STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115733	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Eagle Healthcare and Rehab	206 Main Street East Abbeville, GA 31001

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 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the facility policy titled Conducting and Accurate Resident Assessment, the facility failed to accurately assess and code behavior symptoms on the Minimum Data Set (MDS) for three residents (R) (R1, R4 and R10) from a sample of 14 residents. On [DATE], 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 and Assistant Director of Nursing were informed of the Immediate Jeopardy on [DATE], at 11:47 am. The noncompliance related to the Immediate Jeopardy (IJ) was identified to have existed on [DATE]. An Acceptable IJ Removal Plan was received on [DATE]. 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 was removed on [DATE]. Findings include: Review of the facility's policy titled Conducting an Accurate Resident Assessment with a revision date of [DATE] revealed the purpose of the policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. (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 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the progress notes for R1 revealed the resident exhibited behavioral symptoms on [DATE], [DATE], [DATE], and on [DATE]. A [DATE] Behavior Note documented the resident continued to wander, enter other resident rooms, became agitated when staff attempted to redirect, regularly placed all belongings in a trash bag and asked How do I leave this place?. A [DATE] Health Status Note documented the resident continued to wander and enter other resident rooms. A [DATE] at 1:56 am Behavior Note documented the resident was observed taking off his pants and shoes in hallway, then laying the pants out flat on floor. He then lowered himself to the floor laying down on top of his pants. The writer attempted several times to redirect with no success. A [DATE] at 11:43 am documented the resident was refusing to leave the dining room eating off of resident's plates and undressing in the hallway. At 12:33 pm staff documented the resident was urinating on the dining room floor refusing to allow the Certified Nursing Assistant (CNA) to help change into clean clothes. A [DATE] Skilled Nurses Note documented the resident wanders in and out of other resident rooms, resists redirection and becomes aggressive when staff redirected. However, the physical and wandering behaviors were not coded in section E on the quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date of [DATE]. 2. A review of R4's progress notes in the electronic clinical record revealed that the resident exhibited behavioral symptoms on [DATE], [DATE], and [DATE]. A behavior note on [DATE] documented that R4 smeared fecal matter, urinated in the hallway, intentionally spilled a soda, and exhibited wandering behavior. A [DATE] behavior note documented that R4 had taken a pair of his roommate's pants, went outside to the courtyard, put the pants on over his clothes and began to yell out very loudly and periodically. A [DATE] incident note documented that R4 was observed with an abrasion to the left wrist and stated that he had cut himself and expressed that he wanted to hurt himself. However, the physical and verbal behavioral symptoms directed at others and the behavioral symptoms not directed towards others were not coded, in section E, on the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE]. 3. A review of R10's progress notes in the electronic clinical record revealed that the resident exhibited combative behavior during the provision of incontinence care and dressing. However, the physical behaviors were not coded, in section E, on the annual MDS assessment, with an ARD of [DATE]. During an interview on [DATE] at 3:30 pm, the Social Services Director was questioned about how she obtains information on residents' behaviors to code on the MDS assessments. The SSD responded that she obtained information from staff meetings, verbal reports from nurses and Certified Nursing Assistants (CNA's), and information from the 24-hour report brought up by the Director of Nursing (DON) and Assistant Director of Nursing (ADON). When the Social Services Director was asked if she reviewed resident progress notes (from the clinical record), her response was no. The facility implemented the following actions to remove the IJ: 1. Res. #1 eloped from the facility on [DATE] and was found deceased later in the day on [DATE]. 2. All residents that display wandering behavior could be affected. MDS Nurse completed an audit on all residents with wandering behaviors to ensure most recent MDS assessment is accurately coded to reflect documented behaviors of each resident. One MDS assessment was found to be mis-coded and was resubmitted by MDS Nurse and verified by DON for any errors identified to reflect accurate coding on [DATE]. (continued on next page)

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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 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Administrator educated 1 MDS nurse and 1 Director of Nursing, on [DATE], on the need to accurately code MDS Assessments, utilizing documentation of residents that occurred during the assessment period. 4. MDS Policy, Conducting an Accurate Resident Assessment was reviewed by QAPI Committee on [DATE], no changes were made. Those is attendance will be Administrator, Director of Nursing, Medical Director and other members of the QA Committee. 5. All corrective actions were completed on [DATE]. The facility alleges that the IJ is removed on [DATE]. The facility implemented the following actions to remove the IJ: 1. Verified via review of the Coroner's Report dated [DATE] that documented R1 date and time of pronounced death as [DATE] at 12:50 pm. 2. Verified via review of a list titled, Residents at risk for elopement/Wandering which included nine residents and a statement that an audit was completed for MDS accuracy on [DATE]. The statement was signed by the DON and the ADON/MDS nurse. The nine residents identified with wandering behaviors were R3, R4, R5, R6, R8, R9, R10, R11, and R14. The resident identified as having a mis-coded MDS assessment was R4. The ADON/MDS nurse documented and signed, on a printed out copy of R4's electronic MDS list, that the [DATE] MDS assessment was modified for inaccurate coding in section E related to wandering behaviors. The printed out MDS list showed a [DATE] Quarterly MDS assessment and a [DATE] Modification of Quarterly MDS assessment that verified the correction had been completed. Review of the modification revealed that section E was changed to include wandering behavior exhibited 1-3 days. The coding change was completed on [DATE]. During an interview on [DATE] at 3:33 pm the ADON/MDS nurse confirmed that an audit was completed on all residents with wandering behaviors to ensure MDS accuracy, and R4 was identified with a mis-coded MDS which was corrected and resubmitted. 3. Verified via review of the Staff Development Education Sign In form, dated [DATE] and the accompanying education materials. The topic was MDS Coding Assessments and included signatures of the ADON/MDS nurse, DON, Social Services Director (SSD), and Activity Director. During an interview on [DATE] at 10:28 am, the SSD confirmed that she completes section E (Behaviors) of the MDS and had received re-education on accurate coding of the MDS assessments. During an interview on [DATE] at 3:33 pm, the ADON and DON confirmed they received education on MDS coding accuracy. During an interview on [DATE] at 4:07 pm the Administrator confirmed providing in-service education on accurate coding of the MDS. 4. Verified via review of the Conducting an Accurate Resident Assessment policy. Interviews on [DATE] at 3:33 pm with the ADON and DON and at 4:07 pm with the Administrator confirmed that the policy was reviewed on [DATE] by the QAPI committee with no changes made. (continued on next page)

