STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piedmont Health & Rehab Center	610 West Fisher Street Salisbury, NC 28145

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with staff, Contractor for safety systems, and the Medical Director, the facility failed to effectively supervise a resident, who had diagnoses including dementia and altered mental status and a history of falls, from exiting the facility unsupervised and without staff knowledge for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 was admitted to the facility on [DATE] and according to staff became increasingly confused during the shift which started at 7:00 PM. Resident #1 got out of bed multiple times and self-propelled in his wheelchair up and down the hall and was observed at the exit door looking out the window. Resident #1 was last seen by Nurse #1 in bed at approximately 4:00 AM on 4/26/26 and between 4:00 and 4:30 AM the Nurse Aide (NA) #1 noticed Resident #1 not in bed and immediately began to look for the resident and notified Nurse #1. No staff members recall hearing the 300-hall door alarm that night. NA #2 went out to her car between 4:30 and 4:45 a.m. on 4/26/26 and heard a man yelling for help from the other side of the parking lot. NA #2 could not see because it was dark outside and the area past the parking lot and down the embankment where the man called from was not lit. NA #2 indicated she was afraid to approach because the area felt unsafe, so she dialed 911 as she was walking back into the facility and told NA #3 what she heard and they went outside together. Resident #1 was found sitting on a gravel embankment at the edge of the parking lot, 100 feet from the 300-hall exit door and 200 feet from a fourˆlane road with a 35ˆmph speed limit. Resident #1 was wearing only an adult incontinence brief and a gown lay on the ground next to him. He told the staff he had fallen and needed help getting up. The temperature outdoors was 60 degrees Fahrenheit with a light drizzle. Emergency Medical Services (EMS) was called, and the resident was taken to the Emergency Department (ED) hospital for an evaluation. Imaging of the head, spine, and chest were completed without acute findings, and laboratory studies were normal. A contusion (an injury to the tissues that does not break the skin and can cause bruising or discoloration) to the right hand was treated with cleansing and topical antibiotic ointment. He was discharged back to the facility 4/26/26 with diagnoses of fall, contusion to right hand, and dementia. It was determined by staff the 300-hall door alarm power cord was unplugged which disabled both the lock and wander-alarm system. This noncompliance had a high likelihood of causing serious injury or serious bodily harm.Findings included:Review of the hospital Discharge summary dated [DATE] revealed Residentˆ#1 was admitted on [DATE] for recurrent falls and acute on chronic altered mental status. His diagnoses included typeˆ2 diabetes, dementia, chronic kidney disease, generalized weakness, right leg pain and weakness, and encephalopathy. Hospital documentation stated he had not seen a physician for approximately one year and had not taken medications for two months. He reported multiple falls during the prior week, including one on 4/20/26 in which he remained on the floor until morning. He lived alone with minimal family support, and his baseline cognitive impairment had worsened. Imaging and blood work showed no acute abnormalities. Therapy evaluations beginning 4/21/26 documented confusion, disorientation, impaired processing time, and the need for contactˆguard assistance and full assistance for transfers. Therapy recommended skilled nursing placement. It included (continued on next page)

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	recommendations for skilled nursing care, skilled therapy services, and a referral to neurology for his cognitive deficits.Resident^#1 was admitted to the facility on [DATE] at 12:41^p.m. with diagnoses including dementia, altered mental status, recurrent falls, and right lower extremity weakness and pain.Review of physician orders revealed Resident #1 was not prescribed a blood thinner.Nurse #2's admission Observation on 4/25/26 at 4:11^p.m. documented Resident #1 required moderate assistance with transfers, bed mobility, and activities of daily living. He had intermittent incontinence, groin redness, and right lower extremity weakness. Resident #1 was alert and oriented but intermittently confused. The elopement risk screening question asking if the resident was identified for