhibit and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with the Resident Centered Care Plan addressing the unique factors contributing to wandering or elopement risk. Under Policy Explanation and Compliance Guidelines: 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.4. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.d. Adequate supervision will be provided to help prevent accidents or elopements. 5. c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between facility and the police department. g. Appropriate reporting requirements to the State Survey agency should be conducted.Review of the History and Physical received by the facility before R1's admission and dated 9/18/2025 documented R1 had an altered mental status. R1 was provided with a seater (someone to watch the patient) at the hospital when he attempted to leave the hospital without medical advice and proper discharge.Review of R1's face sheet showed R1 was admitted with diagnoses of but not limited to cerebral infarction, end stage renal disease, cognitive communication deficit, unspecified dementia, and psychotic mood disturbance.Review of R1s admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated R1 had severe cognitive impairment.Review of R1's Comprehensive Care Plan (CCP) Initiated on 10/1/2025 documented R1 was at risk for wandering looking for his home. R1 was disoriented to place, had impaired safety awareness and wandered aimlessly. Care plan directed staff to distract R1 from wandering by offering pleasant diversions, structured activities, food, conversation, television and books.Review of R1s progress notes dated 10/1/2025 at 10:14 pm, Licensed Practical Nurse (LPN) CC documented on 10/1/2025 at approximately 5:30 pm to 6:00 pm. She observed R1 standing at North nurses' station, R1 requested to leave and stated, Am I able to go? I'm ready to go. LPN CC asked R1 to reveal his name and R1 mentioned his correct name. LPN CC informed R1 he could not leave and instructed him to return to his room. R1 acknowledged and turned around and walked back to his room.Review of a written statement signed and dated 10/2/2025, LPN DD documented at approximately 7:00 pm, the alarm sounded, she discovered the sound was coming from the North Hall close to the activity office. When she arrived at the door, she silenced the alarm. LPN DD documented she did not realize a Resident could have triggered the alarm. LPN DD further documented she was unaware R1 exited the facility until she returned to work to start her shift on 10/2/2025, DD worked the 7:00 am to 7:00 pm shift. LPN DD documented and concluded she had since been made aware of facility expectations, when an alarm had sounded and she was required to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	search the inside and outside of the facility and notify the police and the Administrator immediately.Review of R1s progress notes dated 10/2/2025 at 6:00 pm, LPN CC documented the following timeline in R1s progress notes:On 10/1/2025 at 7:00 pm - R1 LPN CC observed R1 standing outside his room, wearing personal clothing. At 8:00 pm - Certified Nurse Assistant (CNA) on North Hall reported R1 was missing. CNA stated she attempted to obtain weight from R1 but was unable to locate him. At 8:05 pm - R1s room checked and R1 was not in bed. At 8:15 pm - South Nurse's station notified to verify if R1 was on their unit. Staff reported they were unable to locate R1. Staff were informed of a potentially missing Resident. Code [NAME] (missing resident code) was announced, and all caregivers looked for R1. At 8:45 pm - Administration notified via phone call. Staff continued searching for R1 and at 10:30 pm - R1 was found seated outside the facility on a sidewalk. R1 was brought back into the building via wheelchair. Head-to-toe assessment completed; no skin injuries noted. R1 denied pain. R1 asked staff how staff knew his name and location and he stated he had never been at the facility before. R1 stated he was able to ambulate, without assistance. R1 appeared alert and oriented to people and time only.Review of the Elopement Risk assessment dated [DATE] at 5:40 pm, the facility documented the following responses on R1s assessment form: Does the Resident have a history of elopement or elopement while at home, facility documented - No. Does the Resident have a history of elopement or attempted leaving the facility without informing staff, Facility documented- No. Does the Resident wonder - facility documented- No.An interview on 10/8/2025 at 9:51 am with the Maintenance Director (MD) EE revealed R1 exited the building through the side door located on North Hall. He stated the alarm bell sounded and Registered Nurse (RN) DD turned the alarm off. RN EE revealed staff did not follow facility protocol. He expected staff to conduct a thorough search and account for all residents. RN EE stated on 10/1/2025 at approximately 10:30 pm, staff notified him, R1 had been located.During an interview on 10/8/2025 at 10:05 am, R2 revealed he was roommates with R1. He stated, on 10/1/2025 at approximately 6:00 pm he observed R1 outside the parking lot as he arrived at the facility to be admitted . He stated he was admitted on [DATE] at approximately 6:15 pm. R2 revealed he was surprised when staff wheeled R1 into his room at approximately 10:45 pm at night. R2 concluded that he wondered why R1 had been