STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER: Absolut Ctr for Nursing & Rehab Gasport L L C		STREET ADDRESS, CITY, STATE, ZIP CODE: 4540 Lincoln Drive Gasport, NY 14067	

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. Based on record review and interviews during a survey, the facility failed to ensure that a resident received adequate supervision and assistance devices to prevent accidents for one (1) (Resident #1) of three (3) residents reviewed for accidents. Specifically, Resident #1 who had severe cognitive impairment, a history of elopement, exit seeking and wandering behaviors, exited the facility through the delayed egress (security device that's restricts exit by sounding an alarm and delays a door from opening for 15-30 seconds) equipped front door on 06/19/2025 at 9:41 PM without staff's knowledge. This resulted in no actual harm that was Immediate Jeopardy and Substandard Quality of Care with the likelihood of serious harm, serious impairment, serious injury or death to Resident #1's health and safety. The findings are:The policy titled Risk for Elopement, dated 01/26/2022 documented a safe environment is provided for residents who are at risk to wander.The policy titled Missing Resident, Elopement, Dr. Walker dated 09/2023 documented a situation in which a resident leaves the premises or a safe area without a facility's knowledge and supervision would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning or being struck by a motor vehicle. All staff will be able to follow an organized plan to enable the facility to locate a missing resident as quickly as possible. The code alert system is utilized to deter resident elopement, for residents with a history of elopement. Maintenance staff, nursing supervisors or staff in close proximity will respond to door alarms and ensure that residents do not elope.The policy titled Elopement Security System Alarms/Devices dated 09/2024 documented security alert devices are used to alert staff to resident movement outside a designated area. All staff will be trained in the proper working of alarm devices and how to respond to an activated alarm.Resident #1 had diagnoses that included dementia, chronic kidney disease (gradual loss of kidney function), and seizures. The Minimum Data Set (a resident assessment tool) dated 04/25/2025 documented the resident had severe cognitive impairment, physical behavioral symptoms directed towards others, rejection of care, and wandering behaviors.The Comprehensive Care Plan dated 07/26/2023 documented Resident #1 was at risk for elopement related to confusion and dementia. Documented interventions included the resident would utilize a wander detection/monitoring system (wearable alert device) to their right ankle. On 04/15/2025, the documented goal was that the resident would remain on the premises through next review. (07/2025 next review due).The Kardex (guide used by staff to provide care) dated 06/19/2025 documented Resident #1 was independent with the use of a rolling walker for ambulation (walking) and was at risk for elopement.The Nursing Elopement Risk Data Collection Tool dated 05/07/2025 documented that Resident #1 had a history of unsafe wandering, opening doors to outside and/or elopement, made statements they were leaving or seeking to find someone/something and were at risk for elopement.The Progress Note completed by Licensed Practical Nurse #2 dated 06/18/2025 at 1:46 PM documented Resident #1 wanders throughout the shift. Resident with repetitive statements help me and/or (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	I'm scared. 1:1 (one to one) support, food, drink, and toileting provided with zero effect. Repetitive statements, wandering and an increase in anxiety noted.Review of video surveillance footage revealed that Resident #1 exited the facility through the delayed egress front door on 06/19/2025 at 9:41 PM. At 9:43 PM, Certified Nurse Aide #1 goes to the front door, reactivating the door's alarm system but neglected to open and verify if any residents had exited the building.The Accident/Incident - Elopement report completed by Registered Nurse #2 dated 06/19/2025 at 9:45 PM documented Resident #1 pushed on the front door; due to the delayed egress Resident #1 was able exit the facility. Resident #1 was found walking down the road by a bystander who called emergency services. The nursing supervisor was notified by local emergency personnel and Resident #1 was brought back to facility. Resident #1 was unable to give an account of the events. The report documented predisposing factors that included the resident had impaired memory, wandered, and exhibited active exit seeking behaviors.A handwritten statement included in the facility's investigation signed by Certified Nurse Aide #2 dated 06/20/2025 documented that Resident #1 was asking for help at approximately 9:00 PM on 06/19/2025, and they assisted the resident to bed.A typed statement provided by Certified Nurse Aide #1 included