STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425054	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Laurens	379 Pinehaven Street Extension Laurens, SC 29360

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** 42424 Based on review of the facility policy, record review, observations, and interviews, the facility failed to ensure that Resident (R)2, a resident with a previous history of elopement, had adequate supervision to prevent the resident from eloping from the facility on 05/19/25 at approximately 10:00 PM. R2 was found by law enforcement, lying down near trees, in a wooded area approximately 75 feet away from the building, on facility property at approximately 3:00 AM - 3:30 AM on 05/20/25. On 05/22/25 at 8:14 PM, the Administrator and Director of Nursing (DON) were notified that the failure to ensure Resident (R)2, a resident with a previous history of elopement, had adequate supervision to prevent the resident from eloping from the facility on 05/19/25 at approximately 10:00 PM. R2 was found by law enforcement lying down near trees, in a wooded area approximately 75 feet away from the building on facility property at approximately 3:00 AM - 3:30 AM on 05/20/25. This elopement constituted Immediate Jeopardy (IJ) at F689. On 05/22/25 at 8:14 PM, the survey team provided the Administrator and DON with a copy of the CMS IJ Template and informed the facility the IJ existed as of 05/19/25. The IJ was related to S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. On 05/23/25, the facility provided an acceptable IJ Removal Plan/Allegation of Compliance. On 05/23/25 at 2:07 PM, the survey team validated the facility's corrective action and removed the IJ as of 05/23/25 at 2:07 PM. At this time, the scope/severity was lowered to a D. An extended survey was conducted in conjunction with the Complaint Survey due to the identification of substandard quality of care. Findings include: Review of facility policy titled Section E: Emergency Procedures for Specific Events 'Missing Resident' dated September 2017, revealed Upon discovery of a missing resident: Alert all staff on the unit. Conduct a quick but thorough search of the unit and logical places where resident may have gone. (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	If a resident cannot be located, the Nurse in charge of the area shall be responsible for notifying the Administrator. The Administrator will advise all units/departments and ensure immediate attempts shall be made to determine where the resident was last seen and what the resident was wearing. This information should be indicated on the INFORMATION ON MISSING RESIDENT form and given to the Command Center. Upon receiving notification of a missing resident do the following: The search of each area will be done by staff normally assigned to that area. If Building Lockdown is ordered, observe exit doors in your assigned work area. Staff searching within the building should visually identify residents in each room. Staff should also be certain to check rooms thoroughly, including empty beds, bathrooms, closets and behind/under beds. Once an assigned area has been searched, the results should be reported to the Charge Nurse/Department Supervisor. As the search of a department/unit is completed, this should be relayed to the Command Center, if activated. Staff assigned to search outside should check areas behind shrubbery, parked cars, etc. Staff searching at night should carry a flashlight and a means of communicating with the Command Center (radio, cell phone, etc.). During cold weather, staff should also carry a blanket for the resident. A picture of the missing resident should be provided to search teams, if available. Page 2 of the policy indicates: If resident is not located after search of building and immediate outside area: Notify [Name of County] Police Department (911). Provide them with a description of the missing resident. Charge Nurse and/or Administrator to notify family/responsible party. If it becomes necessary to call outside authorities, the [Name of State Agency] should also be notified. Record review of R2's Face Sheet revealed R2 was admitted to the facility on [DATE] with diagnoses including but not limited to urinary tract infection, difficulty in walking, dependence on supplemental oxygen, anxiety disorder, and encounter for adjustment and management of a vascular access Peripherally Inserted Central Catheter (PICC Line). Record review of R2's In-Progress Admission Minimum Data Set (MDS) dated [DATE] revealed R2 has a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicates that he is moderately, cognitively impaired. Further review of the Admission MDS revealed in R2's admission mobility assessment, he requires partial/moderate assistance with sit to stand. Substantial/maximal assistance with walking 10 feet - 150 feet; R2 utilized a manual wheelchair during his admission assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R2's Admission Elopement assessment dated [DATE] at 8:09 PM revealed R2 was at risk for elopement, an electronic monitoring device was placed on his lower left