risk(s) for elopement was not selected. An additional elopement risk screening question asked if the resident had any elopement risk factors. The risk factors included whether the resident was ambulatory, moved about independently in a wheelchair, had a history of attempted or actual elopement or unsafe wandering, exhibited exit seeking behavior, resident verbalized wanting to go home, go on a trip, or going to meet someone, resident wandered in and out of rooms and rummages in other's belongings, not accepting of present residency situation/location, or had an acute change in cognition. Nurse #2 documented that none of the risk factors listed were exhibited at that time.During a telephone interview on 5/8/26 at 9:33 a.m. with Nurse^#2, she reported that she admitted Resident^#1 on 4/25/26 around 1:00 p.m. She stated Resident #1 arrived via ambulance stretcher and transferred to the bed with one^person assistance. Nurse #2 described him as pleasant, conversational, mildly confused, and easily redirected, with no exit^seeking behavior. She reported Resident #1 ambulated short distances with assistance and verbal cues. Nurse #2 indicated she completed his admission assessment and informed Nurse^#1 at shift change at 7:00 p.m. that Resident #1 was confused but did not exhibit elopement risks which were listed in the admission Observation. Nurse #2 explained when Resident #1 arrived on 4/25/26, he was pleasantly confused and family did not accompany him and had previously not provided any historical details for Resident #1. Nurse #2 had reviewed the 4/25/26 hospital discharge summary for his medical history, and it did not indicate he wandered or was exit seeking during his hospitalization. Nurse #2 reported she did not see him wander during her shift on 4/25/26, she reported he was admitted to their rehabilitation unit, 300 Hall, and had not observed him hanging around the door at the end of the 300 Hall. Nurse #2 reported that on 4/25/26 between 1:00 p.m. and the end of her shift at 7:00 p.m. Resident #1 did not interact with the other residents after her assessment was completed. Nurse #2 reported she allowed him time to settle in the room before she oriented him to the set-up of the facility, location of his bathroom, lights, explained the call bell, and told him when and how to call for help. Nurse #2 reported that Resident #1 talked a little with her during the assessment and ate dinner in his room. She reported that he needed verbal cues and his meal tray set up and he ate dinner independently. Nurse #2 reported Resident #1 spoke clearly and communicated his needs, and she provided stand by assist and verbal cues for his proper body mechanics and foot positioning as he stood and used a walker to go into the bathroom at the completion of the lengthy admission assessment.The baseline care plan initiated on 4/25/26 included safety monitoring. The Safety Monitoring portion of the care plan included approaches for fall prevention, toileting assistance, pain management, and therapy services. The fall prevention interventions included assisting Resident #1 with transfers as needed, keeping items within reach, and minimizing potential risk factors related to falls and injury.During a telephone interview on 5/7/26 at 4:56 p.m., Nurse #1 stated she received nurse^to^nurse shift report at 7:00 p.m. on 4/25/26 indicating that Resident #1 was confused. She stated that Nurse Aide (NA) #1 brought Resident #1 to the nurse's station in a wheelchair between approximately 11:00 p.m. and 12:00 a.m. for monitoring by she and the other staff entering notes and tasks completed at the desk. Nurse #1 reported the nurse's station is on the corner of the 200 and 300 Halls so if Nurse #1 or NA #1 or NA #3 were responding to a call light down or completing a task, Resident #1 could still be observed and in their direct view. Nurse #1 reported that Resident #1 became increasingly confused during her 7:00 p.m. to 7:00 a.m. shift as the evening progressed into midnight. She reported that (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 got out of bed multiple times and wandered in a wheelchair up and down the 300 Hall hallway and was observed at the exit door looking out the window. She reported that NA #1 and NA #3 redirected Resident #1 and that he remained cooperative and easily redirected. She also reported that she completed walking rounds at the top of the hour, approximately every hour (e.g., 7:00, 8:00, 9:00, etc.). Nurse #1 reported that she observed NA #1 and NA #3 take Resident #1 back to his room around 1:30 a.m. Nurse #1 stated she