in the facility's investigation dated 6/20/2025 documented that they heard the alarm go off. They went to the door, looked out and did not see anybody, so they returned to the floor.A local police department report dated 06/19/2025 at 10:05 PM documented that a caller reported an elderly person appearing confused at a local restaurant (0.2 miles from the facility). Emergency Medical Services responded and found the person had left a nearby nursing home; staff of the nursing home contacted and were responding.During a telephone interview on 02/05/2026 at 9:20 AM, Certified Nurse Aide #1 stated they responded to an activated alarm at the front door entrance on 06/19/2025 at approximately 9:45 PM. They looked out the door into the entryway, did not see anyone, turned the alarm off and reactivated the system. Certified Nurse Aide #1 stated they did not open the door or look outside the secondary exterior doors because they didn't think a resident could get out of the building. Certified Nurse Aide #1 stated they did not notify the nursing supervisor of the sounding alarm.During a telephone interview on 02/05/2026 at 9:27 AM, Licensed Practical Nurse Supervisor #1 stated Resident #1 had been following them around the during the shift on 06/19/2025 and was anxious. Licensed Practical Nurse Supervisor #1 stated they last saw Resident #1 between 9:15 PM and 9:30 PM on 06/19/2025, and assumed staff had assisted the resident to bed. They were unaware Resident #1 had exited the building until local emergency services personnel came to the facility at approximately 10:10 PM and reported Resident #1 was across the street in a parking lot. The emergency services personnel requested them (Licensed Practical Nurse Supervisor #1) to follow them to the parking lot to see if they could identify the individual. Licensed Practical Nurse Supervisor #1 stated when they got to the parking lot of the local restaurant, a good Samaritan was there and they had stated that they were driving on Route 31 (a state highway with a speed limit range of 25 - 55 miles per hour), when they saw a person ambulating with a walker on the side of the highway. They pulled over, assisted them into their car, drove to the restaurant parking lot, and contacted emergency medical services. Licensed Practical Nurse Supervisor #1 stated that no staff members had reported to them that a door alarm had been activated and reset.During a telephone interview on 02/05/2026 at 11:33 AM, the Medical Director stated when the alarm was activated on 06/19/2025, staff should have checked the outdoor area to ensure no residents had exited the facility, notified the nursing supervisor, and ensured all residents were accounted for.During an interview on 02/05/2026 at 11:57 AM, the Acting Director of Nursing stated on 06/19/2025 staff should have determined what activated the alarm, checked the outdoor area for any residents; notified the nursing supervisor of alarm activation, and ensured that all (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents were accounted for.During an interview on 02/05/2026 at 12:11 PM, the Administrator stated when the alarm on the front door was activated on 06/19/2025, the staff should have walked outside the building, checked the surroundings for any residents; notified the supervisor of the alarm activation; ensured all residents were accounted for and activated the elopement protocol if all of the residents were not accounted for. The Administrator stated that facility staff were not aware Resident #1 had exited the building until emergency services personnel arrived at the facility at approximately 10:10 PM to report Resident #1 was at a nearby restaurant parking lot.Based on observations, interviews and record review the survey team determined the facility removed immediacy as of 06/24/2025 and corrected the non-compliance.Resident #1 was assessed by nursing staff for injuries, and none were noted.Resident #1's care plan was updated to include 1:1 staff supervision.The delayed egress locking system on the front door was changed out for a wander guard locking system (an electronic system designed to protect seniors with dementia from wandering away from care facilities). The removal of the delayed egress allows the door to remain secure unless a code is entered.Other exit doors were evaluated and changed to a Mag Lock System (access control device that uses an electrical current and a magnet to secure a door).Resident #1 already had a wander alert device in place, that works in conjunction with the wander guard locking system put in place at the front door.85 % (percent) of all staff were educated on Elopement/Resident Safety and expectations when an alarm was activated. This training is also presented in general orientation for new staff and agency staff.Facility conducts ongoing missing person drills.Facility conducts ongoing audits to monitor compliance with response to alarms and alerts. 10 New York Code Rules and Regulations 415.12(h)(1)(2)