

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115686	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER Nancy Hart Operation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2117 Dr George Ward Road Elberton, GA 30635	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40475</p> <p>Based on observation, staff and resident interviews, record review, and review of the facility's policy titled Elopement Protocols, the facility failed to provide adequate supervision, frequent monitoring, and to ensure one of four exit doors was functioning properly to prevent the elopement for one out of three sampled Residents (R) (R1).</p> <p>Findings include:</p> <p>Review of the undated facility's policy titled Elopement Protocols under the Policy section revealed, It is the responsibility of all personnel to report any residents attempting to leave the premises, or suspected of being missing, to the Charge Nurse as soon as practical. Elopement and wandering are two separate events and shall not be used interchangeably . Elopement is an event which requires immediate attention of the administrative staff up to and including reporting the event to the stated and obtaining a sheriff report. A resident is considered to have eloped if the boundaries of elopement have been crossed. For this facility, elopement boundaries are off the grounds of the nursing home.</p> <p>Review of R1's Admission Record revealed, the resident was admitted to the facility on [DATE] with the following diagnoses that included but not limited to: cerebral infarct, altered mental status, other symptoms and signs involving cognitive functions and awareness, generalized anxiety disorder.</p> <p>Review of R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed, a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment; Section E (Behaviors) revealed, he had behaviors including daily wandering and Section GG (Functional Abilities and Goals) revealed, R1 had no impairment to upper and lower extremities, required supervision with mobility and activities of daily living.</p> <p>Review of R1's care plan initiated on 12/6/2024 and last revised on 4/29/2025 revealed, Focus [R1 Name] is an elopement risk/wanderer related to (r/t) disoriented to place with impaired safety awareness, resident wanders aimlessly. 2/21/2025-continues to try and find a way out of the facility, tries to put in the code on the door pad, find a way out the windows, increase agitation when redirected. 4/19/2025 - resident left facility on foot.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse's note dated 4/19/2025 revealed, [R1 Name] left the facility on foot this morning, Nurse went to give medications a few minutes before 0900 and could not find him in the facility, nurse and nurse supervisor got into their vehicles to go look for him, approximately 0910 nurse found [R1 Name] with a couple of people with him on the side of the road, they had called 911. [R1 Name] had fallen to his knees, no injury noted, and he stated he was going to [Name of Store]. Emergency Medical Services (EMS) transported him to the hospital. [R1 Name] was last seen around 8 am walking in the hallway.</p> <p>Review of the Discharge Summary from the hospital dated 4/19/2025 revealed, R1 arrived by ambulance and was treated for fall. Further review revealed, R1 had good recollection of what happened and reported that he slipped and fell softly on the grass after he left the nursing home because he wanted to go to [Name of store]. R1 had a normal exam and was discharged to nursing home with fall precautions and to follow-up with Primary Care Physician (PCP) in 2 (two) days.</p> <p>Interview on 4/28/2025 at 12:35 pm with R1 while in his room revealed, he did not remember leaving the building about a week ago on a Saturday (4/19/2025). He revealed, he went out the door and pointed toward the end of the 200 Hall and that he didn't use the keypad because the door wasn't locked. He further revealed that he doesn't remember anyone going out the door before him. He stated that he wasn't hurt and that he wasn't going to try that again.</p> <p>In an interview on 4/28/2025 at 1:50 pm with the Maintenance Director (MD) revealed, that staff called him on 4/19/2025 after R1 left the facility to come check the exit doors at the end of the 200 Hall because they didn't think the door was latching all the way. He stated that he probably checked all the exit doors at the facility three to four times a day and changed the door codes at least weekly. He stated that they have residents who watch the staff put in the codes and they will tell other residents what the codes were. He stated that the Administrator had talked to staff about being careful when they put in codes because some of the residents were watching. He stated that R1 wanders all day long checking the doors to see if he could get out. He further stated that the facility's front property extends about 100 yards to the road and from what he was told, R1 was found about 50 yards from the road in front of the church that faces the main highway. He further stated that the doors at the end of the 200 Hall had not had any problems previously with latching when closed and stated that he checked the doors multiple times on 4/19/2025 without any concerns noted.</p> <p>In an interview on 4/28/2025 at 2:00 pm with Certified Nursing Assistant (CNA) CNA AA revealed that she was working on the 200 Hall on 4/19/2025 when R1 got out of the building. She stated that she had seen him walking in the hallway earlier in the shift at about 7:15 am and when she took his breakfast tray to him around 8:40 am, he wasn't in his bed but wasn't concerned because he liked to walk the halls. She revealed that she asked the nurse if she had seen R1 because he wasn't in his room to eat breakfast, and that was when the nurse and Registered Nurse (RN) Supervisor got in their cars and began looking for him while other staff looked inside the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/28/2025 at 2:10 pm with CNA BB revealed that she was working on the 200 Hall on 4/19/2025 when R1 left the facility. She stated she wasn't assigned to him but that she saw him walking in the hallway at around 8:00 am that morning. She stated she went to get the breakfast trays around 8:40 am and while passing out trays to her residents, CNA AA asked her if she had seen R1 because he wasn't in his room. She further stated that when the resident got back to the facility from the hospital, she asked him where he was going when he left the facility, and he told her he wanted to go to the store for hair clippers, but he wouldn't do that again. She stated he told her that he felt 'foolish' because he tried to walk to the store. She further stated that R1 was the only resident who checked the doors to see if they were open and that the other residents who were wanderers just wander in the hallways.</p> <p>In an interview on 4/29/2025 at 10:05 am with Housekeeping Aide CC who stated that she was told by her supervisor to make sure the doors are locked when they take the trash out. She stated that she had seen R1 walking around in the hallways checking the doors to see if they were locked.</p> <p>In an interview on 4/29/2025 at 11:15 am with LPN DD revealed that when she realized R1 was not in the facility around 9:00 am, she and the RN Supervisor got in their vehicles and started looking for him. She stated when she turned off the road onto Highway 17, she saw a truck pulled over on the side of the road with a man and woman standing by R1. She stated that he had evidently tripped in the grass and fell to his knees. She stated that the man and woman had already called 911 to come pick up R1. She further stated that she and the RN Supervisor waited with the R1 until the ambulance arrived. She stated that R1 told them he had left the facility about 30 minutes ago and was going to the store.</p> <p>In an interview on 4/29/2024 at 1:30 pm with the Administrator revealed that after R1 eloped, the MD put alarms on all the exit doors except the front door which had a keypad. He further stated that he had requested a [Name of electronic alarm] system for the facility, but felt R1 was cognitive enough that he would remove it.</p>		