last saw Resident #1 lying in bed awake at approximately 4:00 a.m. during her hourly round and did not observe him getting out of bed. When NA #1 informed her around 4:30 a.m. that Resident #1 was missing, she initiated Code Green. A Code [NAME] was the facility's emergency protocol announcing that a resident was missing. The facility's Elopement/Missing Person policy stated that once staff determined a resident was missing, they were to conduct a roomˆbyˆroom search and complete a head count of all residents on all units. If the resident remained missing after these steps, staff were to announce a Code [NAME] which required a message to be broadcasted across the facility that included the resident's name, room number, and location in the building (e.g., 100 Hall, 200 Hall, 300 Hall). Nurse #1 reported that she and NA #1 began searching the 300 Hall, going room by room and taking a head count of all residents as they proceeded. After completing the search of the 300 Hall, she moved to the Dining Room and then to the 200 Hall. She stated that NA #1 informed her that staff outside had called 911 after hearing someone yelling for help. Nurse #1 recalled that NA #2 and NA #3 found Resident #1 outside around 5:00 a.m. She instructed NA #1 to continue checking to account for all residents. Nurse #1 indicated she exited the facility through the 200 Hall door and approached NA #2, NA #3, and Resident #1. She recalled that Resident #1 was seated on the dirt leading up to the edge of the paved parking lot with his back against the curb. She assessed him at the curbside, where he sat wearing only an adult incontinence brief, and she observed an abrasion on his right hand. Resident #1 told her he had fallen but did not know how he got out. Nurse #1 reported EMS arrived while she was exiting the building to assess Resident #1. Nurse #1reported the EMS and she were assessing Resident #1's condition at the same time. She stated she instructed EMS to transport him to the hospital due to a possible head injury. Nurse #1 reported she had not unplugged the power cord to the 300 Hall door lock and alarm and did not hear a door alarm. She stated that after ambulance personnel transported Resident #1, staff returned inside and checked the building to determine how Resident #1 had exited, as all doors were closed. She reported the 300 Hall door power cord was observed unplugged from the electrical outlet which disabled the door lock and alarm when unplugged. Nurse #1 reported staff plugged it back in. Nurse #1 stated she did not observe Resident #1 unplug the power cord for the door lock and alarm and that she had not unplugged it that night or at any time in the past. She recalled there was a sign above the outlet stating do not unplug and stated she had never seen staff unplug the cord. After observing the 300 Hall power cord unplugged, she reported that staff assumed Resident #1 likely unplugged it and then exited through the 300 Hall door because he had been observed earlier in a wheelchair at the door and window. Nurse #1 recalled seeing an empty wheelchair in the 300 Hall hallway during her last round at 4:00 a.m. but could not recall the exact location. She recalled Resident #1's room was a few doors down from the 300 Hall entry/exit door. She did not recall finding any other items outside near him and stated she was unsure how he ambulated up the sloped parking lot past the dumpsters.During a telephone interview on 5/7/26 at 4:35 p.m. with NA #1, she reported that her shift on 4/25/26 began at 11:00 p.m. and ended on 4/26/26 at 7:30 a.m. NA #1 reported she was assigned to multiple residents on the 300 Hall, which was the rehabilitation unit. She stated the rehabilitation unit had a quick turnover of residents because many stayed only short term for therapy before returning home, so she was not familiar with all the residents on the unit. NA #1 reported she was assigned to provide nurse aide care for Resident #1. NA #1 reported she normally completed hourly rounds opposite the nurse on the unit. NA #1 stated that her Charge Nurse, Nurse #1, informed her that Resident #1 was confused during the evening hours of 4/25/26. NA #1 reported that NA #3 worked with her on the unit and was assigned to the other residents on the 300 Hall and some (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents on the 200 Hall. She stated that NA #3 assisted her with caring for residents who required two-person assistance and those who needed close observation or redirection. NA #1 reported that Resident #1 got out of bed and into a wheelchair around 11:00 