leg. Record review of R2's Discontinued Physician Orders for May 2025 revealed an order with a start date of 05/16/25 - 05/20/25 electronic monitoring device placement, instructions include check placement and site location each shift left ankle, Lot #124109876. Record review of R2's May 2025 Medication Administration Record (MAR) revealed a Physician Order with a start date of 05/16/25 - 05/20/25 electronic monitoring device placement, instructions include check placement and site location each shift left ankle Lot #124109876. Review of the MAR revealed there was no documentation of the device on 05/16/25, 05/17/25, and 05/18/25. Record review of R2's May 2025 Physician Orders revealed an order with a start date of 05/15/25 for Oxygen 3-4 liters (L)/minute (min) every shift. There was also an order with a start date of 05/15/25 for PICC line dressing and flush maintenance. Record review of R2's Progress Notes dated 05/20/25 at 9:00 AM revealed Resident returned form Emergency Department (ED) on stretcher with Emergency Medical Staff (EMS) being assisted to bed. R2 noted to be drowsy but easily aroused, when awake he is alert and talking with staff in room vital signs completed, no voiced complaints of pain, noted with small scratches to scalp, scratches to bilateral arms, small blood-filled blisters to left third and fifth fingers , bruise to right fourth finger, scratches to back, abrasions and scratching to bilateral knees and lower extremities with no issues of complaints of pain. Electronic monitoring device noted to left lower extremity ((Lot# KNKTX0003 A20080903 Exp: 12/27). Neurological checks performed with no issue noted, returned with Foley catheter in place, per EMS he was noted with urinary retention, nurse and therapist assisted him dressing and transferred to Geri chair therapist escorted him to therapy gym. Record review of R2's Progress Notes dated 05/20/25 at 9:30 AM revealed On 05/19/25 this writer received a call from station three nurse stating she entered into R2 room and found the window open with the screen lying on the ground. His roommate [R5] stated he went of the window; this nurse alerted all staff on each nursing station of the missing resident and a thorough search was initiated. This writer arrived at the facility within one minute and contacted the Administrator, Law enforcement, R2 Resident Representative (RR), and Medical Director. The RR stated, oh no, give me a call when you find him. The available staff began to search the premises. Law enforcement arrived and asked staff to cease the premises search and return inside the facility to initiate second search. Law enforcement was given missing person detail information to include a color photo of the resident. Resident was later located on the facility's premises behind the therapy area within 75 feet from the building. He was lying on the ground. He was able to stand and ambulate with limited assist from law enforcement. The resident was assisted to the stretcher and assessed in the EMTs. Resident was taken to ED for a well care evaluation. RR and on-call MD updated on current events. The resident returned to the facility from the ED with a Foley catheter due to possible obstruction. There was a care plan meeting scheduled for today, the RR requested that we reschedule the meeting due to the recent events. The Interdisciplinary Team (IDT) agreed, resident currently in bed being assessed by nurse and therapist. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R2's Progress Note dated 05/20/25 at 11:00 AM revealed Interview with R2 entered into resident's room, this writer observed him lying in bed, with both eyes open. Alert to name. When ask if he recalled what happen last night? He replied Yes. When asked where was he attempting to go? He replied, to a friend's house (a big house with a lot of money), but when I got out there, I realized it was too far. When asked if this friend was a family member? He stated, no he is a friend. The writer asked how did you get outside? He demonstrated (while lying in bed) how he got dressed, pulled up the blinds, pulled the window back, and pushed the screen out. I put one leg out the window and then the other one. Asked why did he exit through the window? He stated, It was the fastest way out. The writer informed the resident that she was out there looking for him. He replied, it was more out there than just me and you. I continued the conversation telling him that I was calling his name. He replied, I heard you. I asked why didn't you answer me? He stated because I didn't want y'all to know where I was, it was too many people out there (as he smiled). The resident was very pleasant during this interview. Record review of R2's Health and Physical Hospital Discharge Summary dated 05/11/25 revealed R2 is an [AGE] year-old who presents with concerns over altered mental status. At the time of evaluation R2 with his Resident Representative (RR) at bedside. R2 is a very pleasant male with a longstanding history of tobacco abuse totaling greater than [AGE] years as a result he does have Congestive Obstructive Pulmonary Disease (COPD), depression, narcolepsy with cataplexy and some concerns over cognitive impairment. Today he was brought to the hospital when he was found sleeping on his neighbor's front porch. When R2 arrived at the hospital he was lethargic but would arouse to a loud voice and could not explain how he got there other than stating he may have been related to his narcolepsy. His RR said however gives a history of extremely worrisome findings over the last few weeks. R2 has been confused in terms of time and sometimes will ask repetitive questions to his son of things he would normally know. Last week he apparently crawled out of his window and ended up at his neighbor's place because he was hallucinating and thought that he may be under attack. He did see his primary care Physician about ten days ago and his Seroquel was stopped. His son states he has still remained intermittently confused since that time. Here in the ED his workup is worrisome for him having some hypoxia and hypercapnia from COPD exacerbation. He was started on BiPaP in the emergency room . He also has evidence for a UTI; he has been referred to the medical service for admission for the same. Record review of R2's Care Plan with a start date of 05/20/25 revealed R2 had an episode of wandering and exit seeking. Interventions include equip with a device alarm (left ankle), check for proper functioning of device every day and check for placement every shift; maintain a calm environment and approach to him; provide 1:1 supervision; when he begins to wander, assess for and provide for basic needs. (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 a Police Department Incident Report with an incident date of 05/19/25 revealed On the incident date and time, police department staff responded to the incident in reference to a missing person. Upon arrival I found multiple facility staff members walking around the rear of the building with flashlights. Police department staff made contact with a facility staff who informed that a patient had climbed out of the window in his room and they were unable to locate him. Facility staff informed the police department that R2 suffered from dementia, had issues with oxygen levels and was a risk for cardiac issues, and is narcoleptic. Immediately upon learning that R2 would be missing/endangered the police department staff asked that all facility staff members clear the area surrounding the window and the rear of the building. Police department staff then requested a bloodhound. Police department staff had a facility staff member to walk to R2's room where they secured clothing of R2 to use a scent article. R2's roommate (R5) stated that he had been gone for approximately an hour . the police department had to reach out to a different law enforcement agency, [state law enforcement]) to assist with the search of R2. Upon arrive [sic] of [state law enforcement] bloodhounds, both police departments initiated a track (search for R2) which was unsuccessful. A reverse 911 call was issued for a four-mile radius and [NAME] were requested from Emergency Services. While waiting for the [NAME], several people began to search a wooded area to the rear of the facility. Down a hill behind a wooded fence, officers located R2 sleeping in the woods, he had removed his pants and was using them as a pillow. R2 had several scratches but seemed to be in decent condition considering the circumstances. R2 was able to walk to the wood line with assistance (up a hill nearby the facility), he was then secured on stretcher and turned over to Emergency Medical Services (EMS) personnel and then transported to the hospital. Record review of R5, (R2's Roommate), Face Sheet revealed R5 was admitted to the facility on [DATE] with the diagnosis including but not limited to epilepsy, anxiety disorder, major depressive disorder, and insomnia. Record review of R5's Quarterly MDS dated [DATE] revealed that R5 has a BIMS score of 13 out of 15, which indicates that he is cognitively intact. An interview on 05/22/25 at 10:02 AM with R5 revealed that he observed R2 successfully elope from the facility out of their window, in their room a few nights ago (05/19/25). R5 stated that R2 unlocked the window and then kicked the window screen to elope. R5 stated he tried to call for help to get staff to stop him, but it took a few minutes before anyone came. R5 was unsure specifically how long R2 was missing from the facility but stated he was gone for a few hours, and the police had to use tracking dogs to find R2. An observation and interview with R2 on 05/22/25 at 11:47 AM revealed that he was unable to recall recently eloping from the facility. R2 was pleasantly confused, an electronic monitoring device was observed on R2's left leg at this time. A phone interview on 05/22/25 at 12:38 PM with R2's Resident Representative (RR) revealed that the facility notified him of R2's elopement on 05/19/25 at 10:56 PM and was notified that the resident was found on 05/20/25 at 3:00 AM by Law Enforcement officials/facility staff. During the interview with R2's Resident Representative, he stated, R2 has a history of elopement and eloped from his home on 05/10/25. R2 was found by his neighbors, which initiated the resident being hospitalized and then admitting to the facility on [DATE]. The RR then stated that facility informed them that R2's window is now screwed shut to prevent the resident from eloping again. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview was attempted on 05/22/25 at 1:02 PM with R2's Nurse from the night of 05/19/25. However, it was unsuccessful. The voicemail was full and surveyor was unable to leave a message. An observation and interview on 05/22/25 at 1:32 PM with the Maintenance Director revealed that they have placed a barricade at the top of the resident's window to prevent it from opening fully. The Maintenance Director stated that he initiated this intervention on 05/20/25, after the resident eloped from the facility from his window. A phone interview on 05/22/25 at 3:14 PM with Certified Nursing Assistant (CNA)1 revealed that they were working on the night of 05/19/25 when R2 eloped from the facility from out of his window. CNA1 stated, Earlier that evening before R2 eloped, he was attempting to stand without assistance, so staff put him at the nurse's station for supervision to prevent R2 from falling. CNA1 stated that they last observed the resident at the nurse's station with other staff but was unsure of what time specifically. CNA1 stated that she was providing another resident with a shower when she overheard someone call out on the intercom, Code Purple (elopement). CNA1 stated that she was unsure who was specifically assigned to R2, but he was not exhibiting exit-seeking behaviors with her, only that R2 was attempting to stand without assistance. CNA1 stated that staff began to search for the resident both inside and outside of the facility until Law Enforcement arrived at the facility and told everyone to go back inside. CNA1 stated that she was unsure of what time R2 was found and brought back to the facility but was approximately between 2:30 AM - 3:00 AM. Lastly, CNA1 revealed that she was unaware of R2's exit seeking behaviors and she knows to identify residents with elopement risks by observing their behaviors and observing for a electronic monitoring devices. (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 Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 05/22/25 at 3:22 PM, the DON stated that she unaware of R2's history of elopement/elopement prior to being admitted to the facility. DON stated, he was taking out his PICC line a lot, so the Registered Nurse (RN) was checking on him every 15 minutes. She checked on him at 9:55 PM because she heard a noise during this observation, he was opening up a piece of candy. She went back at 10:10 PM. When the RN went to check on R2 again, he was missing, and she observed that the window was open, and the window screen was on the ground outside. I immediately came to the facility and saw that staff were outside looking and calling his name. I could see where the screen was on the ground outside. I got a color photo so the police could look for him. The Administrator was called; I then started looking in the therapy area. His room is facing that patio in that parking lot. I called the police after I called the Administrator. The police told us to stay close so the resident's scent wouldn't get mixed up with our scent. We had some of our staff drive up and down the road to see if we saw him. After the police arrived, they took over the search. We also looked up on the roof to see if we could see him. When we found him, he was behind the therapy center and behind a bush. He took his pants off and rolled it up and used it as a pillow. We did call the RR to let them know about what happened. He got up from lying on the ground. They brought the stretcher to him. He walked to the stretcher and EMS took him to the ER. He returned about 08:30 AM. They found him about 3:00 AM in the morning. I wished the police would have let us continue to search for him in the back. The police got a pair of shoes, so the dogs could smell his scent. The interventions we put into place included getting him a 1 on 1 sitter that is assigned to him at nighttime. During the day, we kept him at the desk. We placed a second lock on the window and a window stop. This prevents him from opening the window. R2 told me when he returned here, he was going to visit his friend. He said, the big house and big money. He told me his friend was in [the next town over]. He told me how he left. He pulled the window out and pushed it. He told my daughter he didn't want his jeans on. So, he put his jeans back on and socks. He told me he seen me and heard me call his name, but he didn't want me to know where he was. He continued his antibiotics with the PICC line. He should be finishing up. So, he will probably get his PICC line out. He told me he put his leg over the air condition unit to get over it. He said he saw us, but it was too many people out there for me. We recently had a meeting with the family members, and it would have been nice to know he was an elopement risk. The son stated he sees people, but he doesn't talk to