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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 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. All corrective actions were completed on [DATE]. The facility alleges that the IJ was removed on [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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and review of the facility policy's titled Comprehensive Care Plans and Elopements and Wandering Residents, the facility failed to develop interventions in resident (R1) care plan to include supervision/monitoring and management of the resident's risk for elopement from a sample of 14 residents. On [DATE], 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 and Assistant Director of Nursing were informed of the Immediate Jeopardy on [DATE], at 11:47 am. The noncompliance related to the Immediate Jeopardy (IJ) was identified to have existed on [DATE]. An Acceptable IJ Removal Plan was received on [DATE]. 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 was removed on [DATE]. Findings include: Review of the facility policy titled, Comprehensive Care Plans with a revision date of [DATE] revealed the following: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The policy documented the following definition of Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific situation or setting. The policy noted the care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of an undated policy titled Elopements and Wandering Residents revealed the following regarding Monitoring and Managing Residents at Risk for Elopement and Unsafe Wandering: The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan; and Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: anemia, glaucoma, mild neurocognitive disorder due to physiological condition with behavioral disturbance, Alzheimer's disease, and psychotic disorder with delusions. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident had a Quarterly Minimum Data Set assessment completed on [DATE] indicating a Brief Interview for Mental Status (BIMS) of 5 indicating the resident had severely impaired cognition, having no behaviors or wandering behavior and required supervision with transfers and ambulation. Although the resident had a care plan since [DATE] for being at risk for elopement, the only interventions in place was to redirect resident as needed and picture added to Elopement book. The resident had an Elopement Evaluation completed on [DATE] with a score of 5 indicating the resident was at risk for elopement. Review of the Health Status Note dated [DATE] at 4:15 am documented that upon rounds noted resident not in his room. Staff immediately began search of facility. Resident was not found. The Administrator was notified, then the Director of Nursing (DON) and the local Police Department. Staff made another sweep of the facility with no results. The police arrived and was made aware of situation. The resident's sister was called and made aware of situation. The [DATE] at 4:36 pm Health Status Note documented that at 12:50 pm, the Chief of Police informed the facility the resident had been found at the base of the bridge near the facility deceased at 12:20 pm. During an interview with the Director of Nursing (DON) on [DATE] at 2:25 pm, she confirmed the only interventions in the resident's care plan for being at risk for elopement was picture added to Elopement book and redirect resident as needed. She stated the staff knew the resident and would give him things to do. She then stated she knew if it was not documented it wasn't done. Cross Reference to F689 The facility implemented the following actions to remove the IJ: 1. Res. #1 eloped from the facility on [DATE] and was found deceased later in the day on [DATE]. 2. 9 residents that have been identified as being at risk for elopement and have the potential to be affected by this. Nurse managers reviewed care plans for all 9 residents at risk for elopement to ensure their care plans are updated with individualized interventions. This audit will be completed on [DATE]. The Director of Nursing verified these care plans are in place. New admissions identified as elopement risk will be reviewed by the Director of Nursing to ensure that care plans are in place with appropriate interventions. 3. The administrator will educate 4 of 4 nurse managers, on [DATE], on the need to ensure residents that are at risk for elopement have care plan in place with individualized interventions to prevent elopement. 4. The Director of Nursing provided education to 46 of 46 Nursing Staff including 4 Registered Nurses, 16 Licensed Practical Nurses and 26 Certified Nursing Assistants regarding accessing care plans and interventions to provide care for residents on [DATE]. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Comprehensive Care Plan Policy was reviewed during QAPI meeting on [DATE], no changes were made to the policy. Those is attendance were the Administrator, Director of Nursing, Medical Director and other members of the QA Committee. 6. All corrective actions were completed on [DATE]. The facility alleges that the IJ is removed on [DATE]. The facility implemented the following actions to remove the IJ: 1. Verified via review of the Coroner's Report dated [DATE] that documented R1 date and time of pronounced death as [DATE] at 12:50 pm. 2. Verified via review of a list titled Residents at risk for elopement/Wandering which included nine residents and review of the nine residents' elopement-risk care plans with accompanying interventions. The nine residents identified with wandering behaviors/at risk for elopement were R3, R4, R5, R6, R8, R9, R10, R11, and R14. Review of the Elopement Risk Audit tool revealed that audits all nine residents were completed by [DATE]. During an interview on [DATE] at 3:33 pm, the DON and ADON confirmed that nine residents were identified as being at risk for elopement, their care plans had been updated, and audits completed. The DON stated there had not been any new resident admissions identified as an elopement risk, since [DATE]. 3. Verified via review of the [DATE] Staff Development Education Sign In form with topic, Care Plan Risk Assessments and accompanying education information. The in-service materials included information on elopement risk/exit seeking care plans, directions on completing elopement evaluation, and the Comprehensive Care Plans policy. The sign-in form included signatures for the DON, ADON, LPN unit manager UU, and LPN/Infection Preventionist XX. Interviews on [DATE] at 11:00 am with LPN UU, at 3:33 pm with the DON and ADON, at 4:07 pm with the Administrator and at 4:22 pm with LPN XX confirmed that the Administrator educated the four nurse managers on the need to ensure care plans are in place with individualized interventions for residents at work for elopement. 