p.m. and was observed sitting in a wheelchair at the end of the 300 Hall and watched out the window by the door. NA #1 redirected Resident #1 and put him back to bed. NA #1 stated that NA #3 assisted her with redirecting Resident #1 when he again wandered into the hall from his room shortly after she put him back to bed. NA #1 reported that around 12:00 a.m. Resident #1 got out of bed again, so she assisted Resident #1 into a wheelchair and brought him to the nurse's station for close observation. She stated that she worked with Nurse #1 and NA #3 to monitor Resident #1 closely due to his confusion and repeatedly getting out of bed and wandering. Nurse #1 advised NA #1 that Resident #1 said he wanted to go to bed around 1:30 a.m. and NA #3 assisted him back to bed because she was with another resident. NA #1 reported she left the unit only once during the shift, at approximately 3:45 a.m., to use the bathroom, and afterward went into the nourishment room to prepare her cups and supplies for the final round of the shift. She stated that between 4:00 a.m. and 4:30 a.m. she discovered Resident #1 was no longer in bed. NA #1 reported she did not recall hearing a door alarm. She stated she immediately searched the nurse's station, bathroom, and desk area on the 300 Hall, did not find Resident #1, and notified Nurse #1 at approximately 4:30 a.m., which triggered the facility's elopement procedures. NA #1 began to assist Nurse #1 with a complete head count of all residents in the facility, going room by room. NA #1 reported she did not recall seeing Resident #1 attempt to unplug the cord by the door, open the door, or exit the door at the end of the 300 Hall during her shift. She also reported she did not recall observing any staff unplug the door and denied unplugging the door herself to disable the lock and use it for exit or entry.During a telephone interview with NA #3 on 5/7/26 at 11:00 a.m., she reported on the night shift of 4/25/26 (from 11:00 p.m. on 4/25/26 until 7:00 a.m. on 4/26/26) Resident #1 had been monitored closely at the nurses station by her and his assigned NA (NA #1) through the evening and night because he became more confused and was wandering in the 300 Hall in a wheelchair and went to the window by the 300 hall door. NA #3 reported she did not recall observing Resident #1 unplug the 300 Hall door power cord. NA #3 indicated she did not recall seeing Resident #1 ambulate up or down the hallway and observed Resident #1 use a wheelchair for moving around the unit. NA #3 reported she assisted Resident #1 back to bed between 1:30 a.m. and 2:00 a.m. and he was easily redirected; this was the last time she observed Resident #1. NA #3 reported Resident #1 was confused at the beginning of the shift and was more confused as the night went on. NA #3 reported she thought he had sundowning (a state of confusion that occurs in the late afternoon and lasts into the night and can cause wandering, ignoring directions, or various behaviors) because he talked normally at the start of her shift but was more confused and wandered more as the night went on. She recalled Code [NAME] was paged overhead around 5:00 a.m. while she was on the 100 Hall charting care she provided to her assigned residents. NA #3 stated NA #2 approached her and asked for the facility's address because she heard someone yelling for help outside in the parking lot and was talking to 911. After the call, NA #3 accompanied NA #2 outside to identify who needed help and wait for EMS. They found Resident #1 between the parking lot and the white building beside the facility. NA #3 stated she initially did not think he was a resident but, upon seeing he was wearing only an adult brief with a hospital gown on the ground beside him, she had NA #2 go back inside the facility and notify Nurse #1. She reported she then called 911 to inform them it was a resident of the facility. NA #3 waited with the resident and police arrived shortly after. NA #3 reported Nurse #1 and the ambulance arrived soon after the police. NA #3 indicated the parking lot was dark and dimly lit along the side towards the white building next door, but light from the police car lit up the area well. NA #3 reported it surprised her that Resident #1 was able to ambulate past the 2 large dumpsters and up the parking lot in the dark. NA #1 stated the event happened so quickly, but she thought the ambulance took Resident #1 away soon after she and NA #2 found him. NA #3 recalled Resident #1 appeared calm when Nurse #1 assessed him and asked him questions. NA #3 reported she went back inside through (continued on next page)