them. We had the fire department, the police, and [state law enforcement]. It was a lot of people. Our psych services comes in the first Wednesday in every month. We have some people who have a wanderguard on. I asked him why he chose to go out of the window, and he stated that was the fastest way to get out. The nurse checks the wanderguard. The wanderguard has an expiration date. I expect the staff to check the wanderguard prior to leaving the facility, in order to make sure it is in place. It can go on their wrist. The wanderguard is mostly placed on the ankle, and a check is completed by using 2 fingers, to ensure there is proper circulation. The DON stated, We have training on Relias. The rest of the staff is trained. I haven't had 100% training yet., but my goal is to have 100% completed on checking who to call first if an elopement occurs. I want to go in the assessment to make sure they understand what makes them an at-risk person and acting quickly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview on 05/22/25 at 4:21 PM with RN1 revealed that they were the resident's assigned nurse on 05/19/25, on the night shift. RN1 stated, R2 was exhibiting the behavior of standing without assistance and staff had to constantly re-direct him to prevent him from falling. R2 was placed at the nurse's station for supervision related to this behavior. RN1 stated that they asked the resident if he was ready for bed and R2 was agreeable, RN1 assisted the resident to bed and took off his pants then R2 shortly fell asleep. RN1 stated that she was frequently rounding on the resident because he previously attempted to pull out his PICC line. RN1 stated she last observed the resident on 05/19/25 at approximately 10:00 PM and the resident was in bed, now awake and eating a candy bar. RN1 stated that approximately 15 minutes later, she observed that R2 was missing, the window was open, and the screen of the window was on the ground outside. RN1 immediately notified other staff, the DON, and appropriate parties. RN1 stated that R2 was found by Law Enforcement approximately 75 feet from the facility. Law Enforcement recognized the resident from his previous elopement prior to being admitted to the facility and was able to instruct the resident/make him agreeable to returning to the facility. RN1 was unsure of what specific time the resident was located by Law Enforcement but stated it was approximately 2:30 AM-3:00 AM on 05/20/25. RN 1 then stated that they have not worked a shift at the facility since this incident, but an in-service was completed during her shift/after the resident was located by facility staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Administrator on 05/22/25 at 4:50 PM revealed I got a call from nursing on 05/19/25 at 10:25 PM notifying me that R2 was missing from the facility, I live less than a mile from the facility and arrived at the facility shortly after being called. When I arrived, the DON was here, and the police pulled up about the same time that I arrived. The police requested that facility staff enter back inside the building to allow Law Enforcement to take-over the search process. The facility is paved all the way around and the resident's room is tucked in a corner. Then you have a patio, a parking lot and the therapy center. We set up a command center in the parking lot closest to therapy center. Law Enforcement allowed me to go look at R2 room from the inside. Outside, it was already dew on the ground. Law Enforcement brought the dog in from [state law enforcement]. The dog immediately picked-up the footprints, I don't know the timeframe of how long they were out with the dog, but it was approximately 20 minutes. Law Enforcement had difficulty tracking a scent from R2 because there were also deer in the nearby woods and the dogs picked up on their scent as well. Law enforcement had to allow the tracking dog time reset from the different scents, during this time facility staff went on the roof with flashlight to help search for R2. When they put the dogs back out where the sidewalk goes around the building and the Woodline with a few trees [state law enforcement] said I wasn't to look at the Woodline. [state law enforcement] asked me to give them information on R2. By the time we walked to the office they called me and said they got him (R2), and he was in the Woodline, this was approximately 3:00 AM - 4:00 AM (unsure of time) I went out with [state law enforcement] and saw him as he got up without assistance to started walking to be assessed by EMS. Law Enforcement and EMS staff asked R2 if he was hungry, he said yes and he got up and walked out. R2 is alert and oriented, he had times of confusion with the UTI. R2 was taken to the hospital for further evaluation and returned to the facility on [DATE] around mid-day. When R2 returned to the facility, staff interviewed him and asked did her remember what happened/why did he exit the facility. In interview with facility staff (nurse and therapy) R2 stated I wanted to leave; I got up put my clothes on and step out of the window. I wanted to go to my friend's house. When I got