STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175245	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edwardsville Care and Rehab	751 Blake Street Edwardsville, KS 66111

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility identified a census of 94 residents. The sample included three residents reviewed for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) risk. Based on observation, record review, and interviews, the facility failed to provide adequate supervision to prevent and then identify an elopement for Resident (R) 1, who had a BIMS of 15, schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and a guardian. On 02/05/26 at 02:45 AM, R1 left the facility without staff knowledge or supervision by climbing a fence surrounding a smoking patio at the facility and using a dining room chair. Staff were unaware of R1's absence for nine hours due to a failure to complete resident safety rounds. R1 walked to a truck stop and stayed there for hours before walking back to the facility. R1 walked in temperatures ranging from 29.9 to 45.3 degrees F during the timeframe of 02:45 AM to 11:45 AM when he returned to the facility. This failure placed R1 in immediate jeopardy. Findings included:- R1's Electronic Medical Record (EMR) documented a diagnosis of schizoaffective disorder. The Annual Minimum Data Set (MDS) dated 12/30/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person, although evidence shows it was untrue). R1 had rejection of cares and wandering behaviors on one to three days in the assessment period. The Behavioral Symptoms Care Area Assessment (CAA) dated 01/02/26, documented R1 triggered for behaviors of wandering and rejection of cares. R1's 01/26/23, revised 02/05/26, Care Plan documented R1 was at moderate to high risk for an elopement. The Care Plan documented the following interventions:02/05/26- Staff increased supervision during increased exit seeking behaviors.02/05/26- Staff provided a room away from an exit.02/05/26- Staff provided lodging in a secure unit.02/05/26- Staff requested a medication review from the pharmacist, medical doctor, or registered nurse.02/05/26- Staff requested psychiatric services as needed.02/05/26- Staff utilized a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering), checked placement of the WanderGuard each shift and the function each day. Staff utilized the WanderGuard per manufacturer's recommendations. R1 had a WanderGuard that limited his ability to enter the backyard without staff present. The facility's investigation documented on 02/05/26 at 11:45 AM, R1 requested re-entry at the front door. Staff brought him back inside and assessed him for injury, for which he had none. Staff placed a WanderGuard that locked the smoking area patio door so he would have to ask staff to go outside. The facility inspected the smoking patio and found a dining room chair which staff removed immediately. R1 wore a hooded sweatshirt, long denim pants, and closed-toed shoes. The facility notified R1's guardians of the incident and of the WanderGuard which the guardians agreed to. R1 reportedly climbed the fence earlier that morning and ran away. The facility reviewed their cameras and noted R1 used a chair to climb the fence on the smoking patio at 02:45 AM on 02/05/26. R1 reported he went to a nearby gas station and stayed there a while before making the decision to return to the facility. The facility immediately re-educated staff to visibly check each resident frequently and to remove and moveable furniture on the smoking patio when they (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	see it. On 02/05/26, R1 stated he had intentions to leave the facility and when asked why, he replied he did not know. R1 reported he sat at the gas station for a few hours before he decided to return to the facility. According to the Kansas State University Historical Weather website, the temperatures on 02/05/26 between 02:45 AM to 11:45 AM ranged from 29.9 degrees Fahrenheit (F) to 45.3 degrees F. Review of Google Maps revealed the distance from the facility to the truck stop was 1.8 miles. In a written statement, not dated, Certified Nurse Aide (CNA) M stated the last time she saw R1 was at 09:00 PM for a smoke break and he acted like his normal self. In a text statement, not dated, CNA N stated she could not recall the exact time she saw R1 walking around but she believed it was before midnight. In a text statement, not dated, Certified Medication Aide (CMA) R stated the night went smooth and she did not recall seeing R1 all night. In a text statement, not dated, Licensed Nurse (LN) G stated she believed she last saw R1 ambulating in the hallway and dining room around 02:00 AM. She stated R1 gave no indication of any concerns or unrest during the night. On 03/05/26 at 12:22 PM, Administrative Staff A escorted the surveyor through the dining room to the back door that opened up into a patio area surrounded by a tall fence. The patio area had no readily movable furniture available. On 03/05/26 at 12:26 PM, R1 laid in bed with his blankets pulled up to his chin. He did not want to engage in conversation