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NA #2 reported she unlocked her car to get out her supplies and heard a man yell for help from the other side of the parking lot. She reported she could not see the man because it was dark outside and the area past the parking lot and down the embankment where the man called out from not lit. NA #2 stated she was afraid to approach because the area felt unsafe because of recurrent criminal activity in that area of the city. NA #2 stated she could not stop thinking about it as she went back to the employee entrance and decided to call 911 to report it. She called 911 around 5:00ˆa.m. as she returned inside, she told NAˆ#3 what she heard, and both then went outside. NAˆ#3 recognized the individual as a facility resident. NA #2 reported she was not sure how NA #3 knew it was a resident so quickly. NAˆ#2 stated Resident #1 was sitting in gravel near the parking lot curb wearing only an adult incontinence brief and possibly one gripper sock, with his gown on the ground beside him. NA #2 did not observe a wheelchair near the resident. NA #2 reported Resident #1 calmly stated he fell and needed help getting up. She reported that NA #3 sent her inside to retrieve Nurseˆ#1 while NA #3 remained with Resident #1 until EMS arrived. NA #2 did not recall hearing a door alarm. NA #2 indicated she entered and exited through the staff entrance door on the 200 Hall by the dining room when she retrieved Nurse #1 to assess Resident #1. She reported the location they found Resident #1 was on the side of the parking lot that was outside of the 300 Hall door, past the dumpsters at the edge of the parking lot. NA #2 denied that she unplugged the 300 Hall door power cord to exit or enter the facility through there.During a follow-up observational interview with NA #3 on 5/7/26 at 2:45 p.m. she pointed to the curb where she and NA #2 found Resident #1 sitting up with his back against the curb of the parking lot on 4/26/26 around 5:00 a.m. The location was approximately 100 feet from the 300-hall door exit. She reported that shortly after 5:00 a.m., while she was charting at the nurse's station on the 100-Hall, NA #2 approached her asking for the facility's address for a 911 call because she heard someone yelling for help outside and was afraid to check alone. NA #3 stated Resident #1 was new to the facility and staff were not yet familiar with him. NA #3 went over to the side of the parking lot and pointed to the area where she found him sitting. NA #3 described finding Resident #1 sitting upright with his back against the curb in an area covered with several jagged stones and dirt sloping downward from the parking lot. Resident #1's hospital gown was on the ground next to him, and he was wearing only an adult brief. A wheelchair was not observed outside or in the vicinity of where Resident #1 was found. She reported he was calm and spoke clearly. She stated the police arrived first, followed shortly after by Nurse #1, and the ambulance arrived within minutes and transported him to the emergency department. NA #3 reported the events happened quickly and she was doing her best to accurately recall the details. NA #3 recalled she had observed Resident #1 in a wheelchair by the 300 Hall door but had not observed Resident #1 walking around or standing by the door, unplugging the door power cord, or saying he wanted to leave. NA #3 reported Resident #1 was confused all night, was calm and pleasant, and was oriented only to his name. She reported some details were difficult to recall because her attention was focused on Resident #1 being outside in only his brief sitting on the stones and she was concerned he may have been seriously injured because of where they found him on the bank because there was also broken glass and the location was close to a street that was busy during the day time hours. She reported the ambulance arrived as Nurse #1 began assessing Resident #1. NA #3 recalled police asked her how Resident #1 was able to leave the facility and she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	told him she did not know because all the doors were locked. NA #3 stated on the night of the elopement she observed other staff using the main rear entry door and walking by the window by 300 Hall door where Resident #1 sat and looked outside. The occurred during the first part of the night shift (11:00 p.m. and 2:00 a.m.). NA #3 indicated she used entrance doors by the Dining Room on the 200 Hall to enter and exit during the incident. NA #3 reported once she, NA #2 and