4. Verified via review of the in-service education sign-in forms with topics of Care Plans - [NAME] Access, dated [DATE], and review of the Comprehensive Care Plans policy. The sign-in forms were cross referenced with a master list of staff and confirmed that 46 nursing staff received the education regarding accessing care plans via text or in-person. During an interview on [DATE] at 2:45 pm the DON confirmed providing education to nursing staff and confirmed that they have access to residents' care plans, including those at risk for elopement. During an interview on [DATE] at 3:33 pm the ADON stated that care plan information on residents at risk for elopement also carries over to the [NAME] (which the CNAs access for resident care information). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE] at 10:43 am with Certified Nursing Assistant (CNA) PP, at 10:45 am with CNA QQ, at 10:49 am with Licensed Practical Nurse (LPN) RR, at 10:53 am with Registered Nurse (RN) SS, at 10:56 am with LPN TT, at 11:00 am with LPN UU, at 11:20 am with CNA WW, at 11:22 am with LPN XX, at 11:28 am with CNA NNN, at 11:30 am with CNA OOO, at 11:33 am, at 11:35 am with CNA YY, at 11:38 am with LPN ZZ, at 11:48 am with LPN AAA, at 11:50 am with LPN BBB, at 12:07 pm with CNA CCC, at 12:13 pm with CNA DDD, at 12:15 pm with CNA CC, at 12:27 pm with CNA HH, at 12:36 pm with CNA EEE, at 12:39 pm with CNA FFF, at 12:43 pm with CNA GGG, at 1:15 pm with CNA HHH, and at 2:35 pm with RN LLL confirmed they had received education on accessing care plans and interventions to provide care for residents on [DATE]. 5. Verified via review of the QAPI meeting agenda and minutes, dated [DATE] and titled Ad hoc QAPI For Elopement Event and the Comprehensive Care Plans policy. The QAPI meeting information includes that the Medical Director joined the meeting by phone. Interviews conducted on [DATE] at 3:33 pm with the DON and ADON, at 4:07 pm with the Administrator, and at 4:22 pm with LPN Infection Preventionist XX confirmed that the QAPI meeting was held on [DATE] and the comprehensive care plan policy was reviewed with no changes. 6. All corrective actions were completed on [DATE]. The facility alleges that the IJ was removed on [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 - 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 interviews, record review and review of the facility policy titled, Elopements and Wandering Residents, the facility to provide adequate supervision and frequent monitoring of resident (R1) and failed to ensure a kitchen door was locked to prevent the elopement of R1. The facility also failed to provide adequate supervision of the steam table that was turned on and left unsupervised in the dining room. The sample was 14 residents. On [DATE], 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 and Assistant Director of Nursing were informed of the Immediate Jeopardy on [DATE], at 11:47 am. The noncompliance related to the Immediate Jeopardy (IJ) was identified to have existed on [DATE]. An Acceptable IJ Removal Plan was received on [DATE]. 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 was removed on [DATE]. Findings include: Review of an undated policy titled, Elopements and Wandering Residents revealed the following: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk; the facility is equipped with door locks/alarms to help avoid elopements; 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; Adequate supervision will be provided to help prevent accidents or elopements. R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: anemia, glaucoma, mild neurocognitive disorder due to physiological condition with behavioral disturbance, Alzheimer's disease, and psychotic disorder with delusions. The resident had a Quarterly Minimum Data Set assessment completed on [DATE] indicating a Brief Interview for Mental Status (BIMS) of 5 indicating the resident had severely impaired cognition, having no behaviors or wandering behavior and required supervision with transfers and ambulation. Although the resident had a care plan since [DATE] for being at risk for elopement, the only interventions in place was to redirect resident as needed and picture added to Elopement book. The resident had an Elopement Evaluation completed on [DATE] with a score of 5 indicating the resident was at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Health Status Note dated [DATE] at 4:15 am documented that upon rounds noted resident not in his room. Staff immediately began search of facility. Resident was not found. The Administrator was notified, then the Director of Nursing (DON) and the Abbeville Police Department. Staff made another sweep of the facility with no results. The police arrived and was made aware of situation. The resident's sister was called and made aware of situation. The [DATE] at 4:36 pm Health Status Note documented that at 12:50 pm, the Chief of Police informed the facility the resident was found at the base of the bridge near the facility deceased at 12:20 pm. It also noted an autopsy would be performed. Review of the [DATE] neighboring county Sheriff's Office Incident Report/Narrative indicated the resident had been found under the HWY 280 bridge. A time was not specified in the report. The investigator noted he proceeded to the location of the subject and found an older black male lying flat on his back, arms partially extended in a boxing type position, extended. There were two minor scrapes on his forehead, eyes partially open. Subject was cold to the touch. After the Coroner completed getting photos the body was turned over to look for any marks consistent with being hit by a vehicle. No marks were visible on his back or chest and stomach area. No visible were noted. It appeared the subject had fallen over the edge of the bridge landing at the location he was positioned at. The fall was approximately 19 feet 3 inches. Looking at the bottom of the subjects shoes showed absolutely no dirt or mud even though the whole area was muddy, no shoe impressions were found matching the shoes he was wearing. The subject was directly in line with the bridge above as falling over the side. The investigator had made contact with the Sheriff, Chief of local Fire Department, Coroner and local Police department and was advised that the resident had left the facility through the kitchen door that leads outside, then left through kitchen door to outside kitchen that was not locked. The resident was seen on security cameras leaving the grounds at 12:05 am. The Sheriff advised him that 911 dispatch had received a call that a black male matching the resident's description was seen on the Ga HWY 30 bridge outside of the city at approximately 12:49 am of a male walking into traffic on US HWY 280 (also known as GA HWY 30) at the neighboring counties bridge and the description matches the resident. Review of the [DATE] Coroner's Report documented the date and time of pronounced death as [DATE] 12:50 pm. The Coroner's description of incident leading to death indicated the resident exited through the kitchen door with video review showing he left at 12:05 am walking down the drive to the highway. At 12:45 am 911 received a call of an unknown person walking east on the bridge. The resident was located at 12:21 pm by Department of Natural Resources and a neighboring county firefighter. The resident was found lying flat on his back. There seemed to have been no movement where he was lying. There was no mud or dirt on his shoes. The drop was 19 feet from the bottom of the bridge. He was transported on [DATE] for an autopsy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator and the Director of Nursing on [DATE] at 11:45 am, they stated that on [DATE] at 6:45 pm, the last dietary staff person who left for the day, left the door