STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195568	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyatt Manor Nursing and Rehab Ctr, Inc	4659 Highway 505 Jonesboro, LA 71251

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. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews the facility failed to have an adequate system in place to ensure residents at risk for elopement are supervised to prevent elopement from the facility for 1 (#1) of 2 (#1 and #2) residents at risk for elopement. This deficient practice resulted in an Immediate Jeopardy for Resident #1 on 9/12/2025 at 2:15a.m. Resident #1 was last observed in the facility on 09/12/2025 at 1:55 a.m. The facility was notified by S3Maintenance Supervisor on 09/12/2025 at 7:30 a.m. when Resident #1 was observed at a gas station approximately 5 miles from the facility via a four lane highway. The local sheriff's office returned Resident #1 to the facility at 7:45 a.m. without injury. Resident #1 exited the building through a coded locked door after entering the code himself at 2:15a.m.The facility implemented corrective actions which were completed prior to the State Agency's investigation entry on 09/22/2025. It was determined to be a Past Noncompliance Citation. Findings:Review of the medical record for Resident #1 revealed an admission date of 09/04/2025 with diagnoses that included schizoaffective disorder, bipolar disorder and schizophrenia. Further review of the record revealed Resident #1 was court committed to the facility. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #1 had intact cognition for daily decision making. Review of the care plan dated 09/04/2025 revealed Resident #1 had a potential for elopement. Further review of the care plan revealed interventions for visual checks for resident's location every 1 hour, provide diversional activities as needed and to redirect resident as needed. Review of the Wander Data Collection Tool dated 09/05/2025 revealed Resident #1 wandered about the facility and he voiced that he wanted to go home. Resident #1 was placed on every hour census and Resident #1 was assessed as a wander/elopement risk. Review of the Incident/Accident Report dated 09/12/2025 at 7:30 a.m. revealed S3Maintenance Supervisor called the facility and informed S5Licensed Practical Nurse (LPN) that Resident #1 was sitting in between a gas station and the local sheriff's office. Resident #1 reported he threw his belongings over the fence, then climbed over the fence and walked to a local store. S5LPN and S6Certified Nursing Assistant (CNA) immediately went to retrieve Resident #1 in the facility van. Resident #1 was unwilling to be transported in the facility van, but allowed the local Sherriff's officer to transport him back to the facility. Resident #1 did not have any injuries. On 09/22/2025 at 9:00 a.m. observation of the video surveillance with S1Administrator and S2Assistant Director of Nurses (ADON) revealed on 09/12/2025 at 1:55 a.m. S8LPN opened Resident #1's door. Further review of the video surveillance revealed on 09/12/2025 at 2:15 a.m. Resident #1 came out of his room, closed the door behind him entered the code to the exit door and left the building. S1Administator and S2ADON confirmed the last time a staff member saw Resident #1 was on 09/12/2025 at 1:55 a.m. On 09/22/2025 at 9:00 a.m. during observation of the video surveillance, S1Administrator and S2ADON confirmed on 09/12/2025 at 1:55 a.m. was the last time a staff member saw Resident #1. Further interview with S1Administrator and S2ADON confirmed Resident #1 was not monitored every hour for elopement as ordered.Review of the nurses notes dated 09/12/2025 revealed at approximately 7:30 a.m. S3Maintenance Supervisor called the facility to report that a resident was at a gas station. S5LPN and S6CNA left the facility in the van to pick up the resident. Resident #1 refused to get into the facility van so the local Sheriff's department transported Resident #1 back to the facility. Resident #1 arrived back to the facility at approximately 7:45 a.m.On 09/22/2025 at 10:10 a.m. interview with S13LPN revealed she worked on 09/12/2025 from 7:00 a.m. - 7:00 p.m. and received report from S7LPN. S13LPN further revealed when she received report from S7LPN she was not aware that Resident #1 was not in the building. On 09/22/2025 at 2:10 p.m. phone interview with S3Maintenance Supervisor revealed he was at a gas about 5 miles from the facility and saw Resident #1 sitting and smoking a cigarette. S3Maintenance Supervisor revealed he called the facility and told S5LPN that Resident #1 was at the gas station. On 09/23/2025 at 9:00 a.m. a phone interview with S7LPN that was responsible for Resident #1's care on 09/11/2025 from 7:00 p.m. - 7:00 a.m. revealed Resident #1 took his nighttime medications about 7:15 p.m. S7LPN revealed she got busy with other residents and didn't monitor Resident #1's location every hour as ordered. Multiple attempts were made by the surveyor during the survey to contact S24CNA on 09/22/2025 at 2:35 p.m. and 5:30 p.m., 09/23/2025 at 3:26 p.m., and 09/24/2025 at 9:55 a.m. All attempts to call S24CNA were unsuccessful. S24CNA was responsible for the care of Resident #1 on 09/11/2025 on the 11:00 p.m. - 7:00 a.m. shift when Resident #1 eloped from the facility. On 09/23/2025 at 10:09 a.m.