Nurse #1 went back inside and began to look for where Resident #1 exited the facility and one of them saw the 300 Hall door and alarm cord unplugged. Nurse #1's nursing note on 4/26/26 at 4:30ˆa.m. documented Resident #1 was found sitting on ground outside, Emergency Medical Services (EMS) was notified and took resident to emergency room as she was unsure if he had an injury or how resident got out of the building. Nurse #1 documented she attempted to notify family and no one answered. The Director of Nursing (DON) was notified of event. Review of the 911 Communications Log for 4/26/26 indicated the first call from NA #2 was received at 5:03 a.m. with reports of an unknown person in the back parking lot of the facility calling out for help and was reported to be in immediate danger, and 911 caller (NA #2) did not know where the unknown person came from. The 911 log further indicated the report was coded as a suspicious person and the police department were dispatched at that time, 5:03 a.m. The 911 communications log revealed a second call from NA #3 came in at 5:05 a.m. and NA #3 stated the person calling out for help was a resident of the facility. The 911 call log indicated the police arrived at the facility's back parking lot at 5:05 a.m. The log was updated at 5:11 a.m. to state an officer requested emergency medical services for an elderly male who they located out back of the facility in the wet grass, who was naked wearing only an adult incontinence brief, hospital gripper socks, and a medical bracelet from the facility. The 911 log indicated EMS were dispatched at 5:12 a.m. The 911 log further stated the callers who were employees of the facility came out and provided information on the resident, stated Resident #1 eloped from the facility and may have fallen outside. The callers reported they did not initially know the man calling out for help was theirs. The report also indicated employees stated they did not know how Resident #1 exited the building because all doors were locked.The Emergency Medical Services (EMS) dispatch report for 4/26/26 showed EMS were dispatched at 5:12 a.m. and arrived at the facility at 5:23ˆa.m. EMS documented no head, neck, chest, back, pelvic, or extremity abnormalities, and noted minor scratches. His vital signs and neurological assessment were normal. Resident #1 denied any injury or pain. He was alert but disoriented to time and place and believed he was in another city. He was oriented to person and what was happening and able to answer questions about himself and reported that he had fallen. He could not provide further details of his fall. Resident #1 reported no pain or injuries. EMS documented a primary impression of dementia, with no physical abnormalities. The resident was transported non emergently at 5:36 a.m.to the local hospital. No lights and sirens were used during transport. Upon arrival at the hospital, the final vital signs were all within normal ranges. Resident #1 had a pain level was 0 out of 10 (zero meaning no pain), blood pressure of 110/60 (normal is between 100/60 and 140/90), hear rate of 84 beats per minute (normal is between 60 and 100 beats per minute), he was alert, his condition remained unchanged.The Emergency Department (ED) records revealed on 4/26/26 EMS reported that Resident #1 had a fall and needed evaluation. Resident #1 was alert and oriented to self only and unable to provide details of the fall reported by EMS. Vital signs were within normal ranges with a blood pressure of 119/60, heart rate of 88 beats per minute, 16 breaths per minute (normal is between 12 and 20 breaths per minute), and no pain. Imaging of the head, spine, and chest were completed without acute findings. Laboratory studies were normal. A contusion (an injury to the tissues that does not break the skin and can cause bruising or discoloration) to the right hand was treated with cleansing and topical antibiotic ointment. He was discharged back to the facility 4/26/26 with diagnoses of fall, contusion to right hand, and dementia. There were no new medication or treatment orders. Resident #1 was to follow up with primary care in 3 days, around 4/29/26.During an observational interview on 5/7/26 at 11:45 a.m. with the facility's Regional Clinical Nurse Consultant, it was determined that the facility had a rolling measuring tape that was available to measure how far (continued on next page)