unlocked that lead into the kitchen. The resident walked into the kitchen from the dining room because that door was left unlocked then walked out the second door which led him outside. The resident was last seen by CNA HH on [DATE] at 11:45 pm while she was clocking out. The Administrator stated some CNAs stated they last saw the resident at 1:30 am when they had to get him out of another resident's room. He stated he did not agree with those CNAs because the cameras caught the resident leaving on [DATE] at 12:05 pm. He then stated staff discovered the resident missing between 4:00 am and 4:30 am. The nurse and the CNA who were assigned to the resident that night have been suspended as well as the dietary staff person who did not lock the door. He stated the dietary staff is now supposed to report to nursing when they are leaving and must exit through the main doors at the time clock. Stated they think the dietary staff did not lock the kitchen door from the dining room. That lock has since been replaced. Review of the video surveillance revealed the following timeline: 1. [DATE] at 6:44 pm- two dietary staff observed entering the kitchen from the dining room. Dietary staff DD let the door slam but did not lock the door. At 6:45 pm the two dietary staff exit the building through the back kitchen door. 2. [DATE] at 10:20 pm R1 walks into the dining room talking to himself, looks in the tray carts, walks around the steamtable several times and picks up a plastic cutlery set. At 10:24 pm he opens the kitchen door and enters the kitchen. 3. [DATE] at 10:24 pm, although the resident was out of view, sounds could be heard of the resident humming, feet shuffling and could hear sounds of paper or plastic being moved around. At 10:27 the resident comes into view of the camera and is observed opening the chemical supply closet, looks in the closet for a few seconds, then closes the door closet door and walks out of view of the camera. Although the resident is out of view of the camera sounds could still be heard of the resident humming, shuffling footsteps and what sounded like metal cookware or metal cabinet doors slamming. At 10:35 the resident comes back in view and is seen turning on the lights in the kitchen next to the exit door then walks out of view. There were no more sounds heard in the kitchen after 10:36 pm. He is then seen on the dining room camera leaving the kitchen into the dining room and leaves the dining room. 4. [DATE] at 11:45 pm, CNA HH is seen leaving through the front main double doors at the time clock with the resident in view of camera. 5. [DATE] at 12:05 am, the resident is observed leaving the building through the kitchen exit door stepping outside onto the loading dock area. He then steps down off the loading dock and starts walking the driveway towards the highway. 6. [DATE] at 12:06 to 12:07 am- Front Patio Camera captures the resident briefly walking from the kitchen loading dock area down the driveway. The camera then briefly captures the resident walking east on the highway. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Eagle Healthcare and Rehab	206 Main Street East Abbeville, GA 31001

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the time the resident was in the kitchen on [DATE] from 10:24 pm to 10:36 pm, the resident had turned on the oven and the oven timer. From review of the video surveillance the oven timer alarm started alarming on [DATE] at 11:05 pm and continued to alarm until [DATE] at 4:32 when staff entered the kitchen looking for the resident. During an interview with the Dietary Manager on [DATE] at 2:55 pm, she stated for the oven timer to alarm, the oven must be turned on. This confirmed the oven was left on and unsupervised from [DATE] at approximately 11:05 pm to [DATE] at 4:32 am when staff turned the alarm off. During an interview with Dietary staff DD on [DATE] at 1:41 pm she confirmed she did not lock the kitchen door. She stated she was rushing to get to her second job. She stated they had been instructed to lock the kitchen door when they were leaving which is usually at 7:00 pm. During an interview with CNA BB on [DATE] at 4:04 pm, she confirmed she was assigned to R1 on [DATE]. She stated she was not sure of the last time she saw the resident but guessed around 1:30 am when he was in another resident's room. When the surveyor asked her if she made rounds on the resident every two hours, she refused to answer the question and stated she was not sure how it all happened. She stated that night the resident was going door to door trying to pull the doors open. Two attempts were made on [DATE] at 1:20 pm and on [DATE] at 4:00 pm to call Licensed Practical Nurse AA who was assigned to R1 on [DATE] but was unsuccessful. During an interview with the Director of Nursing (DON) on [DATE] at 2:25 pm, she stated she expects the nurses and the CNAs to make rounds on the residents at least every two hours. Review of the LPN nurse job description noted the general purpose was to provide direct nursing care to the residents and supervise the day to day nursing activities performed by nursing assistants. Such supervision must be in accordance with current Federal, State, and Local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to maintain the highest degree of quality care at all times. It also listed the following administrative functions: Direct the day to day functions of the nursing assistants in accordance with rules, regulations, and guidelines that govern the longterm care industry. Nursing Care Functions: Deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices, Make periodic checks to confirm that prescribed treatments are being properly administered by CNAs and to evaluate the resident's physical and emotional status, review care plans daily to confirm that appropriate care is being rendered, confirm that CNAs are aware of the resident care plans. Other Duties: Protect residents from neglect, mistreatment, and abuse. Review of the Certified Nursing Assistant job description noted the general purpose was to perform direct resident care duties under the supervision of licensed nursing personnel. Assist with promoting a compassionate physical and psychosocial environment for the residents. Essential Job Functions: Provide personal care of residents daily, Observe residents carefully and report changes in condition to Charge Nurse, promptly answer call lights and other resident needs, Protect residents from neglect, mistreatment and abuse, Others as directed by the supervisor or administrator. 2. A review of scheduled mealtimes for the residents' dining room revealed that breakfast started at 7:15 am, lunch started at 12:15 pm and dinner started at 5:15 pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on [DATE] at 1:54 pm, the steam table that is located in the residents' dining room, had approximately an inch of water in four uncovered wells, with steam rising off the water. The dining room doors were open and the steam table was unsupervised and accessible to residents. During a check of the steam table water temperatures on [DATE] at 1:55 pm with dietary aide FF, the water temperatures in the wells of the steam table were 160 degrees, 156 degrees, 147 degrees, and 110 degrees Fahrenheit. Dietary aide FF confirmed that the steam table was turned on and reached down on the lower portion of the table and turned the knobs to turn it off. During the observations on [DATE] at 1:54 pm and 1:55 pm, two residents were observed in the dining room. During an interview on [DATE] at 4:00 pm, dietary aide FF was asked who is responsible for turning off the steam table. Dietary aide FF responded that it is the last person on the (steam table) line and indicated that dietary cook EE was the last person on the line for the previous lunch service. During an interview on [DATE] at 11:13 am, the Dietary Manager stated that the cook is supposed to turn off the steam table at the end of the meal service. The facility implemented the following actions to remove the IJ: 1. Res. #1 eloped from the facility on [DATE] and was found deceased later in the day on [DATE]. 