other than to state he remembered the incident and that he was okay being in the facility. The WanderGuard was not visible at the time of the observation due to the blankets being pulled up to R1's chin. On 03/05/26 at 02:42 PM, the area where R1 climbed the fence was observed to be behind the facility and an employee parking area. The area had several large potholes. Observation of the probable path that R1 took to get to the truck stop revealed posted street signs of 30 miles per hour (mph) to 45 mph with areas of residential and commercial buildings. The street leading to the truck stop had commercial buildings on either side of the street with semi-trucks entering and exiting the street. The street leading to the truck stop did not have a sidewalk on either side of the street. The truck stop was located within a block of the on/off ramps of an interstate. On 03/05/26 at 12:22 PM, Administrative Staff A stated he observed R1 on the camera, using a dining room chair against the fence to climb over it. He stated the door to the patio remained unlocked but R1 had a WanderGuard that alarmed at the door and told him he needed staff if he wanted outside. On 03/05/26 at 12:27 PM, Administrative Staff A stated on 02/05/26, staff did not round on R1. He stated LN G was the last to see R1 in the dining room and she did not do rounds the rest of the shift. Administrative Staff A stated he took statements from day shift that day and not one of them said they did rounds when they took over their shift. On 03/05/26 at 12:31 PM, CMA S stated she worked on 02/05/26 and she was on her lunch break at the time R1 returned. She stated she did not complete rounds that day and R1 did not get medications from her during the day. CMA S stated she now completed rounds when she came in and before she left. She stated she kept residents safe from elopement by having eyes on them frequently and interacting with them. She stated residents at risk for elopement wore a WanderGuard that the nurses checked the function of and the CNAs checked the placement. She stated R1's WanderGuard locked the door to the patio yard. On 03/05/26 at 12:35 PM, LN H stated she worked on 02/05/26 and she completed rounds in the morning but R1's curtain was pulled, and she did not go into his room to see where he was. She stated R1 came back to the facility, and she asked him where he went and R1 stated he jumped the fence. She stated she completed a skin assessment right away then took him to Administrative Staff A. LN H stated he was fully clothed like he was going outside. She stated she kept residents safe from elopement by completing rounds every two hours and if somebody did not do their rounds, she sent them home. LN H stated she told her CNAs to look at the resident face-to-face and if they could not find a resident, they looked for them. On 03/05/26 at 12:39 PM, Administrative Nurse D stated on 02/05/26, R1 hit the button to come back into the facility and LN H let him in. She stated LN H asked him where he had been and how he got there and R1 stated he went to the gas station and meant to come back to the facility, but he fell asleep on the couch. Administrative Nurse D stated she noted he wore tennis shoes, a jacket, jeans, and a t-shirt. She stated R1 now had a WanderGuard that prevented him from going into the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	backyard without staff assistance. She stated after the incident, the facility reassessed all of the residents for elopement to make sure their care plans were current. Administrative Nurse D stated after the incident, the facility made sure staff completed their rounds, the facility educated staff on rounds and elopement, and the facility completed an elopement drill. The facility's Accidents-Elopement policy, dated June 2025, directed staff promptly reported any resident who tried to leave the premises or was suspected of being missing to the charge nurse or Administrative Nurse D. On 03/05/26 at 02:35 PM, Administrative Staff A was presented with the Immediate Jeopardy (IJ) Template and was notified of the facility failure to provide adequate supervision to prevent the elopement of R1, which constituted immediate jeopardy at F689. The immediate jeopardy at F689 also constituted Substandard Quality of Care at 42 CFR 483.25. The facility identified, implemented, and completed the following corrective measures:1. The facility updated R1's care plan on 02/05/26.2. The facility placed a WanderGuard on R1 on 02/05/26.3. The facility conducted education on elopement and rounds with staff on 02/05/26.4. The facility gave written warnings to multiple staff for failure to complete rounds on 02/05/26.5. The facility completed magnetic lock checks on the doors on 02/05/26 and 02/06/26.6. The facility completed an Ad-Hoc Quality Assurance and Performance Improvement (QAPI) meeting on 02/06/26.7. The facility completed an elopement drill on 02/07/26. Due to the facility completion of all corrective actions prior to the onsite visit, the deficient practice was deemed past noncompliance at a scope and severity of a J (isolated, immediate jeopardy).