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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	from the 300 Hall door exit that Resident #1 was found on 4/26/26. When communicating that a review of information from the telephone interview with NA #3 and report from the DON about location where Resident #1 was found, the Regional Clinical Nurse Consultant advised she requested the DON call NA #3 and ask NA #3 to report to the facility and physically demonstrate where she found the resident and provide further details from when she and NA #2 identified that he was one of the facility residents.On 5/7/26 at 6:00 a.m. an observation of the facility's rear parking lot revealed a sloped dark and dimly lit black-top paved parking lot that had an approximately 12-inch blacktop paved curb around the perimeter. There were large trees with heavy amounts of green foliage which made visibility difficult in the pre-dawn hour darkness of 5/7/26. The parking lot faced a 4-lane street which had two-way traffic with a posted speed limit of 35 miles per hour. The was a light on at the end of the facility building outside the 300 Hall door and at the other door designated as staff entrance. There was outdoor lighting that illuminated the sidewalk that went around the perimeter of the building and led to two large metal dumpsters located approximately 25 feet from the exit door at the bottom corner of the parking lot and the grassy lawn located adjacent to the 300 Hall.During a follow up observational interview with DON on 5/7/26 at 2:43 p.m. she stated her investigation and interviews led her to believe Resident #1 was found outside the door at the end of the sloped parking lot between the 300 hall exit and where the 2 dumpsters were located. The DON pointed to where she believed Resident #1 was found after the investigation was complete. The location was approximately 25 feet from the 300 Hall exit. The parking lot's perimeter had a black-top curb with jagged drainage stones on the unpaved side that were 2 to 4 inches in size. The stones sat atop dirt from the edge of the curb and down an approximately 8-foot sloped embankment. The first 50 feet of the embankment edge of the parking lot after the two dumpsters on the bottom corner led to a grassy lawn. The next 50 feet of the curb and embankment led to a paved parking lot behind a multiple unit residential building next door. The location where Resident #1 was found was measured by the state surveyor and the Regional Clinical Nurse Consultant and measured approximately 200 feet from the main street which had 4 lanes for traffic with a posted speed limit of 35 miles per hour. Review of the Weather Underground website recorded weather conditions for the facility's location on 4/26/26 between 4:00 a.m. and 5:35 a.m. indicated the temperature was 60 degrees Fahrenheit, and a light drizzle or rain, with wind gusts at 5 miles per hour.Review of Resident #1's record included a telephone order from Nurse Practitioner #1 dated 4/26/26 at 3:30 p.m. signed by the Director of Nursing for 1:1 observation and to initiate/apply wander guard.Review of Nurse #2's progress note dated 4/26/26 at 3:44 p.m. indicated Residentˆ#1 returned to the facility and his family was present. Nurse #2 completed a full skin assessment, confirmed the rightˆhand contusion, applied a wanderˆguard device, and initiated 1:1 observation. It further stated she moved him to a room closer to the nurse's station for enhanced supervision.In the interview with Nurse #2 on 5/8/26 at 9:18 a.m., Nurse #2 reported when Resident #1 returned to the facility on 4/26/26 from the ED she moved him to a room on the 200 Hall which was closer to the nurse's station. She reported there was an order for 1:1 observation by staff and initiation of wander guard alarm. Nurse #2 reported that a wander alarm bracelet was applied to his ankle and staff were assigned for close 1:1 observation of Resident #1. She stated they sat in a chair in his room close to him. Nurse #2 reported 1:1 observation of Resident #1 continued for the remainder of her shift when she reported off to Nurse #1 when her shift ended at 7:00 p.m. on 4/26/26. In an interview on 5/7/26 at 9:45 a.m. with the Maintenance Director, the Maintenance Director reported approximately 10 months prior he reported to the previous Administrator that the 300 Hall door, located at the rear of the building, posed security concerns. He reported that the timed lock setting allowed extended periods of time each day/night when the door was unlocked. He reported the door was used by staff to take out trash, and anyone could enter/exit to the rear of the building when it was unlocked. A timed lock setting allowed a locked door to automatically unlock and remain unlocked during programm