2. Licensed Practical Nurse AA was suspended pending investigation on [DATE] and terminated on [DATE]. 3. Certified Nursing Assistant BB was suspended pending investigation on [DATE] and terminated on [DATE]. 4. Dietary Assistant was suspended pending investigation on [DATE] and terminated on [DATE]. 5. The facility conducted a house-wide head count to ensure all other residents were accounted for on [DATE]. 6. Law enforcement notified on [DATE] by Administrator. 7. State Agency was notified [DATE] by Administrator. 8. The resident's responsible party was notified on [DATE] by both the staff nurse and the Director of Nursing. 9. Administrator notified the Ombudsman on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Ad HOC QAPI held [DATE]. Reviewed incident and Elopement and Wandering Resident Policy during this meeting, no change were made to the policy. In attendance were the Administrator, Director of Nursing, Medical Director and QA Committee. During this meeting the committee determined the root cause of R1 eloping from the facility was related to the dietary staff not ensuring the kitchen was locked, nursing staff not conducting rounds every two hours on this resident and not providing redirection when resident displayed increase in wandering behaviors. 11. Camera footage of event reviewed and secured [DATE]. 12. Facility obtained statements from staff present during the event on [DATE]. 13. All residents re-assessed for elopement risk and had care plans updated to reflect risk on [DATE], by nurse managers. 14. Maintenance Director checked to ensure kitchen door lock is functioning properly on [DATE], it was functioning properly. 15. Maintenance Director checked to ensure doors throughout the facility were functioning properly on [DATE], all doors were functioning properly. 16. 100% Staff education on Elopement Protocol, Risk and Prevention, Abuse and Neglect and placing a work order when equipment fails and that if equipment is essential for resident safety, a phone call should be placed to Maintenance Director and Administrator to develop a plan to keep residents and staff safe, started [DATE] and completed on [DATE]. 82 of 82 staff educated: 1 Administrator, 1 Human Resources Director, 1 Social Services Director, 3 Activity Personnel, 1 Medical Records Coordinator, 1 Transportation Aide, 13 Therapy Personnel, 7 Dietary Personnel, 8 Housekeeping Staff, 4 Registered Nurses, 16 Licensed Practical Nurses, 26 Certified Nursing Assistants. All staff who have not been in-serviced will be in-serviced prior to their next shift. 17. 100% Nursing staff educated on Rounding every two hours on all residents and more frequently during periods of time which residents may require it started on [DATE] and completed by [DATE]. 46 of 46 educated: 4 Registered Nurses, 16 Licensed Practical Nurses and 26 Certified Nursing Assistants. 18. The kitchen front entrance door keypad door lock was replaced with upgraded locking device on [DATE]. 19. The facility ordered a double-sided keypad door lock for exterior kitchen door, installed on [DATE]. 20. The keypad lock installed on one dining room door on [DATE]. The dining room will be locked at 7:00pm by dietary staff daily. Then checked by nursing staff and logged into the door check log. 21. On [DATE], the steam table was left on after lunch service, with 1 resident present in dining room, when the cook realized the steam table was on, the steam table was turned off. 22. No residents identified as being harmed by steam table. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	23. The administrator educated all 7 dietary staff on [DATE] on turning off the steam table after meals and staying with the steam table when hot and residents have access. 24. Ad HOC QAPI held [DATE] with Administrator, Director of Nursing, Medical Director and QA Committee to discuss findings of this investigation, survey and plan of action to address identified concerns. 25. All corrective actions were completed on [DATE]. The facility alleges that the IJ is removed on [DATE]. The facility implemented the following actions to remove the IJ: 1. Verified via review of the Coroner's Report dated [DATE] that documented R1 date and time of pronounced death as [DATE] at 12:50 pm. 2. Verified via review of the Status/Payroll Change Report, dated [DATE], that documented LPN AA was out pending investigation. Review of the Separation Notice, dated [DATE], revealed LPN AA's employment period was [DATE] through [DATE] with reason for separation documented as poor job performance. 3. Verified via review of the Status/Payroll Change Report, dated [DATE], that documented CNA BB was suspended due to investigation. Review of the Separation Notice, dated [DATE], revealed CNA BB's employment period was [DATE] through [DATE] with reason for separation documented as poor job performance. 4. Verified via review of the Status/Payroll Change Report, dated [DATE], that documented Dietary Assistant DD was suspended due to investigation. Review of the Separation Notice, dated [DATE], revealed that Dietary Assistant DD's employment period was from [DATE] through [DATE] with reason for separation documented as not following company procedures and poor job performance. 5. Verified via review of a [DATE] untitled document by the DON who documented that upon arrival to the facility, repeat head count performed with all other residents accounted for. 6. Verified via review of R1's clinical record that included a [DATE] Health Status progress note that the local police department was notified of R1's elopement. 7. Validated through review of the Facility Reported Incident (FRI) form dated [DATE] which reported R1 was missing. The FRI indicated the date and time of incident was [DATE] at 4:30 am. 8. Validated via review of the [DATE] at 4:15 am Health Status Note which documented the resident's sister was called and made aware of the situation. 9. Validated through interview with the Ombudsman on [DATE] at 2:05 pm, who stated the facility had notified her of R1's elopement. Review of the [DATE] Social Services note documented she spoke with the Ombudsman at 12:40 pm to inform her of R1's elopement. 10. During an interview on [DATE] at 4:07 pm the Administrator confirmed that an Ad Hoc QAPI meeting was held on [DATE] following R1's elopement and the Elopement and Wandering Resident Policy was reviewed with no changes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:33 pm the DON and ADON also confirmed attending the Ad Hoc QAPI meeting on [DATE]. Review of the QAPI form with initial date of [DATE], confirmed the facility identified the root cause of R1's elopement from the facility. The [DATE] QAPI form included a problem statement of: A resident eloped the facility and had a negative outcome. The root causes included that the kitchen door was not locked prior to dietary staff leaving for the day and nursing staff were not rounding every two hours. 11. Confirmed by surveyor review of camera footage of event. 