outside for that long without supervision. An interview on 10/8/2025 at 10:39 am, RN DD revealed on 10/1/2025 she worked from 7:00 am to 7:00 pm. She stated at approximately 6:40 pm, the alarm sounded and she went out to investigate. RN DD revealed she did not observe anything, she proceeded and turned the alarm system off. She stated at the time she did not realize a resident may have triggered the alarm and exited the building. She did not investigate the cause of the alarm; it was the end of her shift and was thinking about going home. She stated she should have thoroughly searched, reported to the administrator and accounted for all the residents. She concluded she had not done elopement drills and was unaware of what she was required to do at the time.During an interview on 10/8/2025 at 10:45 am, the Director of Nursing (DON) BB revealed R1 was a new admission. She explained on 10/1/2025, R1 left his room and exited the building through the North 1 Hall exit door. She explained when the alarm sounded, and RN DD looked and did not observe anything, and she turned the alarm off. According to the DON, RN DD thought everything was okay and went home after her shift ended. The DON further explained R1 was ambulatory. The DON stated staff should have conducted a head count and account for all the residents. The DON concluded staff did not follow facility policy and procedure.During an interview on 10/8/2025 at 11:59 am with the Administrator revealed on 10/1/2025 at approximately 8:20 pm, staff reported R1 was missing. She told staff to look everywhere inside and outside the building. The Administrator explained that facility staff were under the impression R1 was unable to walk and concentrated on searching the inside of the facility. The Administrator explained at approximately 10:15 pm that the facility owner located R1. The Administrator stated she attempted to call law enforcement and was on hold for 40 minutes and eventually hung up without making a police report.During an interview on 10/8/2025 at 12:45 pm, the Social Services Director (SSD) II revealed elopement assessments were due at admission. She stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she visited R1 the night after the incident occurred. She stated R1 could not recall he had exited the facility and was not aware of the date and time. She stated R1s family requested R1 to be transferred. During an interview on 10/8/2025 at 3:37 pm, the Cooperate Owner (CO) FF revealed he was in the area when the Administrator reported R1 was missing. He stated he drove around the facility and located R1 a quarter of a mile away from the facility at approximately 10:15 pm. He stated R1 was seated on the curbside of a road. Corporate Owner FF was unaware if local law enforcement were notified. Review of a written statement signed and dated 10/9/2025, CNA QQ documented she recalled she observed R1 on 10/1/2025 at approximately 7:00 pm, when the morning shift was leaving for the day. CNA QQ documented she asked if R1 was a visitor and staff stated R1 was a Resident. CNA QQ further documented she asked R1 if he needed anything and R1 stated he was okay. At approximately 8:40 pm, CNA QQ checked R1s room and was unable to locate him. CNA QQ informed the nurse and another CNA, and they started looking for R1. CNA QQ proceeded outside the building and searched the nearby apartments and was unable to locate R1, she returned to the facility after 10:00 pm and was informed R1 had been located. During an interview on 10/9/2025 at 9:12 am, CNA JJ revealed she worked on the Rehabilitation Unit. She stated she had not done training regarding elopement drills and explained the facility talked about elopement training on 10/2/2025. She explained prior to that the facility had not done any elopement drills or training.During an interview on 10/9/2025 at 9:55 am, RN OO explained that the facility had not done elopement drills and stated RN DD did not investigate the cause of the alarm as required and stated that a head count should have been completed and staff should have completed rounds and made sure all residents were accounted for.During an interview on 10/9/2025 at 10:55 am, the Administrator revealed she was the only one with access regarding video camera reviews. She said she did not review the video camera because she was too busy.During an interview on 10/9/2025 at 11:55 am, R1s Resident Representative (RR) revealed a facility nurse called her on 10/1/2025 between 7:00 pm - 8:00 pm and stated R1, her father, was missing. RR stated that staff told her the police had been notified. She stated facility staff later called her and informed her that R1 was located inside the building and explained to her that R1 never left the building. RR stated R1 had attempted to leave the hospital without medical advice and explained he had wandering tendencies. She stated facility staff did not ask the family if R1 had elopement tendencies prior to his admission.During an interview on 10/9/2025 at 12:29 pm, the Administrator revealed she did not notify the State since R1 was not harmed. The Administrator stated she started the inservice at night on 10/1/2025 and placed a wander guard on R1. She concluded the facility was unaware R1 had exit seeking behaviors and concluded staff did not go through R1s history and physical prior to admission and stated mistakes were made.