out, he said it was too far. The Administrator stated, During an interview with the resident, staff questioned R2 about the reasoning behind leaving the facility from the window and R2 stated that he heard staff calling his name and saw people looking for him, but he didn't want to be found. R2 is a conscious person, he knew he couldn't go out of the door because he had an alarm on (electronic monitoring device). R2 left the facility Against Medical Advice (AMA), and I don't consider this an elopement because residents have a right to make decisions to discharge/leave. Eloping is when they (a resident) do not know what they are doing. R2 consciously decided upon himself to leave the facility from the window and told facility staff what he did/demonstrated to staff how he exited the facility. R2 also consciously avoided Law Enforcement and facility staff by rolling in the ground to avoid the tracking dog from picking him up. After the incident, we met with R2's Resident Representative for a Care Plan meeting and were informed by his RR that the resident has had other attempts to elope/leave his home. We have now put a window stop in R2 window, and we keep him out of his room as much as possible during the day at the nurse's station for supervision. At night, we have someone sitting with him for supervision. R2 had an electronic monitoring device placed on him on admission because he made a comment to staff that he wanted to go home. Lastly, the Administrator stated, The facility was unable to prevent the resident from leaving the facility because he made the decision to leave on his own because the resident's decisions were calculated (avoiding Law Enforcement, tracking dogs, facility staff, etc.). A phone interview on 05/23/25 at 11:57 AM with Medical Doctor (MD1) revealed they assessed R2 on admission and R2 spoke about wanting to go home. R2, on admission, was oriented x 3 (aware of name, location, approximate time). MD1 later stated that he was not included in the decision to place an electronic monitoring device on R2 related to his wandering and that was a facility staff decision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425054	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - Laurens	379 Pinehaven Street Extension Laurens, SC 29360

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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	An interview on 05/23/25 at 12:40 PM with R2's Social Worker (SW) revealed On admission, R2 had a BIMS of 12 (moderate cognitive impairment) initially, but when I spoke with R2 after the incident (elopement), his BIMS was a 10 (moderate cognitive impairment). The next day, I spoke to R2 and his BIMS was back to a 12. In conversations with R2, he spoke about wanting to go home, R2's Resident Representative is now looking into placing R2 on a locked unit after he discharges from the facility, due to his wandering/exit seeking behaviors and history of elopement. Prior to admission, R2's Resident Representative supervised R2 by bringing him to work daily. The SW indicated, Our discharge plan is currently to assist R2's RR with home health services, if they are not able to find a locked/secure unit for R2. A phone interview on 05/23/25 at 2:03 PM with MD2 revealed that they were notified of R2's elopement at 2:00 AM and that staff and the police department were searching for the resident in the woods. MD2 stated, R2 has a history of exit seeking/elopement behaviors and facility staff notified him appropriately when the resident was located. The facility's removal plan for the IJ related to F689 included Immediate Actions Taken: 1. Implemented 1:1 supervision for this resident when he is not in group settings. Implemented upon his return to the facility on Tuesday, 05/20/25 and will remain for this resident for the duration of his stay at [the facility]. Compliance will monitored by Department Heads along with the Administrator and Director of Nursing. 2. Installed a double lock/window stop system on his patient room window to increase safety. The system was installed at 8:10 AM on 05/20/25 (prior to the resident returning to the facility). Window lock/stops will be checked for proper operation twice daily for the duration of R2's stay at the facility. The lock/stop system has been installed on all patient room windows and will be monitored quarterly. Compliance will be monitored by the Director of Plant Maintenance. 3. Reeducated the staff on the facility's Emergency Procedure for a Missing Resident. education began during and immediately after the search on 05/20/25 and concluded on 05/23/25. Education will continue for all employees quarterly on each shift. Compliance will be monitored by the Department Heads along with the Administrator and Director of Nursing. 4. A Quality Assurance Performance Improvement (QAPI) was initiated on 05/20/25 to ensure that R2 and other facility resident have appropriate supervision and assuasive devices in place to prevent accidents, especially those with exit seeking behaviors. Compliance will be monitored by Department Heads along with Administrator and Director of Nursing.