12. Verified via review of staff's written statements concerning the events on [DATE]. 13. Verified via review of the tnd1vIdual elopement evaluations, dated 315/2025, that were completed on all residents. A review of the assessments confirmed that nine residents were identified as at risk for elopement. The nine residents were R3, R4, RS, R6, RB, R9. R10, R11, and R14. Reviews of the clinical records for the nine residents identified at being at risk for elopement revealed that the resident care plans had been updated to include the risk with accompanying interventions. During an interview on [DATE] at 3:33 pm the DON and ADON confirmed that all residents were reassessed for elopement risk on 315/2025 14. Review of the typed statement dated [DATE] by the Maintenance Director noted he inspected the dining room to the kitchen door and that the deadbolt lock was in working order. 15. Validated via review of the [DATE] Daily Door Checks form which documented all exit doors, side dining room door, front kitchen door and the back kitchen door were functioning properly 16. Interviews on [DATE] at 10:10 am with Dietary [NAME] GG and Dietary Aide II, at 10:19 am with Houskeeper(HK) JJ, at 10:23 am with HK KK, at 10:25 am with HK LL, at 10:28 am with HK Supervisor MM, at 10:31 am with Activity Director NN, at 10:34 am with the Social Worker, at 10:37 am with Medical Records/Scheduler OO, at 10:40 with Human Resources/Payroll Manager, at 10:43 am with Certified Nursing Assistant (CNA) PP, at 10:45 am with CNA QQ, at 10:49 am with Licensed Practical Nurse (LPN) RR, at 10:53 am with Registered Nurse (RN) SS, at 10:56 am with LPN TT, at 11:00 am with LPN UU, at 11:10 am with the Maintenance Director, at 11:15 am with Director of Rehab, at 11:20 am with CNA WW, at 11:22 am with LPN XX, at 11:25 am with Activity Assistant MMM, at 11:28 am with CNA NNN, at 11:30 am with CNA OOO, at 11:33 am with Marketing/Admissions, at 11:35 am with CNA YY, at 11:38 am with LPN ZZ, at 11:48 am with LPN AAA, at 11:50 am with LPN BBB, at 12:07 pm with CNA CCC, at 12:13 pm with CNA DDD, at 12:15 pm with CNA CC, at 12:27 pm with CNA HH, at 12:36 pm with CNA EEE, at 12:39 pm with CNA FFF, at 12:43 pm with CNA GGG, at 1:15 pm with CNA HHH, at 1:27 pm with Laundry Aide III, at 1:35 pm with the Dietary Manager, at 1:41 pm with Dietary Aide JJJ, at 1:47 pm with Transportation Aide KKK, at 2:35 pm with RN LLL and at 3:33 pm with the Administrator and the DON confirmed they had received education on Elopement Protocol, Risk and Prevention, Abuse and Neglect, placing a work order when equipment fails and if the equipment is essential for resident safety and a phone call should be placed to the Maintenance Director and the Administrator to develop a plan to keep residents and staff safe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:22 pm LPN Infection Preventionist XX clarified that housekeeping and dietary staff do not have access to the electronic system used for placing work orders, but their supervisors do have access. They were educated on notifying their supervisors immediately so that an (electronic) work order can be completed by the supervisor. LPN XX also stated that education with newly hired staff had also been completed. Verified via review of the in-service education sign-in forms with topics of elopement and two-hour rounding with sign-off forms and the accompanying education information. The sign-in forms were cross referenced with a master list of staff and confirmed that 46 nursing staff received the education regarding rounding every two hours on all residents. During an interview on [DATE] at 3:33 pm the DON and ADON confirmed education to nursing staff had been provided regarding two-hour rounding. Interviews on 3121/2025 at 10:43 am with Certtf1ed Nursing Assistant (CNAJ PP. at 10:45 am with CNA QQ, at 10:49 am with Licensed Practical Nurse (LPN) RR, at 10:53 am with Registered Nurse (RN) SS, at 10:56 am with LPN TT. at 11:00 am with LPN uu.at 11:20 am With CNA WW. at 11:22 am With LPN XX, at 11:28 am with CNA NNN, at 11:30 am with CNA 000. at 11:33 am. at 11:35 am With CNA YY. at 11:38 am with LPN zz.at 11:48 am With LPN AAA, at 11:50 am with LPN BBB, at 12:07 pm with CNA CCC, at 12:13 pm with CNA DD, at 12:15 pm with CNA CC, at 12:27 pm with CNA HH, at 12:36 pm with CNA EEE, at 12:39 pm with CNA FFF. at 12:43 pm with CNA GGG, at 1:15 pm with CNA HHH, and at 2:35 pm with RN LLL confirmed they had received education on accessing care plans and interventions to provide care for residents on [DATE]. A review of completed Rounds Sheets, from [DATE] through [DATE], tor all three halls (100, 200, and 300 halls with resident rooms, revealed that staff signed off as completing rounding on residents every two hours starting on [DATE] The form included instructions for nurses to document on even hours and CNAs document on odd hours. 17. Verified via observation on [DATE] at 1:50 pm with the Administrator and the Maintenance Director of the new keypad with a deadbolt lock on the kitchen front entrance door. The new lock was noted to be functioning properly. 18. Verified via review of the invoice dated [DATE] where the facility had ordered a new upgrade double sided keypad door lock. Also verified via observation on [DATE] at 12:10 pm of the new lock installed on the exterior kitchen door that was functioning properly. The facility had also installed an Exit Stopper Multifunction Door Alarm on the exterior kitchen door. 19. Verified via observation with the Administrator on [DATE] at 10:45 am of the new keypad lock on the main dining room door. The keypad lock was observed to be functioning properly. Also verified via review of documentation on the Daily Door Checks log dated [DATE] through [DATE] of staff checking all exit doors and the main dining room door in the morning and the afternoon. 20. This was observed by surveyor on [DATE]. 21. Per surveyor observation no resident was identified as being harmed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	22. Verified via review of in-service education document dated [DATE] with the topic of: steam table safety and shutdown procedures. The signatures on the form were cross-referenced with a master list of staff and confirmed that all seven dietary staff received the education. During an interview on [DATE] at 4:07 pm, the Administrator confirmed providing the education to dietary staff. The Administrator stated that the staff were receptive to the education and understood the importance of it. He stated that staff would remain in the dining room with the steamtable, while it cooled down. Interviews on [DATE] at 10:10 am with Dietary [NAME] GG and Dietary Aide II, at 1:35 pm with the Dietary Manager, at 1:41 pm with Dietary Aide JJJ, at 1:47 pm confirmed they had received education on steam table safety and shutdown procedures. During an observation on [DATE] at 10:15 am, the dining room was open with a few residents seated at tables, watching tv on the large screen. The steam table was roped off with a staff person seated, in front of it, within the roped off area. 23. Verified via review of the QAPI meeting agenda and minutes, dated [DATE] and titled Ad hoc QAPI For Elopement Event''. The QAPI meeting information includes that the Medical Director joined the meeting by phone. Interviews conducted on [DATE] at 3:33 pm with the DON and ADON, at 4:07 pm with the Administrator, and at 4:22 pm with LPN Infection Preventionist XX confirmed that the QAPI meeting was held on 3/ 19/2025. 24. All corrective actions were completed on [DATE]. The facility alleges that the IJ was removed on [DATE].

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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 interviews, record reviews, and review of the job descriptions for the Executive Director and the Director of Nursing (DON), the facility Administration failed to provide frequent monitoring and protective oversight of the facility environment to prevent the elopement of resident (R1) and prevent resident access to potentially hazardous kitchen equipment. On [DATE], 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 and Assistant Director of Nursing were informed of the Immediate Jeopardy on [DATE], at 11:47 am. The noncompliance related to the Immediate Jeopardy (IJ) was identified to have existed on [DATE]. An Acceptable IJ Removal Plan was received on [DATE]. 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 was removed on [DATE]. Findings include: A review of the Executive Director's job description revealed General Purpose: To lead and direct the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. Section Facility Management: Monitor each department's activities, communicate policies, evaluate performance, provide feedback and assist, observe, coach, and discipline as needed. Oversee regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of facility; morale of the staff; and ensure resident needs are being addressed. Verify that the building and grounds are maintained appropriately and that equipment and work areas are clean, safe and orderly, and any hazardous conditions are addressed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the DON's job description revealed General Purpose: To manage the overall operations of the Nursing Department in accordance with Company policies, standards od nursing practices and government regulations so as to maintain excellent care of all residents' needs. Section Administrative Functions: Plan, develop, organize, implement, evaluate and direct the nursing services department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the long-term facility. Assume administrative authority, responsibility and accountability for all functions, activities, and training of the nursing department. Organize, develop, and direct the administration and resident care of the nursing service department. Section Personnel Functions: Delegate to nursing service supervisory personnel the administrative authority, responsibility, and accountability necessary to perform their assigned duties. Make daily rounds of the nursing department to verify that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards. Section Nursing Care Functions: Schedule daily rounds to observe residents and to determine if nursing needs are being met in accordance with resident's request. Regularly inspect the facility and nursing practices for compliance with federal, state and local standards and regulations. Section Safety and Sanitation: Assure residents a comfortable, clean, orderly and safe environment. Section Care Plan and Assessment Functions, Documentation: Verify that medical and nursing care is administered in accordance with the resident's wishes. Assist with development of and approve final version of the Interdisciplinary Plan of Care for each resident in coordination with the physician, Medical Director, nursing staff, and outside consultants (i.e., nursing, dietary, pharmacy, therapists, etc.) and in accordance with corporate , state and federal guidelines. Confirm accurate completion of forms/reports for the admission, transfer and/or discharge of each resident including, but not limited to, the nursing portion of [NAME], Initial Nursing Assessment, Minimum Data Set (MDS), Resident Care Plan and the Annual MDS. R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: anemia, glaucoma, mild neurocognitive disorder due to physiological condition with behavioral disturbance, Alzheimer's disease, and psychotic disorder with delusions. The resident had an Elopement Evaluation completed on [DATE] with a score of 5 indicating the resident was at risk for elopement. Review of the Health Status Note dated [DATE] at 4:15 am documented that upon rounds noted resident not in his room. Staff immediately began search of facility. Resident was not found. The Administrator was notified, then the Director of Nursing (DON) and the Abbeville Police Department. Staff made another sweep of the facility with no results. The police arrived and was made aware of situation. The resident's sister was called and made aware of situation. The [DATE] at 4:36 pm Health Status Note documented that at 12:50 pm, the Chief of Police informed the facility the resident was found at the base of the bridge near the facility deceased at 12:20 pm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115733	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Eagle Healthcare and Rehab	206 Main Street East Abbeville, GA 31001

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator and the Director of Nursing on [DATE] at 11:45 am, they stated that on [DATE] at 6:45 pm, the last dietary staff person who left for the day, left the door unlocked that lead into the kitchen. The resident walked into the kitchen from the dining room because that door was left unlocked then walked out the second door which led him outside. The resident was last seen by CNA HH on [DATE] at 11:45 pm while she was clocking out. The Administrator stated some CNAs stated they last saw the resident at 1:30 am when they had to get him out of another resident's room. He stated he did not agree with those CNAs because the cameras caught the resident leaving on [DATE] at 12:05 am. He then stated staff discovered the resident missing between 4:00 am and 4:30 am. The nurse and the CNA who were assigned to the resident that night have been suspended as well as the dietary staff person who did not lock the door. He stated the dietary staff is now supposed to report to nursing when they are leaving and must exit through the main doors at the time clock. It was further reported that they think the dietary staff did not lock the kitchen door from the dining room. During an interview with the Director of Nursing on [DATE] at 2:25 pm, she stated she expected the nurses and the CNAs to make rounds on the residents at least every two hours. Cross Refer to F641, F656, and F689. The facility implemented the following actions to remove the IJ: 1. Res. #1 eloped from the facility on [DATE] and was found deceased later in the day on [DATE]. 2. Administration failed to provide monitoring and protective oversight of the facility environment to prevent elopement of R1. Specifically, the facility administration failed to ensure the kitchen entry door was locked, failed to accurately assess and code R1's wandering behavior on the Minimum Data Set, and failed to develop interventions in the care plan to include management/supervision to address the resident's risk of elopement. 3. On [DATE], The Administrator and Director of Nursing were re-educated on the job description by the Human Resources Director. 4. On [DATE], The Administrator and Director of Nursing were educated by [NAME] President of Clinical Services on Elopement Prevention. 5. The Director of Nursing verified that all 9 residents identified as being at risk for elopement have been properly assessed for elopement risk, MDS's are that have been submitted are accurately coded and that residents have care plans in place with appropriate interventions. 6. Beginning [DATE], the Administrator has conducted rounds daily on all exit doors to ensure they are functioning appropriately Monday through Friday. On the weekends these same rounds are completed by the Nurse Supervisor and reviewed on Monday morning by the Director of Nursing. If issues or concerns are identified they are addressed immediately. The Administrator and/or Director of Nursing are available by phone to address any concerns 24/7 when not in the facility. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Beginning [DATE], The Administrator and Director of Nursing will conduct rounds over the phone with nurse supervisors during night shift to inquire about residents with wandering behaviors, what interventions are being utilized to deter the behavior, ensuring all doors are secure including the kitchen door, and to ensure residents don't have access to hazardous equipment. Nurse supervisor completes an audit form nightly, and the Director of Nursing is reviewing the following day. If issues or concerns are identified they are addressed immediately. The Administrator and/or Director of Nursing are available by phone to address any concerns 24/7 when not in the facility. 8. Elopement and Wandering Resident Policy was reviewed during QAPI meeting held [DATE] with the Administrator, Director of Nursing, Medical Director and QA Committee. No changes were made to this policy. The root cause of the events were discussed and plan put into place to address identified concerns. 9. All corrective actions were completed on [DATE]. The facility alleges that the IJ is removed on [DATE]. The facility implemented the following actions to remove the IJ: 1.Verified via review of the Coroner's Report dated [DATE] that documented R1 date and time of pronounced death as [DATE] at 12:50 pm. 2. This was confirmed as evidenced by R1 eloping from the facility on [DATE] and not being missed for at least four hours after he eloped. 3. This was verified via review of the Job Descriptions for the Executive Director (Administrator) and the Director of Nursing with their corresponding signatures and dated [DATE]. Also verified through interview with the Human Resources Director on [DATE] at 10:40 am who confirmed she had educated the Executive Director and the DON regarding their job descriptions. 4. Verified via review of the Inservice Sign In Sheet titled Elopement Prevention Procedures dated [DATE] by the [NAME] President of Clinical Services. Also verified via interview with The [NAME] President of Clinical Services on [DATE] at 3:23 pm who confirmed she provided the education to the Administrator and the DON. 5. Verified via review of a list titled, Residents at risk for elopement/Wandering which included nine residents and a statement that an audit was completed for MDS accuracy on [DATE]. The statement was signed by the DON and the ADON/MDS nurse. The nine residents identified with wandering behaviors were R3, R4, R5, R6, R8, R9, R10, R11, and R14. During an interview on [DATE] at 3:33 pm the ADON/MDS nurse confirmed that an audit was completed on all residents with wandering behaviors to ensure MDS accuracy. Verified via review of a list titled Residents at risk for elopement/Wandering which included nine residents and review of the nine residents' elopement-risk care plans with accompanying interventions. The nine residents identified with wandering behaviors/at risk for elopement were R3, R4, R5, R6, R8, R9, R10, R11, and R14. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:33 pm, the DON and ADON confirmed that nine residents were identified as being at risk for elopement, their care plans had been updated, and audits completed. The DON stated there had not been any new resident admissions identified as an elopement risk, since [DATE]. 6. Beginning [DATE], the Administrator has conducted rounds daily on all exit doors to ensure they are functioning appropriately Monday through Friday. On the weekends these same rounds are completed by the Nurse Supervisor and reviewed on Monday morning by the Director of Nursing. If issues or concerns are identified they are addressed immediately. The Administrator and/or Director of Nursing are available by phone to address any concerns 24/7 when not in the facility. This was verified via review of the daily Room Rounds Sheet that included all of the exit doors dated [DATE] through [DATE] Monday through Friday. Also, verified via review of the Daily Door Checks sheet that was done twice a day from [DATE] through [DATE]. The checks included all of the exit doors, front kitchen door, back kitchen door and the dining room second entrance. Also verified through interview with the Administrator and the DON on [DATE] at 3:33 pm that daily door checks were done and documented. 7. Verified through review of the Call Audit to Facility Off Shift form with documentation of audits from [DATE] through [DATE]. There was documentation from [DATE] through [DATE] of rounds conducted with nurse supervisors over the telephone with the DON's signature each day for review. During an interview with the DON on [DATE] at 3:33 pm she stated the nurses have been calling her every night to discuss any behaviors, securing all doors including the kitchen doors. 8. Verified via review of the [DATE] Ad Hoc QAPI meeting minutes that included the signatures of the Administrator, DON, Infection Preventionist, ADON, Unit Manager, Social Services, Housekeeping Supervisor, and the Activity Director. The Medical Director attended by Teams Meeting. Also verified through interviews with the Activity Director on [DATE] at 10:31 am, with the Social Worker on [DATE] at 10:34 am, at 11:22 am with LPN XX, with the Administrator and the DON on [DATE] at 3:33 pm, who all stated they were in attendance of the [DATE] Ad Hoc QAPI meeting and there were no changes made to the Elopement and Wandering Resident Policy. They also stated the root cause of the events were discussed and a plan was put in place. 9. All corrective actions were completed on [DATE]. The facility alleges that the IJ is removed on [DATE].